OPUS 2

Scottish Covid-19 Inquiry

Day 1

October 24, 2023

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(10.00 am)

Opening statement by THE CHAIR

THE CHAIR: Good morning and welcome to the first session of the Scottish COVID-19 Inquiry's substantial evidential hearings, which will focus on the health and social care impacts of the pandemic.

I wish to begin by reiterating my sincere condolences and those of the Inquiry team to those who lost loved ones to COVID-19 and our sympathy to the many people who have been and continue to be affected by the pandemic. I am aware that some people experience physical and mental health issues after contracting COVID-19 and continue to suffer from those long-lasting impacts. For the families of the bereaved and those still living with COVID-related conditions, the pandemic's legacy will never end. We extend our deepest sympathies.

During our Health and Social Care Impact Hearings, we will hear from some of the people most profoundly impacted by COVID-19. Witnesses will include bereaved family members, care home relatives and people who were required to shield because of underlying health conditions. We will also listen to the accounts of others who continue to suffer the pandemic's

consequences, such as people with long COVID and those who were unable to receive the urgent medical treatment they required because of the pressures the pandemic placed on the NHS.

In addition, in the next phase of hearings commencing in February of next year, we will hear the accounts of key workers, including front-line health and social care staff, who did all they could to try and alleviate others' suffering, at times putting their own health at risk. These hearings will give a voice to all of these people. Their experiences will help inform the Inquiry's ongoing investigations, including into the decisions taken by Scotland's leaders, which we will turn to at a later date.

As I have said previously, the Inquiry team is resolutely committed to conducting a robust investigation without fear or favour. We will not take sides and we will act with fairness towards everyone involved. By delivering a robust independent inquiry with a clear set of recommendations, we hope to reduce suffering and deaths in the event of any future pandemic and prevent others from having to experience the distress and sorrow which COVID-19 caused.

I should remind you, however, that the Inquiry is not a court. It cannot make any findings of civil or

criminal liability nor is it set up to be able to award any compensation. Giving evidence at a public inquiry will be daunting for many of those involved, particularly for those grieving for loved ones and others living every day with the legacy of COVID-19. I would like to thank everyone who gives evidence to this Inquiry for their courage, commitment and public service, for which we and the Inquiry are all immensely grateful.

We recognise that, for some witnesses, being asked to re-live traumatic experiences can be extremely challenging, which is why the Inquiry has adopted a trauma-informed and human-rights-based approach in conducting both its investigations and hearings.

We have set aside a dedicated room at Regus Princes Street for use by any attendees who are upset or distressed during the proceedings and need to take time out of the viewing room. We also have dedicated private rooms for witnesses at George House. Inquiry staff trained in trauma-informed practice will be available here and at our viewing room at Regus Princes Street to provide emotional support and signposting to specialist organisations. A CRUSE Scotland bereavement counsellor is also available at both venues. In addition, we have published on the Inquiry website a list of independent

organisations which can provide support to people affected by the pandemic. If you require any assistance while attending the hearings, please speak to a member of Inquiry staff, who can be identified by their orange lanyards.

My aim is to report as soon as possible, while ensuring the Inquiry conducts a robust and thorough investigation. This means that by necessity we have to limit the number of witnesses who will give evidence. In discussion with core participants' legal representatives, to whom we are grateful, we have sought to bring forward the accounts of people whose experiences are representative of the issues and themes the Inquiry will investigate.

Through Let's Be Heard, our listening project, we are encouraging as many people as possible to share their experiences of the pandemic in Scotland with us, to tell us how they were affected and to share the lessons they believe should be learned. You can find out more about Let's Be Heard on the Inquiry's website.

I wish to assure you that everyone's experience is valued and all information shared with us will be analysed and will inform our reports and recommendations. We anticipate that the Inquiry's Health and Social Care Impact Hearings will conclude in

spring 2024. However, with a public inquiry of this unprecedented breadth and scale, it may be the case that we will need to revisit this and other timescales.

I am joined today by several Inquiry colleagues who will be assisting me during the course of these Impact Hearings. Stuart Gale KC, who is sitting in front of me and has just nodded in acknowledgement, is co—leading counsel to the Inquiry, Alan Caskie KC, who is sitting behind him, is senior counsel to the Inquiry and Gordon McNicoll is the interim solicitor to the Inquiry, and he's the gentleman who is not nodding at you —— but has now. Mr Gale and the counsel team will be responsible for questioning witnesses during our Health and Social Care Hearings.

However, before Mr Gale begins, I wish —— in fact I think I have to share a few housekeeping points with you. We have shared witness statements in documentary bundles with core participants who have an interest in health and social care and who I have granted leave to appear. These will be published on the Inquiry's website, where we will also publish transcripts of our hearings. Any directions or orders, including restriction orders that I have made or will make in the future, will also be published on the Inquiry's website.

Ordinarily hearings will begin at 10 o'clock and run

until approximately 4.00 pm. There may be occasions when hearings begin earlier than 10.00 am and I would ask you to please check the hearings calendar on the Inquiry's website for details or follow our social media channels. All attendees should arrive in good time to be seated in the hearing room for the start time. We will break for lunch at about 1.00 pm and there will be a short morning and afternoon break.

The health, safety and well—being of all those attending the hearing is a priority for the Inquiry. Hand sanitiser and disposable face coverings will be available for use by all attendees who wish to avail themselves of that. The hearing room is ventilated by mechanical means, with capacity managed to meet the British Council for Offices standards. I would also ask that if you are feeling unwell, you please do not attend and follow the hearing via the broadcast on the Inquiry's YouTube channel, if you are able to.

Eating and drinking is not allowed in the hearing room, except for water. Smart phones and other electronic devices are allowed, though they should be on silent mode at all times while you are in the hearing room. You should not make or accept private calls, take photographs or make video or audio recordings in the hearing room at any time. Hearings should proceed

without disruption or interruption. Anyone attempting to disrupt a hearing may be required to leave the venue.

Inquiry proceedings are broadcast on the Inquiry's YouTube channel where they may also be viewed and watched on demand. Video cameras are located at the rear and sides of the hearing room and face the front. You should be aware that members of the public attending our hearings may be captured occasionally on wide angle or room overview camera shots. To assist with the video recording and transcriptions, I would ask all parties to state their names when addressing the Inquiry, speak clearly into the microphone and not to speak too quickly.

I will now hand over to Mr Gale KC, who will provide more detail on how we intend to conduct these hearings. Mr Gale.

Opening statement by MR GALE, Co—lead Counsel to the Inquiry

MR GALE: My Lord, thank you and good morning, and good morning to everybody in the room. Good morning to everybody who is listening to us and watching us on our online service.

As will be appreciated by your Lordship, together with everybody else here today and watching us, today is a significant milestone in the progression of this Inquiry. Today and tomorrow we will hear opening

statements from core participants with leave to appear in this section of the Inquiry and on Friday of this week we will commence our first evidential hearings. These will continue until the week ending Friday, 8 December. There will then be a pause in our proceedings and in January of next year the UK Inquiry will be conducting hearings in Scotland. This Inquiry will resume in February next year and, as my Lord has said, will continue until Easter of next year in these hearings.

In the hearings between now and Easter we will hear from those who have been impacted in Scotland by the pandemic and its consequences. The focus is on the impacts and health and social care. As we previously stated, the Inquiry took a deliberate and considered decision to commence its investigative work leading to our first evidential hearings by considering the impacts that the strategic decisions taken by the Scottish Government and implemented by it, its agencies and others, had upon the population of Scotland, all within the Inquiry's terms of reference.

At the risk of some repetition, I would like to reiterate the rationale behind that decision. The strategic decisions taken during the pandemic affected everybody in this country. They placed restrictions on

our lives that had not been previously experienced during peace—time. The former First Minister said on 23 March 2020 —— and I quote:

"For everyone, you must stay at home unless it is absolutely necessary to go out and that includes working from home wherever possible."

The restrictions which followed on from that broad instruction, whether they took the form of legislative directions or guidance, had an ongoing effect on our lives for the next two and a half years. In that period, politicians, decision—makers and implementers had to act in circumstances of developing and fluctuating urgency, having regard to novel and distressing circumstances. As your Lordship said in the preliminary hearing which was held on 28 August of this year —— and I quote:

"The COVID—19 pandemic presented the most serious public health crisis in living memory. It affected everyone."

So why impacts? It appeared to us in the Inquiry team that to properly understand both the decision—making and the implementation of those decisions, we should consider them having regard to the impacts which they had. The Inquiry did not subscribe to the view that impacts were matters apparent to us

without further examination. Consideration of the statements that the Inquiry has taken and the information that it has gathered has reinforced us in that view. The detail and nuances of the impacts have informed us and will be used by us when we come to examine the decision—making process and, in particular, whether the impacts and their adverse effects could and should have been anticipated and factored into the decision—making process and the implementation of the decisions.

Recently I noted in a statement an observation by a health professional that there required to be —— and I quote —— "a better understanding of vulnerable groups and their needs. The soft stuff (emotional and spiritual care) is important, and we really only focused on the hard stuff".

In addition, we've obtained a statement from Dr Jennifer Burns, who I will refer to in more detail in due course, and in her statement she says this:

"If there is another pandemic, it is likely to have similar impact on older people and those with other vulnerabilities."

She goes on:

"The need is to ensure a balance is achieved between protecting care home residents from a virus that could

be fatal to them and also protecting the human rights of individuals to see their families and loved ones. Planning for the response to a pandemic should involve experts on the population most affected by the illness in question at the earliest possible stage."

That seems to us to encapsulate a very significant issue which this Inquiry needs to address. The Inquiry has also issued, as my Lord has said, a policy statement on our trauma—informed and human—rights—based approach. At paragraph 11 of that statement we say that, in line with that approach, we took the decision to begin public hearings with evidence that the impacts of the pandemic had on people, giving a voice to those who are most affected. Again with the benefit of having read many statements, we hope that for some witnesses there will be a cathartic relief in expressing their accounts of deeply distressing experiences in public and to this Inquiry, knowing that it will form a public record of those experiences.

We also recognise for many people who will be giving evidence to us in these Impact Hearings that they would rather be in any place but here, that they could have avoided the tragedy and the circumstances that have brought them here. The Inquiry is extremely grateful for all those witnesses who have given their time and

consideration to engage with us.

Can I indicate at this stage that the Inquiry's investigations have been informed by material from a number of sources. The Inquiry team has worked tirelessly over the past month in assembling that information and I would want to pay tribute to them all for their work.

Members of the public have communicated directly with the Inquiry in conveying information. Other members of the public have engaged with the listening arm of the Inquiry's operation, Let's Be Heard. Other members of the public have engaged with us through organised groups and, in particular, I would like to thank the Care Home Relatives Scotland group and their solicitors, Thompsons, and the Scottish Covid Bereaved and their solicitors, Aamer Anwar & Co, for the assistance which they have given the Inquiry in identifying witnesses and arranging for the Inquiry's team of statement—takers to have access to those witnesses.

The ultimate decision as to which witnesses provide oral evidence to the Inquiry is mine. These decisions have not always been easy and the aim, so far as I have been concerned, is to identify those witnesses who will give oral evidence so as to provide a broad range of

evidence of impacts. I would, however, as my Lord has already done, like to emphasise to everybody who has provided information to the Inquiry but who has not been asked to give oral evidence, your information is important to us and will be considered by us.

Also, in connection with the health and social care portfolio, I would like to mention the academic research that the Inquiry has commissioned. Introductory academic research was published on the Inquiry website in June 2022. That research covered the period up to April 2022. Given the terms of the Inquiry's remit, reports for both Portfolios 1 and 3 —— 3 is the Health and Social Care Portfolio —— have been updated to cover the period up to 31 December 2022 and these were published on our website last week.

In addition, the Inquiry has received from Professor McKay and his team at Napier University the first draft on the provision of social care support, including the management and support of staff and the recognition, involvement and support of unpaid carers. The final draft of that report is expected shortly.

Other areas of ongoing academic research include research into the impact of the pandemic on refugees and asylum seekers and the impact of the pandemic on women and girls. These reports are those which have relevance

to Portfolios 1 and 3. Further research has been carried out in relation to Portfolios 2 and 4 and will be available on the Inquiry website in the forthcoming months.

I would like to also give an update on the work of the Inquiry's Let's Be Heard project. Its national engagement phase began on 23 May of this year, with the aim of encouraging the Scottish public to share their experience of the pandemic, to describe the impacts which the pandemic had and to provide views of the lessons they think should be learned. Let's Be Heard has had almost 4,000 responses from individuals and groups from across the country. The national engagement phase has been extended until 20 December of this year and the Inquiry would like to thank everyone who has taken part so far for their invaluable contribution to the Inquiry's understanding of matters across the board.

Over the previous months, the Let's Be Heard team has been involved in over 50 events across the country. They have also supported group discussions, with a range of people on different topics, such as unpaid carers, people living with dementia, women who were pregnant during the pandemic and those persons with sensory impairments. Let's Be Heard has heard from people in every council area in Scotland and there has been

a particularly strong response from working—age Scots.

Those who have responded have offered a depth and richness of experience on themes such as the trauma of bereavement, separation from loved ones, how lockdown impacted mental health, both positively and negatively, the crucial role played by key workers and how school closures affected children's education. To extend the range of information received, Let's Be Heard would particularly welcome hearing more directly from children and young people so that adults aren't speaking on their behalf. Further communication from people of retirement age as well as from men and from those who are less financially secure would be appreciated.

Geographically, Let's Be Heard has heard proportionately less from people in North Lanarkshire, South Lanarkshire, West Lothian, Renfrewshire and Glasgow City. It is also seeking further insight into the experiences of people across the Highlands and Islands and is also keen to hear from people from a diverse range of ethnic and religious backgrounds, people born outside the UK and Scotland as well as people whose first language is not English. The Inquiry wishes to ensure that all your views are heard by us.

In addition, the Inquiry has followed carefully the hearings in the UK Inquiry and is mindful of our

obligation not to duplicate material with that Inquiry.

Turning to the timetable. Our hearings will commence on Friday this week and will continue next week, when we will present evidence from a number of witnesses speaking as representatives of organisations that have advised and supported people during the pandemic. In assembling information, it appeared to us that the Inquiry would benefit from hearing from those who saw at first hand the effects of the pandemic and the strategic decisions that were taken on wider groups of individuals.

We will hear first from Jane Morrison on behalf of the Covid Bereaved Scotland group. She will speak movingly about the loss of her wife, Jacky, from COVID and provide us with detailed observations of both good and bad practices gleaned from her experiences and from those of members of the group who have encountered bereavement during the pandemic in various circumstances. She will also discuss prolonged grief disorder in the context of a loss during the pandemic.

We will also hear from four core members of the Care Home Relatives Scotland group, a group that was established during the pandemic with the aim of enhancing the quality of life of loved ones who were resident in care homes by working to achieve the

resumption of essential family contact. In particular, we will hear the efforts to secure Anne's Law. I think it's useful if I just indicate what those objectives are. They are that every care home resident should be entitled to have meaningful contact with one nominated person despite any type of lockdown the care home experiences; that the nominated person has to be recognised as a partner in care and trusted to access the care home in the same way as staff do; recognition that the nominated person is there to provide emotional and well-being care, something that a member of staff cannot offer as much as we know they may try to do so; to recognise that many people residing in care homes have complex needs and that allowing one nominated person to have meaningful contact can and will ease distress for both of them and their families; and finally to recognise that a nominated carer would also help to support the work of care staff. We will also see how the present legislative proposal on that matter fits with those objectives.

Next week we will also hear from two witnesses, Henry Simmons, the chief executive of Alzheimer's Scotland and Dr Jennifer Burns, who I mentioned earlier. Dr Burns was the president of the British Geriatric Society for the period of the pandemic up to her

retirement at the end of November 2022. They both have particular expertise in supporting those with Alzheimer's and dementia and those in need of more general geriatric care. These witnesses will assist the Inquiry in understanding dementia and frailty.

Your Lordship may remember that he raised the issue of frailty when Dr Croft gave evidence -- it's Day 2 of Dr Croft's evidence at page 35 of the transcript -- and the evidence of Dr Burns assists in understanding frailty. Both Dr Burns and Mr Simmons assist in our understanding of the complexities and the various stages of Alzheimer's and dementia from diagnosis. This assists us in setting some of the evidence that we'll hear from relatives and loved ones in context.

If there is one thing that comes out from reading many of the statements, it is that for some whose loved ones suffered dementia, there had already been a loss of the person they knew. Coincidental with my involvement with this Inquiry, I heard what I thought was a very insightful song written from the perspective of a woman whose husband was a resident in a care home, suffering dementia. In the song they had -- and I quote -- "moments when clarity reigned", but a particular line from that song came to me many times as I read the various statements. It was that:

"Surgery leaflets offer advice, but there's no preparation for losing him twice."

In the course of next week we will also hear from Sara Redmond, who speaks on behalf of the Health and Social Care Alliance Scotland, which is the national third sector intermediary for health and social care. We will also hear from Tressa Burke of the Glasgow Disability Alliance, an organisation which has over 5,500 members and which is now a leading example of a grassroots community driving improvements in the lives of disabled people.

We will hear also from Dr Marsha Scott, who is the chief executive of Scottish Women's Aid, who will provide a statement, together with Catherine Murphy of Engender, on behalf of five organisations: Scottish Women's Aid, Close the Gap, JustRight Scotland, Rape Crisis Scotland and Engender, who together are referred to as "Scottish Women's Rights Organisations".

We will also hear from Helen Goss, who is the chief operating officer of Long Covid Kids Scotland, and the Inquiry has previously announced, having taken legal advice on the matter, that it would look at the healthcare impacts of long COVID where those potentially affected the strategic response to the pandemic.

Thereafter, we will embark on our detailed

examination of individual impact statements. In the period from early November until 8 December we will hear from members of the Care Home Relatives Scotland group, the Skye Care Home group, the Scottish Covid Bereaved group and from individuals who are not part of any organised group. Next year, when we resume our hearings in February, we will hear from organisations who supported those who were employed in the health and social care sector and from individuals who will speak to the personal impacts. We will also hear from unpaid carers. We will hear from those who were impacted in the hospital setting and those impacted in the community. We will also hear from particular groups who were impacted by the pandemic and its circumstances: refugees and asylum seekers; those who are homeless; those who are drug- and alcohol-dependent; those who are in prison and custody; those from ethnic and minority communities. We will also hear from Long Covid Kids and those who have been impacted having been vaccinated. We will also hear from representatives of those who are in receipt of end of life and palliative care.

In considering all the statements that we have received, a number of common themes do emerge. In particular we will hear from witnesses of the emotional trauma of bereavement during the pandemic. Death

occurred in different locations and in varying circumstances. Jane Morrison puts it this way when she's talking of the bond that exists between those who have experienced bereavement. I quote:

"I think we've all found out that bereavement during a pandemic is a very different thing from, for want of a better expression, normal bereavement. People were denied the opportunity to be with loved ones in the times before and the moments of their passing and then in the period after death, all at times when comfort was most needed. There were restrictions on funeral services and, in particular, restrictions on the numbers attending; the inability of families to grieve together and to offer mutual comfort; the difficulties presented by the restrictions with what should otherwise have been the relatively straightforward arrangements in the period after bereavement."

The harsh reality of bereavement is conveyed by the number of deaths. As at 15 October, just over a week ago, a little more than a week ago —— and this is the most recent date for which figures are available —— the number of deaths in Scotland in which COVID—19 was mentioned was 18,037. As at the same date, the number of deaths where COVID—19 was the underlying cause was 14,272. There have been frequent observations made by

witnesses regarding the confusion they experienced in navigating their way through the legislation and the guidance which regulated the contact that they could have with loved ones. Of particular concern was the often rapid and sometimes contradictory changes. We will hear of inconsistencies in the applications of rules and guidance across different settings at the same time and indeed, on occasions, within the same setting.

Many witnesses speak of the need for proper considered and compassionate communication. This was necessary in all situations where those in charge of the care of an individual were communicating with that individual and with loved ones. In particular it was necessary in the circumstances of end of life care and the use of do not attempt cardio—pulmonary resuscitation notices.

Other common themes include the following:

The impact of social isolation and loneliness, which was particularly acute when an individual's cognitive functions were impaired.

The difficulties of communicating through windows and by way of hand—held devices.

Relationships between family members and their loved ones were adversely impacted, particularly where those were people with dementia or impaired cognitive

abilities and they experienced frustration in not understanding the reasons for the restrictions.

Where an individual was cared for at home with family members or they were otherwise in the community, their carers, who were often unpaid, were placed under increased and sometimes intolerable stress.

Family members witnessed the mental and physical deterioration of their loved ones, deterioration which they frequently put down to isolation and its accompanying circumstances. Frequently there were feelings of helplessness, feelings of frustration, of anger, of guilt and inadequacy on the part of family members. Family members and carers themselves suffered adverse impacts on their mental and physical well—being.

Changes in care routines were frequently abrupt and unexpected, from home or otherwise in the community to care homes, from care homes to hospitals, from hospitals to care homes.

Concerns were frequently expressed about the availability of treatments for ongoing conditions.

There was also a lack of respite for carers, leading often to carer exhaustion.

In the forthcoming weeks the Inquiry will hear distressing accounts of enforced separation from loved ones, the effects that isolation had on people, whether

they were in institutions or in their own homes, whether they were young or old, whether they were capable of comprehending the circumstances or not. The nature and extent of those impacts are largely presented by their family members and friends who viewed the impacts from the outside. Of particular force is the evidence from loved ones who had to deal with the impact on elderly relatives and, in particular, those who were affected by dementia.

Witnesses express in varying ways their frustration about their inability to have meaningful contact with their loved ones. Many, but not all, of those suffering from dementia were elderly and frail. In the famous soliloquy in As You Like It, spoken by Jaques, and begins "All the world's a stage", it talks of the seventh age of life and the faculties that leave or diminish in that age. What is apparent from many of the statements the Inquiry has received is that in the time of the pandemic many in the seventh age of life spent their days sans the comfort, the compassion and the understanding that would normally come from contact with their families and loved ones.

As we embark on these hearings, on behalf of my counsel team, the wider Inquiry team and myself, I take this opportunity to convey to all those bereaved and to

all those who have suffered during the pandemic and those who continue to suffer our sincere and genuine condolences and sympathies.

Thank you, my Lord.

THE CHAIR: Thank you very much indeed. Now, we will turn to opening statements on behalf of the core participants. We will hear firstly from the Scottish Ministers, who I understand is represented by Mr Geoffrey Mitchell KC. If you can come forward now. Can I say while Mr Mitchell is coming forward, you are all aware that you have been allocated 20 minutes each and the reason for that will be pretty obvious. We have a fair number to get through and, as a matter simply of expedition and efficiency, we have had to limit you to 20 minutes. I don't want to sound rather headmasterly, but I'll keep you to 20 minutes, and if that means cutting you off in mid-flow, I will. I'm sure I won't have to.

With that admonition, Mr Mitchell, please.

MR MITCHELL: Thank you, my Lord.

Opening statement by MR MITCHELL
for the Scottish Government

MR MITCHELL: Good morning, ladies and gentlemen. This is the opening statement on behalf of the Scottish Government. I appear today along with

Kenneth McGuire, Advocate. We are instructed by Caroline Beattie of the Scottish Government Legal Directorate.

I would like to thank the Inquiry for granting the Scottish Government leave to appear at these hearings and for the opportunity to make these opening remarks. As the body that was responsible for steering a path for Scotland through the pandemic, the Scottish Government is well placed to explain the strategic decisions during that time. Those decisions are not, however, the immediate focus of the Inquiry. The focus of the current hearings is the impact of the pandemic on and experienced by those within the Scottish health and social care sector. The Scottish Government is too well aware of the loss and suffering experienced in that sector and of course in Scotland as a whole.

Today, on behalf of the Scottish Government, I would like to recognise that loss. All of Scotland suffered, yet undeniably some suffered far more than others. Thousands lost their lives and their families and friends continue to grieve. The health of many individuals has been affected in innumerable ways. Many people lost their jobs whilst living circumstances of others were affected in countless different ways. Children and young people, often thought to be less

susceptible to the virus than adults, nevertheless suffered greatly also. Further, many people continued to work through the pandemic in extremely challenging circumstances.

This pain, suffering, sacrifice and endurance is recognised, understood and acknowledged by the Scottish Government, yet recognition, understanding, acknowledgement are plainly not sufficient. The Scottish Government understands that legitimate questions arise as to whether the suffering needed to have been so great. This was one of the reasons that the Scottish Government established this judge-led statutory Inquiry into the handling of the pandemic in Scotland. It was also one of the reasons why, when the Inquiry was first established by the former First Minister, Nicola Sturgeon, she emphasised that it would take a person-centred, human-rights approach. Indeed, one of the Inquiry's terms of reference is "To demonstrate how a human rights based approach by the inquiry has contributed to the inquiry's findings in fact and recommendations".

The Scottish Government understands that the most meaningful and genuine way to recognise the loss suffered is to listen to the evidence and to learn lessons from it. To that end, it is important, as

I stress, that the Scottish Government is fully committed to the Inquiry process, to the Chair and to the people of Scotland. That commitment is to assist, to cooperate fully and openly, to listen and to learn. I recognise that, for some people, the giving of evidence at these public hearings will be a difficult experience. I can reassure any such person that their evidence will be listened to by the Scottish Government with great respect and consideration.

I should firstly make clear one important point. That is the distinction between, on the one hand, decisions made on health and social care during the pandemic by the UK Government and, on the other hand, those made on behalf of the Scottish Government. This is relevant since, as we know, Module 2 of the UK Covid-19 Inquiry is currently hearing evidence that relates to the UK's core political and administrative decision-making in relation to the pandemic between early January 2020 until February 2022. This will doubtless include evidence on decisions taken by the UK Government in relation to health and social care in England.

The important point is this: public health, the NHS, social care and social services are generally devolved matters in Scotland; that is, in Scotland, the

Scottish Government has primary responsibility for and the powers necessary to make decisions in these areas. Given the widely varying geographical and epidemiological circumstances across Scotland and conscious of the need to balance the impact on social and economic activity of measures necessary to suppress virus transmission, the Scottish Government took the approach of tailoring restrictions to local circumstances. The Scottish Government, where possible, worked in partnership with a number of bodies, including, for example, NHS boards, the Centre of Sustainable Delivery and Public Health Scotland. The decisions that it took in these areas were always taken in the interests of people in Scotland.

I turn now to the issue of impact in the area of health and social care and begin by setting out in a little more detail the ways in which the impact was felt. The entire health and social care system was affected in multiple and varied ways. Structures, services, processes and organisations were all impacted. Most importantly, however, the impact was felt by individuals, also in multiple and varied ways. Factors such as COVID-19 infection control requirements, the redeployment of staff, the ability of hospitals to provide the capacity to treat COVID-19 patients, delayed

discharges and COVID 19-related staff absences all had a detrimental effect on the system and, consequently, on individuals. Some people were reluctant to seek medical help for fear of contracting the virus. Some adult screening programmes, for example, for the detection of cancer, were paused during the pandemic. Some of the impacts continue to be felt. For example, there has been an increase in waiting times for certain medical treatment.

The impact on the social care sector was severe. Deaths that occurred in care homes and that were attributable to COVID-19 accounted for a significant percentage of all COVID-19 deaths in Scotland. Visiting restrictions caused great hardship for residents and families. The suffering of residents and the continuing pain of their relatives is palpable. Evidence on these issues will surely and understandably figure prominently in these hearings.

The pandemic affected the health and social care workforce. In jobs that were already demanding and that carried high levels of responsibility in any event, the pandemic presented further challenges of stress and fatigue for hospital and social care staff. Their roles were further complicated by the shortage at times of personal protective equipment or PPE, when unprecedented

demand placed strain on the distribution mechanisms.

There has also been an impact on the health of the Scottish people in a variety of ways. For example, in addition to illness and death caused directly by the virus, the mental health of the population suffered. The full impact of long COVID has yet to be fully understood and pre-existing health inequalities were exacerbated. Truly the full effects of COVID-19 have yet to become clear.

The Scottish Government is fully committed to the recovery of the NHS and the social care system to its pre-pandemic level and beyond. The detail for recovery will no doubt be dealt with in future hearings, but I shall briefly mention three aspects: first, the NHS Recovery Plan of 2021 to 2026 sets out how the Scottish Government will address the backlog in care, meet the ongoing health needs of the population, enhance primary and community care and enhance well-being support; second, an early example of recovery planning was the Scottish Government's Mental Health Transition and Recovery Plan. Published in October 2020 and backed by £120 million of investment in recognition of the negative impact of the pandemic and associated restrictions on people's mental health, coupled with the limitations it placed on clinical services, the

Scottish Government expanded the range of support available from public messaging to new digital services; third, a further early example of recovery planning was the report "Coronavirus (COVID-19) initial health and social care response: lessons identified", focusing on the period March to September 2020. The report examined what worked well and what improvements could be made so that Scotland was better equipped for an ongoing recovery and remobilisation plans.

I turn now to the Four Harms approach. Standing the focus of the current hearings, it is not appropriate to explore strategic decision-making. However, the Scottish Government does consider that, if the Inquiry is to hear evidence about impact, it should have an understanding of the principles that were applied to decision-making in an attempt to manage that impact. What I propose to do is briefly explain to those listening not the decisions themselves but, rather, the steps that were taken to minimise the impact or harm suffered during the pandemic.

COVID-19 posed an unprecedented systemic threat not only to the health of those susceptible to infection but also to healthcare systems, economic activity and wider society. The Scottish Government's strategic aim in dealing with the pandemic and in particular in the

development and use of non-pharmaceutical interventions or NPIs was to minimise the overall harm of the pandemic through the whole of Scotland, not merely in the urban areas but also in the most rural and remote areas where people live. In April 2020, building on the "Coronavirus: Action Plan" that had been published by the four governments of the UK, the Scottish Government explained the way it would take future decisions on its pandemic response in a document entitled "The Framework for Decision Making". This document sets out the Scottish Government's principles and approach to dealing with the pandemic, particularly in relation to the use of NPIs.

A key part of the approach described and enshrined within the framework was to marshall the many and various harms of the pandemic into four categories or "harms". The concept of "Four Harms", as the strategy became known, was that broadly speaking the pandemic and measures in response to it could cause harm in four areas, namely:

Firstly, direct COVID-19 health harms. Primarily this is the mortality and morbidity associated with contracting the disease.

Secondly, the broader health harms. Primarily this is the impact of the effective operation of the NHS and

social care services associated with large numbers of patients with COVID-19 and its consequential effects on the treatment of illness.

Third, social harms: the harms to our wider society in terms, for example, of education attainment as a result of school closure.

And fourth, economic harms; for example, through the closure of businesses and workplaces.

Indicators chosen as representing key aspects of each harm were reported on an online portal called the "Four Harms Dashboard" to support understanding of the impact of the pandemic across the Four Harms. This included key indicators on the direct health impacts, such as trends in COVID-19 hospital admissions as well as wider impacts on health and social services, societal impacts and economic impacts, such as the number of accident and emergency admissions and planned hospital admissions.

I must emphasise that equalities impacts and issues of fundamental human rights were considered alongside the Four Harms. Inequalities were regarded as a factor within each of the Four Harms. This ensured that equality issues were included within the assessments made of each of the Four Harms and not viewed in isolation of the other factors. This approach is

consistent with the aspirations of the Scottish Government both before and after the pandemic to build equality into policy-making across all areas of government.

The complexity of the systemic challenge posed by the rapid spread and evolution of the COVID-19 virus meant that there was no single or individual correct response. The Scottish Government had to address an alarming situation that posed a threat to the whole of society. It had to calibrate its decision-making to address multiple issues, often under great time pressure. It quickly became apparent, given the nature of the challenges posed by the virus, that there were few, if any, harm-free decisions open to governments, including the Scottish Government. Measures designed to curtail the spread of the virus reduced the direct health harm, but, on the downside, risked causing isolation and loneliness, economic upheaval and disruption to education. On the other hand, a decision not to impose or lift restrictions might be said to lessen wider harms but only at the risk of possibly increasing harm to health.

The Four Harms were interlinked and this was well understood by the Scottish Government at the time. For example, an increase in employment and poverty would

have, over time, both physical and mental health implications. The challenge was for the Scottish Government and other governments to balance risks and benefits and take decisions to reduce overall harm as much as possible.

In conclusion, let me repeat and reaffirm something that I said at the outset of this statement, that the Scottish Government will listen to the evidence given at these Impact Hearings with great respect and consideration. The Scottish Government is committed to learning from that evidence. The Scottish Government is grateful to the Chair, my Lord, for the opportunity to make this opening statement and my team and I hope that we can be of assistance to the Inquiry in the weeks to come.

THE CHAIR: Thank you very much indeed, Mr Mitchell.

Now, ladies and gentlemen, actually a little ahead of time, we will take the break now, which will be for 20 minutes. So we'll come back not at 11.30, as the programme says, but at 11.20, where we will hear from Care Home Relatives Scotland, who I think are represented by Ms Galbraith KC. So 11.20. Thank you very much.

(10.59 am)

(A short break)

(11.20 am)
THE CHAIR: Now, when you're all ready, if you please, Ms Galbraith.

Opening statement by MS GALBRAITH

for Care Home Relatives Scotland and CHRS Lost Loved Ones

MS GALBRAITH: Good morning. My Lord, I represent Care Home Relatives Scotland and CHRS and CHRS Lost Loved Ones, which I will hereinafter refer to as "CHRS".

As at March this year, around 40,000 of Scotland's population lived in residential care homes: children, husband, wives, grandparents. The community is very diverse in terms of age and range of disabilities. All are individuals with thoughts, feelings, memories, family bonds and, crucially, the same rights to life, equality and dignity as those in wider society.

On behalf of CHRS it is submitted that during the COVID-19 pandemic, residents in care homes and their relatives suffered an unnecessarily disproportionate impact on their lives which left them at times feeling isolated, unheard and discriminated against. CHRS recognises the challenge presented by the COVID-19 pandemic. However, it asks this Inquiry to consider carefully the very particular impact experienced by those in care homes and their relatives as a consequence of the restrictions imposed. Many of these impacts are

still being felt today, when the rest of society has returned to normal and we're looking at the COVID years with hindsight. For many, these consequences have been permanent.

CHRS was established in August 2020 to support the growing number of people who had been denied any opportunity for meaningful contact with their loved ones in residential care since shortly before the national lockdown. This Inquiry will undoubtedly hear from such individuals, from husbands who had to look through a window at their distressed wife, reaching out to a carer for a reassuring touch, or people watching their confused and distraught parents through an online or iPad communication with no ability to help or reassure.

One member spoke of visiting her mother with advancing dementia in late summer 2020. She had to sit 2 metres away and watch her mother be physically restrained from walking towards her for a cuddle. A carer could sit beside her and hold her hand but not her daughter. What is that if not discrimination? Why were carers considered less of a risk to health than parents or children? Relatives were not afforded the same opportunity to interact with their loved one that employed carers had.

Carers could go home at the end of a shift to

interact with their own friends and family, as was normal at various stages, and that was entirely appropriate, but they could then go back into the care home and be in contact with the residents, but those residents' own relatives were not afforded that same opportunity or equality. Why would adding a mum, daughter or husband to the care team have increased the risk? While some residents may have understood the potential dangers of the pandemic and why they were being kept isolated, others may not. Their mental state may have been such that all they knew was being suddenly left alone with no visits, no touch, not even allowed to see others in the home. Faces became hidden behind masks and skin hungry with no cuddles or hands to hold. Perhaps they would being paraded out behind glass like an exhibit at a reptile museum or a prisoner. Those who did understand the problems posed by the pandemic and the need for isolation rules were still left feeling isolated and imprisoned in their environment when they watched as restrictions eased for the rest of society but not for them.

It is submitted that the visiting arrangements in care homes, without consistent adherence to guidance, became inhumane, discriminatory and had little apparent regard for the rights or dignity of those involved.

When the rest of the country began to experience lightening of restrictions in July 2020, sadly those in care homes were not afforded that dignity. For almost a year guidance would not permit residents to leave the home or to go out for a drive in the car. After 14 months, many residents were only receiving half-hourly socially distanced visits and many had not left their home in over a year. They had been effectively imprisoned.

A literature review by the Care Inspectorate found that meaningful connection is profoundly important to people's emotional, mental and physical well-being and their quality of life. There are countless stories of sadness, isolation and suffering and it is anticipated that the Inquiry will listen carefully as those unfold over the coming weeks.

A lack of connection can lead to social isolation and loneliness which can have a detrimental effect on people's health and well-being, and many residents, particularly young adults, had an active life outwith the care home before the pandemic and dismantling those opportunities and routines in one fell swoop had a devastating effect.

It is not proposed to detail individual impacts in this statement. The Inquiry will hear many stories over

the coming weeks. However, one in particular I would suggest is important, and it's the story of Anne, who provides the foundation for Anne's Law. Anne developed early onset dementia and moved to a care home at the age of 60. Although she had to live apart from her dearly loved husband, he visited every day and she had other friends and family visiting her throughout the week. She thrived from these visits. Her joy at receiving cuddles and listening to her visitors' stories was clear. So imagine how her life changed on 12 March 2020. Why was nobody visiting? Why was everyone wearing masks? She celebrated her 35th wedding anniversary but could only meet her husband's eyes through a window. Carers, with appropriate PPE, could spend time with her but her husband could not. A year later, on their 36th anniversary, although they could meet, her husband still had to wear gloves, an apron and a mask. Not a smile or a kiss. Anne went 483 days without seeing her husband's smile and she died in November 2021. How would any one of us have felt to have experienced such separation and loneliness?

Each story and impact will be important for the Inquiry to hear in order that lessons are learned and history is not repeated. In listening to this evidence, the key message that CHRS would like the Inquiry to

consider and which will be emphasised at every stage of these hearings is that family members of those in care homes should be seen as care—givers and healthcare partners who play a vital role in a care setting. They should never again be excluded, as happened from March 2020, and, further, the right to a designated essential care—giver should be clearly enshrined in law.

This Inquiry is also invited to give consideration to the number of people that have died without any meaningful contact with loved ones in the weeks or months leading to their deaths. Whether they died as a consequence of COVID or not, the key point is they died without having seen, touched or perhaps even spoken to those closest to them for months. Husbands, wives and children died alone, and how would that feel? It's probably near—impossible to comprehend the exquisite loneliness of dying alone.

Between 12 August 2020, which is when CHRS was formed, and 28 November, some three months, 3,500 people died in a care home. They were dying at a rate of 300 a week. Over a 12—month period, 16,000 residents died, many of whom hadn't seen loved ones until their final hours. The life expectancy of those living in care homes is consistently shorter than those of the same age living elsewhere. The quality of life for the

time they do have should be paramount.

The Inquiry has been and will continue to be provided with documentation from CHRS which it is hoped and anticipated will be carefully considered. While the gravity of the COVID—19 pandemic was at all times appreciated, CHRS strived from the early stages to ensure that those in power considered the adverse impacts that were being felt. The evidence provided demonstrates that emphatic and urgent pleas were being made from August 2020 to public health consultants, to Scottish Government ministers and MSPs to ask that the voices of those in care homes be heard and that urgent action be taken to consider the very grave impact on mental and physical health of being denied access to their loved ones. From that time the cry was going out for family members to be given essential care—giver status and that cry remains.

CHRS asks that the Inquiry consider the forthcoming evidence in the Impact Hearings with particular regard to what is being sought in terms of Anne's Law, and Mr Gale has already referred to Anne's Law and these aims which is greatly appreciated. However, I would just like to take a moment to repeat these aims, given their importance. These are that: every care home resident should be entitled to have a meaningful contact

with one nominated person, despite any type of lockdown the care home experiences. The nominated person must be recognised as a partner in care and trusted to access the care home in the same way that staff do; recognition that the nominated person is there to provide emotional and well—being care, something that a member of staff cannot offer in the same way a family member can, as much as it is known that they do try; to recognise that many people residing in care homes have complex needs and by allowing one nominated person to have meaningful contact can and will help ease distress for both of them and the families. This should include visiting to continue as regular as it was before any lockdown; and lastly to recognise that a nominated carer would also help support the work of the care staff.

CHRS passionately believe that safe visiting can happen and that view is shared by leading IPC experts. Infection prevention and control measures applied in the right way at the right time will keep people safe from the harms of infection while protecting their human rights through compassionate care.

The First Minister stated to Parliament on 7 September 2021, "We will introduce Anne's Law, giving nominated relatives or friends the same access rights to care homes as staff". It is submitted on behalf of CHRS

that the current proposals fall far short of that assurance. In the forthcoming hearings it is hoped that the evidence will demonstrate the crucial role played by relatives and friends in a care-giving context and it is likely that CHRS will ask this Inquiry to make findings and recommendations to ensure that this right is enshrined in primary legislation and not simply left for direction or guidance.

So, in conclusion, it is submitted that there has been widespread disregard for fundamental human rights and freedoms where the most vulnerable in our society have been left isolated and discriminated against and it is hoped that the findings and recommendations of this Inquiry will ensure that this does not happen in the future.

THE CHAIR: Thank you very much indeed, Ms Galbraith.

Now, the next core participant to make their opening statement is the Church of Scotland who I think is represented by Mr Di Paola; is that correct? Thank you. Mr Di Paola.

Opening statement by MR DI PAOLA
for the Church of Scotland/CrossReach

MR DI PAOLA: My Lord, ladies and gentlemen, good morning. My name is Mr Di Paola and I'm here today on behalf of the Church of Scotland in the guise of CrossReach.

CrossReach offers care to people of all ages with locations all over the country. It is one of the largest voluntary sector care providers in Scotland, with services including homelessness, mental health, learning disabilities, criminal justice, substance abuse, residential care for older people, day care, care in education for children and young people. At this Inquiry it seeks to speak both for those who were supported by its services and the staff who delivered that support.

CrossReach believes that it is important to understand the context in which the health and social care voluntary sector was operating even before the start of the pandemic. This sector was already significantly under-resourced due to years of under-investment. It was into this already fragile situation that the pandemic hit.

CrossReach recognises that all citizens of Scotland faced significant disruption during the pandemic and all were impacted by the advice and guidance issued by the Scottish Government. The scale of disruption and the choices being faced were almost unimaginable at the time. However, it believes that there was a particular impact on social care which had significant consequences for those supported, some of which might have been

avoided. This was due to a fundamental lack of understanding about its nature and scope, which led to guidance being issued which swung between being non-existent for some services and misguided and heavy-handed for others. Ultimately and in some instances it led to those it was supposed to protect being open to wider harms.

I will refer briefly to a number of impacts experienced by CrossReach. First, difficulties created by the guidance issued by the Scottish Government. It took a significant effort to interpret and implement guidance which came thick and fast, was often unclear, sometimes unhelpful and came with short implementation windows. Sector representatives had to intervene to stop critical guidance from being issued by the Scottish Government late on a Friday with impossibly short lead-in times, often the following Monday morning. The guidance changed too frequently to allow staff on the front line to keep up with it. As a result, much effort was expended in issuing regular updates which could be easily understood by staff and supporting implementation before it all changed again. It was also clear that guidance was mandatory as it was enforced by the regulator via inspection. The guidance was applied across the board and failed to properly recognise the

controls which care homes already had in place which were not replicated in community settings.

Second, the rules of self-isolation. CrossReach staff were identified as key workers and it was critically important that these rules were followed to reduce the risk of outbreaks in services. The rules prevented staff from attending work if someone in their household tested positive or had symptoms of COVID. This was a sensible move, however, it fell outwith the circumstances which allowed this time off to be paid. Only if staff tested positive could they be paid.

CrossReach put in place a system whereby staff could elect to mitigate the loss of pay by using holidays and, if they did so, CrossReach would match those used. In effect, the member of staff and employer each paid for half of the time off. It wasn't until the Social Care Fund was announced in June 2020 that the situation was rectified. In terms of lessons learned for the future, should self-isolation be mandated and there is reliance on the goodwill of staff to do the right thing for others, it is essential to ensure that financial pressure to attend work is avoided for key workers.

Third, the supply, distribution and use of personal protective equipment was hugely problematic. The supply of PPE, initially at least, was a matter for care

services to deal with under their normal purchasing arrangements. The procurement and use of PPE was not new to care homes, who were used to taking infection control measures and dealing with infectious diseases on a routine basis. However, because of the unprecedented quantity of PPE needed, much earlier effort was directed by CrossReach towards sourcing and distributing good-quality PPE.

Whilst residential care settings were eventually prioritised by the Government, housing support and daily services felt relegated. These services in particular experienced difficulties obtaining PPE, even in situations where there was a confirmed outbreak. The PPE shortage was a risk to the lives of service users and staff and CrossReach believe that there was an inequality in the support given to health services as against social care providers.

Fourth, as guidance was issued to social care settings by the Scottish Government, there was a failure to distinguish between distinct types of care setting. Recommendations which made sense from a COVID infection control perspective and were appropriate in an ordinary setting or, alternatively, a hospital setting did not work where other risks to health or well-being specific to the context were overlooked.

There was a significant lack of understanding of the context of social care. Residential care homes, for example, which had previously been inspected against care standards to ensure they were as homely as possible started to be assessed against the same clinical standards as hospitals. Those supported in community settings had their normal routines and support services suddenly withdrawn. Whilst this was true in many settings, the consequences for those supported through social care was at times catastrophic. Whether supported as a result of a physical disability, learning disability or emotional trauma, the decision taken to cut off regular routines had implications for supported people which went to the heart of them being able to live independently or cope emotionally due to the circumstances that they were already in. Not consulting with the representative bodies for social care providers or with providers direct at an early stage meant that opportunities were lost to ensure that guidance issued allowed the significant expertise of those working in social care to be harnessed rather than disempowered.

Social care operators work in different settings to hospitals and other clinical care settings. They have soft furnishings, places to congregate, communal spaces to eat. They are home. They are not short-term,

high-level clinical settings. There appeared to be a mistaken belief that the care services were akin to clinical settings. This resulted in infection control and hygiene requirements that were either overly onerous or impossible to achieve. It also resulted in an expectation that care settings could provide high-level and critical clinical care that was not realistic to achieve in terms of staffing, setting and equipment.

The guidance to separate those with COVID symptoms from other care home residents, whilst understandable on paper, took no account of the practicalities and fundamentally misunderstood the impacts on the people using the service, particularly people with dementia, whose quality of life depends on having familiar routines and surroundings. The general public were not asked to move home when they were infected and yet one set of guidance suggested that all infected residents should be kept in one part of the building with infection-free residents being cared for in another, which would have necessitated uprooting them from their familiar rooms. This should not have been expected of vulnerable people in care. Also, the separation expected within care settings posed additional practical physical difficulties.

In substance misuse residential services, vulnerable

residents living chaotic lives and sometimes suffering mental health difficulties were simply unable to comply with the guidelines as set out and required support in a different way. In adult care services, whilst one harm was prevented, often another was created, seemingly without any balancing exercise being done to determine which was the greater risk or whether both could be mitigated. This was true of having to balance emotional harm against physical harm, as in many settings within social care and outside of it, because sometimes it was a case of creating a physical harm potentially greater than the risk of infection for some.

The guidance for children's services was almost non-existent in the early stages of the pandemic and, when it was issued, the rights of children were not upheld because a risk assessment approach was not adopted. Some children in care were prevented from seeing their family members and at one point the self-isolation guidance could have led to a whole team of staff having to isolate, leaving children with no adults whatsoever. This would not have been tolerated in a normal family setting and should not have been thought appropriate in a children's care setting.

The fundamental impossibility of applying the mandated infection control practices and services was

left to managers and staff to grapple with. Residents without capacity could not be kept in their rooms and asked to self-isolate without experiencing significant distress. They could not abide by physical distancing requirements when in communal areas and many could not remember even simple instructions issued by staff about what they could and could not do. Inspection standards imposed on care settings were too clinically driven. Care inspection evaluations which had previously focused on the quality of care and outcomes for individuals became too prescriptive and were almost entirely based around infection, protection and control, using clinical standards, and care providers were found wanting because they could not react quickly enough and meet the standard. Where a care home was found wanting in this regard, their deficit was reported openly, which allowed for public shaming through the press to occur. This was not the same for hospitals or other settings.

Fifth, there were significant financial pressures. CrossReach experienced income shortfalls and incurred extra costs not adequately covered by payments from the Scottish Government. There was a significant difference to sustainability payments by various local authorities and official guidance was inconsistently applied. The "light touch" approach promised was often ignored.

Financial difficulties were evident in all aspects of CrossReach's work and cash flow difficulties were experienced.

There was a rise in insurance premiums and major difficulties in renewing cover which eventually led to the withdrawal of cover for COVID-19 harms. This was due to the police investigations into COVID-19 deaths and the level of loss of society awards seen in Scotland. This effectively forced CrossReach into self-insurance in this respect. The sector called for the same indemnity as was offered to the NHS in these circumstances, but this was denied.

Public sector day centres closed without considering alternative ways of providing support. People supported by CrossReach for part of their care and support packages had to be entirely supported by CrossReach staff 24/7, requiring increased staffing which was only possible via expensive use of agency staff, leading to cash flow pressures.

PPE shortages caused significant price increases. Some companies would supply only to the NHS, but where it was available for purchase, it was bought from private providers at a significant uplift, with some companies charging up to seven times the normal rate.

Sixth, there was a considerable impact flowing from

the transfer of residents to or from homes and restrictions on visiting. There was at times a breakdown in the necessary movement of people from the community to care or clinical settings. When people were transferring from the community to care homes, there was a lack of clarity on responsibility for testing prior to admission and in the early stages no testing at all of those moving to care homes from hospitals, even where the potential for COVID-19 infection was present in a ward.

Those who would ordinarily have required hospital treatment for the many problems that the frail and elderly can face were stuck in care homes. At one stage there was a resistance to provide healthcare to these individuals, even in acute situations. Key healthcare support suddenly became very difficult to access, even on a remote basis. One further area of difficulty in care homes was the complete cessation of visits. Managers were besieged by complaints from relatives and having to manage some very emotional conversations. There was no discretion given to managers in the early stages of the pandemic in terms of being able to balance the risk to health and well-being caused by the potential of catching COVID-19 against that of being isolated from family and friends.

Managers could see significant deterioration in some residents, particularly with dementia, which might have been ameliorated should the early guidance have been taken into consideration. CrossReach supported essential visits to the dying wherever possible throughout the pandemic, but the tardiness of the guidance in care home settings in terms of allowing social interaction caused untold harm for many residents and their closest families at the time and could be seen as an infringement of their human rights.

Finally, there was a huge impact on staff within the sector. In whatever area of support they worked, they were required to turn customary practice on its head and deliver care, often of the most personal and intimate kind, in a situation where they themselves were at risk. Only those in the most vulnerable category were furloughed. The majority of the workforce of CrossReach turned themselves inside out to provide care and support in new ways to supported people, even where face-to-face services had to close. This was particularly important in the mental health and addiction services, where the risks associated with services being withdrawn could have had catastrophic consequences for those relying on them.

Care homes were effectively requisitioned by the

Scottish Government but without the Scottish Government taking any responsibility at the time for the consequences of the guidance being applied. Care home residents with COVID were not, in many cases, admitted to hospital but were required to stay and be treated in the care home. This put pressure on the care homes without the resources, protections or status of the NHS. There was a feeling of abandonment. This principle was adopted without understanding that care home provision is very distinct from nursing care or cottage hospital settings, with neither the clinical skills nor equipment to administer the treatment that may have been necessary to treat patients with COVID.

During the course of the pandemic, resources were ploughed into CrossReach to support staff to stay resilient and to access support for themselves whilst they supported others. The well-being of the workforce remains fragile. We believe the strain of the pandemic on staff coupled with the negative perceptions of social care in some settings due to its treatment by the Government regulator and the press has exacerbated the recruitment and retention issues now prevalent across the sector.

We recognise that the Scottish Government too poured in welcome resources and there have been some

longer-term benefits to both supported people and the workforce as a result of their investment. Digital solutions with social care forced by necessity to keep people in contact at the time have now been widened to access support in some areas. The well-being funds which were made available have been put to good use to support exhausted staff.

We welcome the opportunity provided by this Inquiry to learn lessons from the strategic response to the pandemic in Scotland and to be recommendations for the future.

THE CHAIR: Thank you very much indeed, Mr Di Paola.

Now, the next core participant to speak is Kirsty Solman. I'm afraid I don't know who represents Ms Solman. You do. Thank you.

Opening statement by MS HOLT for Kirsty Solman and Families of Children with Additional Support Needs

MS HOLT: Good morning, my Lord, ladies and gentlemen. I'm Rachel Holt and at today's hearing I represent the core participant group Kirsty Solman and Families of Children with Additional Support Needs.

The core participant group comprises seven individuals and two charities, Children's Health Scotland and the National Autistic Society Scotland. Of

the individuals, all have provided statements to their legal representatives and all but one wish to give oral evidence to the Inquiry if called. Each individual story is different but there are broad themes that can be taken from each experience.

The common themes are that, whilst prior to the pandemic the needs of the respective children were not necessarily being fully met due to limited or restricted services in the field of children's mental health, most of the children were coping with life and in some cases flourishing. Without exception our members reported that the Scottish Government's strategic response to the pandemic had a direct adverse impact on their child's life. While all had a measure of sympathy for the decision to impose a lockdown in March 2020, all considered that the Scottish Government's subsequent strategic responses to the pandemic failed to consider their demographic, with significant long-term consequences for their children.

This core participant comprises individuals of extraordinary resilience who are raising non-neurotypical children, many of whom have comorbidities. For these children, the prolonged closure of schools, the withdrawal of already limited essential services and what seems like constantly

changing rules caused and continues to cause significant disruption to their lives.

In relation to the two charities who are members of this group, while their evidence is in part anecdotal, their overview of their members' struggles because of the Scottish Government's strategic response to the pandemic echoes and therefore reinforced the experiences narrated by the individual members of the group.

Turning to an overview of the evidence of the individual members of the group. One of the individual members told us it was her opinion that the Scottish Government's strategic response to the pandemic caused her previously happy child to attempt to take his own life five times. The child is currently 12 years of age. He first attempted to take his own life in November 2021, when he was ten years old. This member's evidence is that prior to the pandemic she and her husband struggled to get a diagnosis of autism for her child. She considered that this was in part due to services not taking her concerns seriously and poor and inconsistent service provision. Once there was a diagnosis of autism, the child was diagnosed as having ADHD and during the pandemic as having anxiety. The member says that prior to the pandemic, while there were challenges for her child educationally due to resources

issues, he managed academically, albeit he was behind his peers. The member had to fight to get an education plan put in place, again citing a reluctance on the part of professionals to listen to and acknowledge the concerns of she and her husband.

All that said, the member describes the child pre-pandemic, while having a diagnosis of autism, ADHD and being anxious, as a generally happy boy who was coping with life. She stressed he needed routines and coped when routines and structures were in place. She explains that her child enjoyed out-of-school activities and had three regular hobbies that he engaged in with joy and enthusiasm. All in all, despite less than ideal services and support, the member says that prior to the pandemic and the Scottish Government's strategic response thereto, her child was doing well in the sense that he enjoyed life despite his diagnoses and the challenges those brought to his day-to-day life. She said she and her husband were generally able to meet his needs and they were satisfied that they were doing so.

Following the pandemic, the member reported that her child's health and well-being progressively declined. He struggled to cope with the first national lockdown as his routines and the necessary structure that enabled him to manage life ended abruptly. The child's

extra-curriculum activities also ended abruptly. We were told that as the child is a rule-follower and a very literal thinker, the over-simplistic messaging was problematic. The child's anxiety increased and he believed that if a person caught COVID, they would die or end up in hospital, hooked up on machines, as was being reported daily. The constant news stories which were often reported in a sensational and dramatic manner over numerous outlets became a source of anxiety for him.

The child became obsessed with following the myriad of rules, which became a bigger issue over time as the rules kept changing. The child worried that his grandparents, two of whom were key workers, would get COVID and die as COVID was reported as a disease with a very high mortality rate. The child withdrew from family life, he withdrew from his parents and, when restrictions eased, from wider family, such as his grandparents.

The child spent increasingly lengthier periods in his room. When school started, he struggled with the mass mandate and the constant changes to the rules. The member said she was aware her child's anxiety had increased exponentially at the start of the pandemic. She sought assistance from services. As the child was

already under Child and Adolescent Mental Health Services, CAMHS, due to his diagnosis of ADHD, he was offered a six-week session of talking therapies on a remote platform. The member reports that the child struggled to engage with remote therapy sessions as he could not see body language and pick up on non-verbal cues via a screen. The child had tended to cope in social interactions by observing non-verbal cues and body language, which he had learned to do. These learned responses helped him understand the whole context of his interactions with others.

We were told that during the therapy sessions the child would pick his fingers until they bled but the counsellor was not aware of this because she could not see his hands on the screen. The child was able to give the counsellor the responses he considered she sought and her inability to fully assess him in person likely impacted her approach to his care. The member says the child continues to pick his fingers and he now wears gloves to stop him doing so.

The child's first suicide attempt was not treated appropriately and, in the member's view, was dismissed with inadequate treatment from CAMHS. It was only after the child's third attempt on his life that he was referred to a psychiatrist. The member considers that,

prior to the pandemic, CAMHS was an underfunded and under-resourced organisation but believes that it used the pandemic as a means of not seeing children face to face. This member feels that, had her son been seen face to face by CAMHS when his anxiety levels first increased, it would have allowed a more proactive approach to his treatment as the full extent of his presentation was not fully assessed during the remote therapy sessions.

This witness raises many broader concerns about the Government's attitude to children with mental health which go beyond the strategic response to the pandemic. However, she is also adamant that, in responding to the pandemic, the Government's response was heavily focused on the economy and on maintaining only a few essential services. This member considers that the heavy focus on the clinically vulnerable to the impacts of COVID meant that the Government failed to consider the impacts of the virus on other vulnerable members of society. She is of the view that, while the strategic response to the pandemic may have saved clinically vulnerable members of society, it has caused the loss of many more members of society who are or were vulnerable in other ways. This, she claims, requires to be factored into an assessment of the Scottish Government's strategic response to the

pandemic.

Other individual members of the group have recounted similar experiences to the individual member whose experience has just been set out. They speak of the devastating impact of services being withdrawn, schools being closed and, when re-opened, operating in new and unusual ways; further, the difficulties of home-schooling and their struggles to motivate their non-neurotypical children.

Most, if not all, consider that the Government's strategic response to the pandemic was too heavily focused on the clinically vulnerable and not on children, especially vulnerable children. Most feel their child's development was adversely impacted by the strategic response to the pandemic and some consider the damage to their child caused by the impacts of that response will be lifelong.

The stories of the individual members of the group are often harrowing. There can be additional challenges raising a child with additional support needs. Prior to the pandemic, members' experiences were worsened by inadequate provision of services and under-resourcing and underfunding of other services, including schools. However, the members and their children were generally managing as life was structured and organised. The

closure of schools, the withdrawal of what services there were and the frequent introduction of new rules which were often changed or abandoned after a short period brought an end to the largely structured and organised society that provided a constant and essential backdrop to the lives of our members and their children.

The failure of many services such as CAMHS to return to pre-pandemic service exacerbated matters. It seems to our individual members that their children did not feature in the Scottish Government's strategic response to the pandemic and the consequences of that are ongoing for them and for their children.

Turning to an overview of the evidence of the organisations of the group. The two organisations who are members have each provided a detailed statement setting out the experiences of those they support. Children's Health Scotland is a leading health charity in Scotland. It is the only charity in Scotland dedicated to informing, promoting and campaigning on the healthcare needs and rights of all children and young people. The National Autistic Society Scotland, NAS Scotland, is part of the UK's leading charity for people affected by autism. It offers a range of services and support, including supported living, befriending social groups, advice and information, local

branches, outreach and training. Part of its services include statutory functions which apply to adults only. Accordingly, so far as this core participant is concerned, the evidence from NAS Scotland refers only to its charitable function, which provides support to, among others, children and young people.

Children's Health Scotland is a small charity. Prior to the pandemic, the employees worked in their individual locations and made little use of technology in furthering the aims of the organisation. When the first lockdown happened, the organisation did what it could by telephoning members. Many of the young people to whom Children's Health Scotland offers support have physical health limitations and disabilities. Those young people were more concerned about the effect of the pandemic on their health than many young people of a similar age without such health difficulties.

Over time, Children's Health Scotland moved meetings and engagement with others to Teams and Zoom. The organisation engaged the services of a tech company, which helped them build an online platform. Whilst this was not the same as in-person meetings, the representative we spoke to considered that her organisation managed to provide confidential and secure support to its members during the pandemic in this way.

The representative with whom we spoke opined that health ought not be defined as being an absence of illness but as holistic well-being. The representative said that, after the pandemic, there was a focus on the fact that the response to it had isolated the elderly but that there were limited investigations into the response to the pandemic on children and the young. She reports that the closure of respite and day centres during the pandemic had an impact on the overall health and well-being of many young people and their families. She considers that the redeployment of resources to, for example, vaccine centres resulted in those resources being withdrawn from services for children and young people, although that is anecdotal evidence only.

The representative considers that many NHS services for children were slow to re-open after lockdowns for reasons that are not clear to her. The representative believes that, in terms of the decisions that the Government made, their effect on children has been "horrendous". She observes that even during the world wars the schools remained opened and so the magnitude of the decision to close the schools cannot be underestimated.

Children's Health Scotland is aware that more children remain off school with anxiety and more

children are not attending school than at any other point in time, according to their records. The representative does not think that it is coincidental that more children are refusing to attend school than ever before and believes it to be linked directly to the Scottish Government's strategic response to the pandemic. The representative states that her organisation has recorded a massive increase in childhood anxiety, which she believes is a huge barrier for children engaging with their education.

The representative from Children's Health Scotland can offer a unique perspective on the effect on children with additional support needs and their families of the Scottish Government's strategic response to the pandemic. Her evidence echoes that of the individual members but her insight into the effect on children of the decisions of the Government has been gleaned from hearing numerous stories directly from vulnerable children and their families about how the decisions made in response to the pandemic affected them.

At least one child of almost every member of the core participant group, children of families with additional support needs, has an autism diagnosis. Their individual narratives about the effect of the Government's strategic response to the pandemic on their

children and family were echoed by what we were told by the representatives of NAS Scotland.

NAS Scotland told us, among other things, about their concerns in relation to the oversimplistic messaging, which not only raised anxiety levels for many non-neurotypical people, but which failed to address many important issues for non-neurotypical members, such as exemptions from mandatory mask-wearing. While it was understood by NAS Scotland that the desire was for a pure message, it was felt this desire overlooked the fact that many people who are neurodiverse were left unsure of what they could and could not do and, crucially, left without key information that would have helped them navigate their own response to the pandemic and the measures imposed.

NAS Scotland told us that while they attempted to keep their website updated with changes to the rules, that became increasingly challenging when the rules started to change on an almost daily basis. To conclude, the experience of each member of the core participant group, families of children with additional support needs, as a result of the Scottish Government's strategic response to the COVID-19 pandemic, is unique.

That said, all individual stories are linked by common themes which highlight that a more nuanced and

balanced strategic response to the pandemic which considered and which made provision for the families of children with additional support needs ought to have been possible. Likewise, the two charity members of the group reinforced those common themes and thereby reinforced that a more nuanced and balanced strategic response to the pandemic and one which made provision for the families of children with additional support needs ought to have been possible.

Thank you, my Lord, for the opportunity to present this opening statement.

THE CHAIR: Thank you very much indeed, Ms Holt.

Now, the next core participant is PAMIS and I think we're back to Ms Galbraith.

Opening statement by MS GALBRAITH for PAMIS

MS GALBRAITH: My Lord, I appear on behalf of Promoting a More Inclusive Society, PAMIS.

PAMIS is grateful to have this opportunity to provide an oral submission at the start of these Health and Social Care Impact Hearings. PAMIS is the only charity that supports and works exclusively with children, young people and adults with profound learning and multiple disabilities, PMLD. After 31 years in existence, PAMIS can state with confidence that the

COVID-19 pandemic represented some of the most traumatic and challenging times for people with PMLD and their families. In their written opening statement, PAMIS took the opportunity to include some photographs, and this was done with the hope and intention of bringing their submissions to life, to put faces to the experiences and so that the real people who were impacted can be seen, their voices heard, even if they are not able to do so in person.

"Abandoned", "forgotten" and "invisible". These are the words that come closest to describing the impact of the response to the COVID-19 pandemic on those with PMLD. As one of the most vulnerable and marginalised groups in Scottish society, families had spent years dedicating their life, love and energy to ensure the provision of meaningful support packages of care for their loved ones which would bring together a number of different professionals and services and this vital framework of support collapsed in March 2020 and the Inquiry will hear that the feeling of abandonment continues.

For people with PMLD and their families, there was no feeling of all being in it together as there might have been for others in society. People with PMLD have a combination of intellectual, physical and sensory

difficulties which are often compounded by serious health problems. It's accepted that providing appropriate care in the midst of a pandemic or public health emergency will pose significant challenges, but this applies all the more so to people with PMLD.

There appeared to be no plan A, plan B or indeed any plan at all for people with PMLD and their families during this time, and as days, weeks and months passed after lockdown began, the silence from public bodies was deeply disappointing and frustrating. Families did not know what was happening and there seemed to be little appetite to engage with them or listen to what they were saying or asking for. The Inquiry will hear evidence of various impacts over the forthcoming weeks and for people with PMLD I would like to highlight some specific examples.

There was an absence of guidance tailored to the needs of people with PMLD and the guidance that was available was interpreted inconsistently by local care providers, meaning that the overall meaning and objective was lost. There was an inconsistent approach to the re-opening of day services and respite facilities. In many cases, families felt that local authorities used the situation as an opportunity to close services without consultation.

Care packages were reviewed during COVID-19 despite the Scottish Government's reassurance that would not happen. There were inconsistent approaches to allowing family to visit relatives in care homes or supported living settings. There was a lack of family involvement in risk assessments regarding loss of contact, again despite the Scottish Government's guidance recommending such involvement.

There was an inconsistent approach to accompanying people with PMLD into hospital and within ambulances. Families had to ask repeatedly for shielding letters to be provided and there were difficulties accessing PPE. Importantly, allied health professionals and support services were withdrawn and key respite services were lost.

The practical effect of these feelings were that families felt they were being kept on a knife-edge, with little certainty or predictability for the future; for example, families concerned they would not be able to travel with their loved ones in an ambulance. One mother has spoken of having to race to a hospital because she was so concerned that clinicians there would make a judgment about her child's quality of life and decline treatment options. Another mother expressed concern about care arrangements for her son if she and

her husband became ill with COVID themselves, and she was told the only option would be for him to be placed in a care home. Some families became so worried that they considered suicide pacts.

Health conditions deteriorated due to the lack of basic and routine medical provision and in many cases they have never recovered. The Inquiry will hear of many experiences. However, I would like to reference just a few particular examples that have been highlighted by PAMIS.

One young woman with PMLD had injured her shoulder and there was no option for a face-to-face appointment with a GP. However, she was non-verbal and that meant that a physical examination was essential. By the time she could be physically assessed, she had developed severe tissue damage. Provided with no support, her family required to seek therapies in the private sector. They were in the fortunate position of being able to do so while others were not.

Another example comes from one mother explaining how her son had gone down. Before the pandemic, he had been actively engaging, but without the weekly support from allied health professionals, he had simply withdrawn into himself. It was difficult for the family to find outside spaces and activities for him when he had been

actively engaged beforehand. His mental and physical state deteriorated and the family are legitimately concerned he may simply never return to how he was before.

Another young man with very complex needs had his last day at school in March 2020 and after that was left with no physiotherapy, no respite or day opportunities and over the next two years his health and well-being seriously deteriorated. By the time his mother managed to obtain space at a day-care centre, two and a half years later, he had deteriorated so much, he just couldn't cope with attending the sessions, both physically and cognitively. The future looks very bleak for him and his single parent mother is not getting sufficient help to cope.

One other young man was in a group home but was in contact with and visited by his mum and dad several times a week and came home once a week. He was an affectionate son who loved nothing more than a hug. He had limited communication and so most of his communication was through touch. He needed to see people's faces to understand their communication and so COVID was devastating for him. He did not understand why he couldn't see his parents, why he couldn't see their faces, why he had to wave through windows or sit

in the cold outside and not hold their hands. His mood deteriorated significantly and he was sad all the time. He is now able to see his parents but his mood has not recovered. His family worry he will never be the same again.

The abandonment felt continues today. So many experienced allied health professionals have not returned to service. People have retired or left service providers for other employment, leaving a void. Many services simply have not returned. In one example, a mother had witnessed a change in her daughter's physical, mental and cognitive condition during the pandemic and, when services eventually did return, she was allocated an inexperienced staff group. There was a lack of allied health support to reconnect and provide interventions and training. The mother's own health has now declined and she has been admitted to hospital, but herself requires to arrange for respite and support for her daughter.

The withdrawal of front-line services and allied support workers means that many with PMLD have their long-term conditions compromised and that more people will be lost in the future. Even if services have returned, the lack of trust and confidence means there is a genuine fear that organisational support could

easily be withdrawn again in the future.

The Equality Act and the Human Rights Act prohibit discrimination of people with PMLD. They were entitled to expect that public bodies would comply with their equality duties in substance with rigour and an open mind. They are entitled to expect that public bodies would have been proactive in prioritising care arrangements. However, the reality was that people with PMLD and their families felt at best an afterthought and at worst forgotten and discriminated against.

Against that background, PAMIS appreciates that many public bodies represented at this Inquiry have expressed their willingness to listen and to learn. That sentiment is to be welcomed because trust has been lost. Many families remain fearful that services will never return or those which have could be taken away again at any time. The path to rebuilding relationships and trust is a long and difficult one. The first step to rebuilding trust requires that the stated commitment to co-operation and transparency holds good through this Inquiry. This is not a time for further broken promises and PAMIS is confident that the Chair and Inquiry team will ensure that core participants act with candour.

PAMIS welcomes the beginning of the public hearings and commends the Chair's and Inquiry team's commitment

to ascertaining the truth. PAMIS is ready to contribute towards a process which is robust, exhaustive, fair and ensures accountability. Lessons can and must be learned so that suffering of people with PMLD is avoided in future pandemics and public health emergencies.

Moving forward, PAMIS hopes that people with PMLD and their families are involved as partners at a local and national level in developing appropriate policies, guidance and solutions and this Inquiry represents an opportunity for that change to begin to materialise.

Thank you.

THE CHAIR: Thank you, Ms Galbraith.

Now, we've been moving with more alacrity than might have been expected. I do have time to hear the next participant plainly before lunchtime or we can start lunch early and finish early, but I appreciate that Mr Blair, who I think is acting for the next core participant, for the Royal College of Nursing, might not want to have his schedule disrupted and it might not be suitable to him. But I'm willing to hear him if he wants to speak now.

MR BLAIR: My Lord, I'm entirely content to speak now.

THE CHAIR: Well, even if you speak now, we'll still have an early lunch, but we'll finish earlier in any event so I'm very grateful for that. Thank you, Mr Blair.

Opening Statement by MR BLAIR
for Royal College of Nursing Scotland

MR BLAIR: My Lord, on Thursday 26 March 2020 millions of people across Scotland and throughout the rest of the UK emerged from their homes for the first "Clap for Carers" event. That day and for the following nine Thursdays the public gathered on their doorsteps and applauded the NHS and other key workers helping to fight COVID-19. Amongst those receiving the public support were the 48,500 Scottish nursing staff and students who formed the membership of RCN Scotland.

While the intention behind the initiative was a noble one and the public support welcome, behind this was a nursing and healthcare workforce which had been underfunded and under-resourced for years and without enough of the relevant PPE to do the work required of it safely, both for nurses and for patients.

For RCN Scotland, care for patients, their safety and well-being must be at the forefront. It is what nurses do. But as a result of that underfunding, under-resourcing and the decision-making on PPE, a very stretched workforce had to do their very best to deliver on the front line what the public expected, often at great personal cost. RCN Scotland is clear that, unless something is done about the funding and resourcing

issues, taking account now also of the effect of long COVID on the workforce, public acknowledgement alone will not be anywhere near enough to see the NHS through another pandemic.

In this Inquiry RCN hopes to be a critical friend of the Scottish Government and of all health and social care providers, particularly NHS Scotland, to emphasise where there was good practice during the pandemic but also to highlight where lessons must be learned in order to provide future support for key workers, patients and the public at large.

The Royal College of Nursing is also a core participant to the UK Covid-19 Inquiry and will take that opportunity to address these points and the decision-making at the UK Government level as well. The Royal College of Nursing is the representative voice of nursing across the four nations of the UK and is the largest professional union of nursing staff in the world. As the Inquiry will be aware from the RCN's written submissions, RCN Scotland is a distinct directorate of the UK-wide Royal College of Nursing.

RCN Scotland brings two important perspectives to this Inquiry's work which it hopes will be of assistance. Firstly, from the outset of the pandemic it was a key stakeholder in a number of Scottish Government

decision-making bodies. Its views were heard as part of, amongst others, the Workforce Senior Leadership Group, the Clinical Professional Advisory Group, the Louisa Jordan Programme Board and the Pandemic Response in Adult Social Care Group. It also remained in contact with all of Scotland's NHS health boards, advising them of its concerns through each stage of the pandemic.

It is hoped that in due course RCN Scotland's associate directors, Norman Provan and Eileen McKenna, through their witness evidence, can assist the Inquiry in understanding the manner in which Scottish Government decision-making was undertaken throughout the pandemic and in particular the extent to which third party stakeholders were involved in that process.

Secondly, my Lord, the Royal College of Nursing is of course a representative organisation. It represents nearly 50,000 nursing staff and students in Scotland. Each of those nurses has a story to tell about the pandemic experience. Those stories include the student nurses who were sent out on to the wards to provide further support when they would otherwise have been in the classroom. They include the retired nurses who returned to front-line nursing. They include those who worked in intensive care and those who provided care in the community for vulnerable patients. They included

nurses in the NHS and those working in the private sector. They include the large cohort of nurses now suffering from the effects of long COVID, having contracted COVID, in many cases on repeated occasions at work. They include innumerable accounts of nurses going above and beyond to ensure the best for their patients. They include countless stories of Scottish nurses putting their own physical and mental health at risk in order to keep the Health Service functioning.

The RCN therefore has a privileged perspective when it comes to what was happening in our hospitals and our care homes on a day-to-day basis from March 2020 onwards. Those stories from the RCN's members are not offered solely in the interests of Scotland's nurses. The RCN is proud to represent its members' interests, but it believes strongly that those interests align with the interests of patients. A strong, properly resourced nursing profession is essential to ensuring the health of Scotland's people.

My Lord, the Inquiry will have seen the RCN Scotland's written submission and this afternoon I don't intend to rehearse what is said in that submission with reference to each of the Inquiry's terms of reference. Rather, I'd seek to highlight three key themes which run through the RCN Scotland response and

which form key areas of focus in its ongoing engagement with this Inquiry. Those are firstly Scotland's nursing workforce, secondly, issues with the procurement and supply of PPE and, thirdly, the impact of the pandemic on the health of Scotland's nurses. As will be clear from the written submission, these themes cut across a variety of the Inquiry's terms of reference.

Turning to the first issue, Scotland's nursing workforce. There is simply not enough nursing staff in Scotland to provide the care our population needs. Evidence and experience show that having the right numbers of nurses with the right skills in the right place at the right time improves health outcomes, the quality of care delivered and patient safety.

Over the years, the Scottish Government has made a number of commitments relating to the nursing workforce, however it has been difficult to track the delivery and impact of those commitments. The RCN heard from its members throughout the pandemic that there were concerns regarding patient safety and staff well-being as a result of shortages of staff on Scotland's wards and in Scotland's care homes. Some of that can be attributed to COVID-specific issues. As the largest clinical profession, nurses were, proportionately speaking, significantly more exposed to the virus than

other Scottish workers, leading to high incidences of sickness absence.

However, the workforce problem is one that predates the pandemic. Over the last five years the number of nursing vacancies and the vacancy rate have risen steadily, including for long-term vacancies, being posts unfulfilled for three months or longer. At no point has the planned establishment been achieved. In fact, the increase in vacancies indicates that the gap between planned staff and actual staffing is widening. There have been historic problems with funding sufficient student nursing courses domestically to meet the planned establishment.

During the pandemic, this manifested with demands for longer working hours and compromised nurse to patient ratios. Even when pulling in resource from nursing students and the retired, the NHS did not reach the planned establishment which is being aimed for during normal times. The pandemic, in the RCN's submission, simply emphasised an underlying systemic weakness in Scotland's Health Service, that there are not enough nurses. That has been clear in the post-pandemic experience, where a desire to return to more run-of-the-mill healthcare services and to deal with the backlog of non-pandemic cases has faced

a continuing capacity shortage. Scotland's nurses remain overworked because there simply are not enough nurses to provide sufficient support to Scotland's population.

It is essential that the Scottish Government and NHS Scotland learn from the COVID experience. Proper resourcing and workforce planning is necessary to ensure that the health sector never again faces the strains which it did in 2020.

Turning to the second theme, my Lord, the availability of appropriate PPE was a recurring issue for the RCN and its members during the pandemic. As early as 9 April 2020, Theresa Fyffe, the then director of RCN Scotland, wrote to the Chair of the Health and Safety Executive to highlight an unconscionable lack of PPE and the risk which this posed to its members as well as nurses and healthcare workers more generally. Those concerns extended to hospitals, GP surgeries, care homes, hospices and community nursing visits.

Notwithstanding those concerns, RCN Scotland's experience was that in the early days of the pandemic, the Scottish Government and the NHS in Scotland took a highly effective approach to the provision of PPE and was responsive to developing concerns. RCN Scotland's leadership was aware on more or less a daily basis of

how much PPE there was in the country and to where it was being deployed. In the context of an international PPE shortage, the Government and the NHS should be commended for this.

However, as the pandemic progressed, the RCN's concerns grew. In particular, it considered that it was inappropriate for nursing staff to be fitted with simple surgical masks when providing care to patients. Nursing is perhaps the most hands-on caring role. The concern was that a loose-fitting surgical mask was unlikely to provide much protection in the context of an airborne virus. However, calls for the provision of FFP3 masks were not met with a positive response. Unsurprisingly, concerns about costs were raised. However and perhaps more concerningly, the RCN encountered consistent resistance to the idea that an FFP3 was necessary at all.

RCN Scotland consistently argued that the evidence indicated that the virus was airborne and that proper masking was essential. That argument was challenged by decision-makers within the Scottish Government, who continued for a prolonged period to argue that the virus was spread through droplets, the implication being that the provision of FFP3 masks would be disproportionate in those circumstances.

Further, the RCN noted repeated reliance on the so-called hierarchy of control mechanisms. In theory, masks may not be necessary in situations where, for example, proper levels of ventilation were maintained. However, time and time again nurses found that the other points in the hierarchy of control were aspirational at best. There were also continued concerns that the provision of PPE was focused on acute secondary care institutions, leaving those working in the community and primary care under-resourced.

Eventually the Scottish Government accepted that FFP3 masks should be provided. However, even at that point, the decision was qualified and FFP3 would only be provided if a member of staff requested it and a risk assessment concluded it would be necessary. Overall the RCN is concerned that the Scottish Government's response to this issue was both too slow and ultimately inadequate. RCN Scotland continued to receive reports from nurses who are concerned that they were infected with COVID-19 at work as a result of a lack of effective PPE.

That turns to the final theme, my Lord. The Inquiry is about to commence a prolonged series of Impact Hearings. It is essential that those include hearing about the profound impact which the pandemic had

on Scotland's nurses. The issues highlighted above in terms of workforce planning and provision of PPE as well as the general strain placed on the health sector by the pandemic had a severe effect on the nursing profession. Those effects were felt in the mental and physical health of those providing care to patients. Many nurses reported and continued to report the trauma and its consequences of seeing so many people, many more than would ever be usual, dying whilst at work.

It was quite simply impossible to provide nursing care in an absolutely safe manner during the pandemic. The airborne nature of the virus, the type of PPE provided and the fact that much nursing care is literally delivered hands—on meant that the nurses were putting themselves at risk by simply turning up for work each day.

In that context, it is unsurprising that nurses have seen a disproportionate death rate from COVID—19 as compared against the general population once certain personal factors such as age are taken into account. Whilst it is unsurprising, that does not render it any less a matter of extreme regret. Even for those who survived infection, there have been long—term consequences for many of the RCN's members.

The RCN has received and continues to receive

a significant volume of reports from nurses who have contracted extremely debilitating symptoms from occupationally acquired long COVID. Many nurses have been absent from work sick since the early months of the pandemic and some may never be able to return to work.

Whilst full pay was continued for all NHS nurses who were absent with long COVID during the pandemic, since September of this year the NHS has reverted to treating these cases in line with other capability issues and it is anticipated that nurses will accordingly lose their jobs. As well as this, nurses and healthcare workers in the private care sector who do not have the same pay and conditions as NHS staff have reported issues regarding their financial situation in relation to sick pay for illness as a result of COVID.

On the subject of long COVID, RCN Scotland notes the Inquiry's position as regards the extent to which long COVID falls within the terms of reference as currently expressed. It is a matter of significant regret that the Inquiry considers that the ongoing effects and future treatment of long COVID do not fall within the terms of reference. Given the significant effect this syndrome has had on the clinical workforce, it is the RCN's view that long COVID and its ongoing effects represent another matter which places strain on

the ability of the Health Service to respond to any future crisis.

Lastly, in terms of the effect of the pandemic on nurses, the RCN in Scotland and across the UK is concerned by the approach taken by the NHS to RIDDOR reporting, particularly in relation to nurses who contracted COVID. The Inquiry will no doubt be aware of the requirements on employers in terms of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulation 2013. RCN Scotland repeatedly experienced resistance from health boards to the suggestion that they should be reporting incidences of COVID which appear to have been acquired at work. That resistance is likely to render some of the data unsafe. It also likely inhibited the HSE's ability to investigate potential concerns in the workplace.

RCN Scotland also sought to encourage the Health and Safety Executive to take a more robust approach to enforcing boards' duties to make such reports. It found the HSE to be equally resistant to these approaches and considers this again to be a matter of very significant regret.

In conclusion, my Lord, returning to the opening image of the NHS clap for carers, whilst it is essential both for the welfare of the clinical professions and for

patients that public support for the nursing and healthcare front line continues, it is also essential that lessons are learned, both from what went well and what did not, and it is essential that future plans are informed by the lived experiences of nurses. The human—rights—based approach must include consideration of the human rights of Scotland's nursing profession.

Turning to the work of this Inquiry, the RCN continues to bang its own drum in support of nurses across Scotland and the UK and to ensure a workforce properly resourced and ready for the next set of challenges, whatever they may be.

It hopes to assist the Inquiry in any way that it can.

THE CHAIR: Thank you, Mr Blair. I'm very grateful.

Right. It's still only 12.40 but I think we will take lunch there. Can I ask you all please to be back at 1.40? I think at 1.40 we're going to hear from Scottish Care. Again I'm not entirely sure —— I don't have a firm —— is it Ms O'Neill that's going to —— yes, it is. Sorry, I didn't know that definitely. If you can be ready at 1.40, please.

(12.40 pm)

(The short adjournment)

(1.40 pm)

THE CHAIR: Good afternoon. Everyone here? Good. I think it's Ms O'Neill now.

Opening statement by MS O'NEILL for Scottish Care

MS O'NEILL: Thank you, my Lord. This opening statement is made on behalf of Scottish Care and describes Scottish Care's particular interest in the part of the Inquiry's work which focuses on the impacts of strategic decision-making in relation to the themes of health and social care insofar as those are matters related to the Inquiry's terms of reference. It does not address other issues that the Inquiry may consider at later stages of its work. Nonetheless this is also the first occasion on which Scottish Care has had the opportunity to make a statement in the context of a hearing of the Scottish COVID-19 Inquiry and is grateful to the Chair for the opportunity to do so.

In the circumstances, Scottish Care would wish to begin by acknowledging that the COVID-19 pandemic brought great trauma and pain to many people who received social care in care home settings, acknowledge the challenges faced by front-line staff and acknowledge the impact upon friends and family members who were in many cases bereaved as a result of the pandemic and who in other cases were unable to be with family members

when they wanted to be.

While Scottish Care's participation in this part of the Inquiry's work is principally for the purpose of ensuring that the Inquiry understands the impacts of strategic decision-making on those who delivered social care, it does so with an acute awareness of the impacts experienced by those who received that care. It will listen carefully to the evidence given during those hearings by those who can speak to that impact and on behalf of those who cannot give evidence themselves. It will do so in person where possible. Its chief executive, Dr Macaskill, is present in the hearing today and will do so virtually where it's not possible to be here in person.

Scottish Care is a membership organisation and a registered charity representing the independent social care sector in Scotland. It works with its members and those who commission, regulate and use social care with the aim of creating conditions that support the provision of sustainable human-rights-based care and support. It has approximately 350 members which provide around 900 services, with some members operating several care homes or organisations that provide care at home.

During the pandemic and as is well known, Scottish Care's members were at the forefront of the

front-line response to the pandemic, caring for older people and people with disabilities in residential settings and/or in individuals' own homes. Scottish Care was also directly and deeply involved in supporting its members in the delivery of those services and in communicating to the Scottish Government and other decision-makers the experiences, concerns and fears of those delivering social care services. Scottish Care's involvement in supporting its members and the response of the Scottish Government and others to Scottish Care and the social care sector during the pandemic are matters that Scottish Care anticipates being examined by the Inquiry at a later stage.

In relation to these Impact Hearings, Scottish Care considers that it can assist the Inquiry by providing evidence about the impact of strategic decision-making on care providers and on individual social care workers. Those impacts are wide-ranging and continue to be felt. By way of a small number of examples, they include the following: first, the impacts on the health of care workers who contracted COVID-19 and whose risk of infection was contributed to by strategic decisions. Those include the prioritisation of the NHS in relation to the procurement of PPE and the failure to mandate the use of PPE in March and April 2020, when PPE was

available only after positive or suspected cases had been identified. The failure to prioritise testing for social care staff resulted in staff having to take longer absences from work after coming into contact with a person who was COVID positive. By contrast, by mid-March 2020, NHS staff were receiving tests following such contact so that they could return to work after a 48-hour period. This resulted in the care sector having to operate with a reduced workforce despite the increased challenges it was facing. This in turn led to staff shortages and also had a negative financial impact on social care staff who were, given their role, unable to work during periods of self-isolation.

Second, the psychological and emotional impact on social care providers of strategic decisions that made it difficult for them to provide effective support for those in their care. One example was the difficulty that care home operators experienced in obtaining healthcare support for residents. Care home providers and care workers reported to Scottish Care a sense of what might be called "clinical abandonment" -- and I note, my Lord, that the word "abandonment" has been used in a number of opening statements already today -- that sense being reported in the early part of the pandemic, with care homes struggling to access GP

services or to have GPs come into care homes to see patients.

Many factors contributed to this difficulty, but Scottish Care considers that they include strategic decisions. So, for example, clinical guidance issued by the Scottish Government in March 2020 created a belief that care home residents who had contracted COVID-19 should not be transferred to hospital. Although the guidance was later clarified, the practice of care home staff being strongly discouraged to transfer COVID positive residents to hospital remained. In many instances, it was appropriate for the resident to remain in their care home, but the presumption of a blanket ban in transferring residents was unhelpful and placed enormous pressure upon care home staff as well as being hugely damaging to individuals with ongoing and developing clinical conditions.

Third, the impact on the morale of social care providers and individual social care workers of criticism which resulted from inconsistencies in national guidance. A particular example was public criticism of social care providers in relation of the provision of PPE to their workers but without acknowledgement that national guidance prescribed different PPE requirements for staff working in social

care compared with those working in healthcare settings. On occasions, media shared photographs taken of social care workers while they were providing care, together with criticism of the way in which PPE was being used.

Fourth, the impact on care providers of strategic decisions made about scrutiny and oversight. One example was the announcement by the Scottish Government in May 2020 of arrangements for "enhanced professional clinical and care oversight of care homes", which instructed health boards and health and social care partnerships to establish multidisciplinary teams to scrutinise and support care homes. The result of this decision was that, in addition to inspections from the Care Inspectorate, care homes were inspected and visited by teams from Public Health Scotland, infection prevention and control specialists and appointees of the health board nurse director among others. This approach frequently resulted in contradictory advice and guidance being provided to staff and led to a clinical approach to care homes from practitioners who did not have any expertise in a social care context.

In particular, infection prevention and control measures appropriate to an acute hospital setting were imposed on care homes by staff from an NHS background where, in the view of Scottish Care and its members,

those measures were not appropriate. An example was the failure to recognise care homes as the homes of individuals with dementia. Personal items which were often critical for residents' well-being were assessed as infection risks and removed from residents' rooms, often causing real upset to those residents.

Social care workers felt that in many cases their experience and expertise was not respected by those who provided oversight and that their autonomy to make decisions in the best interests of their residents was reduced. While improvements were made over time, Scottish Care undertook research in 2021 into the impact of this oversight and scrutiny model being imposed upon the sector. Findings included a significant reduction in staff morale during an already challenging time.

Finally, the financial impact on social care providers of funding decisions. The immediate financial pressures faced by independent social care providers, including due to the increased cost of PPE and loss of staffing, meant that there was an urgent need to establish financial support. This process took time to establish and for the relevant criteria to be developed.

Social care providers were not eligible to apply for business support funds that were available to other small businesses and a separate funding process was

developed by the Health and Social Care Directorate within the Scottish Government specifically for social care providers. Difficulties arose as a result of the approach to funding that was adopted. Those difficulties involved payments having to be applied for retroactively and multiple changes to the terms on which they were available.

The availability of funding was regularly extended on the week, if not the day, that the fund was due to end. This type of intervention did not allow for longer-term financial viability and business planning and affected the stability of care providers. Due to its lasting financial impact, coupled with the rising cost of living, the sector is currently experiencing the highest level of care home closures in Scottish Care's existence.

Scottish Care is hopeful that the Inquiry will hear directly from individual care providers and social care workers about the impact on them of strategic decision-making. There are, however, reasons to believe that many providers and workers will hesitate to come forward to give evidence to the Inquiry. For many involved in the sector, the pandemic was an extremely traumatic period during which they were put under extreme pressure, were exposed to significant risks to

their health and to their livelihood and witnessed the extreme suffering of those for whom they cared. Scottish Care understands that for many of those affected, they do not wish to revisit that trauma.

There is also hesitation on the part of some individuals as a result of the ongoing effect of Operation Koper, the name given to the investigation resulting from the Lord Advocate's announcement in May 2020 that the death of any care home resident due to COVID-19 or presumed COVID-19 was to be reported to the Procurator Fiscal.

This decision and the subsequent reporting and investigation of such deaths has caused trauma within the care home sector and Scottish Care knows that individual providers and care home workers remain anxious about the potential consequences for them of Operation Koper.

Scottish Care is able to assist the Inquiry in relation to these impacts because of its direct and immediate involvement in supporting the social care sector throughout the pandemic. It was in constant receipt of information, concerns and questions from its members about the impact of the pandemic on them, on the social care workforce and on those for whom they were providing care.

Its work during that period, in addition to extensive engagement with the Scottish Government, local authorities and regulators, included substantial work to ensure that its members were aware of legislative changes and guidance issued by the Scottish Government by Public Health Scotland, by COSLA and by the Care Inspectorate and the impact that such changes and guidance would have on their operations.

Amongst a wide range of activities and in order to actively support its members, Scottish Care delivered webinars on COVID-19 twice a week from 17 March 2020. Those were then added to by the hosting of surgeries to provide a forum in which members could ask Scottish Care questions and share information with each other. These provided Scottish Care with feedback from members in relation to what was happening in the care sector in each part of the country and supplemented the daily intelligence it was receiving from its regional staff based throughout Scotland.

Scottish Care looks forward to working with the Inquiry to ensure that the impacts of strategic decision-making on its social care providers and social care workers are well understood. It will assist the Inquiry in relation to this part of its work and in later phases of the Inquiry's work to the greatest

extent possible.

THE CHAIR: Thank you.

Now, the next core participant that we're to hear from is the Scottish Vaccine Injury Group, Mr Bryce, I believe.

MR BRYCE: My Lord.

THE CHAIR: Thank you.

Opening statement by MR BRYCE
for the Scottish Vaccine Injury Group

MR BRYCE: It's customary, I've noted, to begin these statements by expressing gratitude to the Chair both for being designated with core participant status and for being given leave to appear at this stage in the Inquiry. The Scottish Vaccine Injury Group especially is grateful because it is a group of people who have suffered, as has been set out in our opening statement, a degree of stigmatisation and public calumny. Quite often members of the group have been characterised as anti-vaxxers, which particularly wounds them since by definition they would not be vaccine-injured if they had not taken the vaccine. So I do expressly endorse the remarks of gratitude.

I have lodged an opening statement and the Inquiry has that and I adopt it. I will seek to move through it quite quickly because I want to focus on the submissions

made at the end of the statement about the nature of the evidence which we would wish to formulate and present to the Inquiry.

THE CHAIR: You can be sure that we will have read it --

MR BRYCE: I knew that.

THE CHAIR: -- and that we will analyse it in detail, so feel free to skip to the parts you want to without hesitation or fear.

MR BRYCE: I knew that.

The group, as is known, is one of the unusual groups in that it has core participant status in both the UK and the Scottish Inquiry. The participation in the Scottish Inquiry is under Term of Reference (d), the design and delivery of vaccine strategy; the participation in the UK Inquiry is in relation to Module 4, vaccines and therapeutics.

A word or two first about who the Scottish Vaccine Injury Group are. The Scottish Vaccine Injury Group were formed in September 2021 to apply for core participant status in this Inquiry and to provide tailored support for Scottish people who have suffered an adverse reaction to the vaccine. Initially membership was restricted to those who had themselves suffered an adverse reaction but it became apparent that there were a number of people who had bereavements as

a result of vaccine injury and, from November 2022, those people have been allowed to join. There are currently a total of 258 members in the group, of whom 15 are bereaved people.

The founding members of the group are Ruth O'Rafferty who has been permitted to come to the hearing room today, John Watt and Alex Mitchell. A few of the group's members are now full—time carers. They've had to give up their jobs to care for a loved one and some are still extremely ill. The group liaises with similar groups internationally, including Australia, US and several European nations. The group has its own website and people who are watching who have an interest in this —— may I plug the website?

THE CHAIR: Adverts are allowed.

MR BRYCE: Thank you very much, my Lord.

The website is www.scottishvaccineinjurygroup.org and it provides everybody with a vaccine—injury—related problem in Scotland with information and support. It is to be stressed that the group is entirely voluntary and all the help that it gives to the vaccine—injured is also done on an entirely voluntary basis, even though the people providing the assistance have challenging health issues. One of the submissions which we would be wanting to make to the Inquiry is that resources for the

vaccine—injured should be being provided primarily by health and social care services in Scotland, not by a voluntary group operating on a shoestring.

It is appropriate that the Inquiry should investigate vaccine injury because it has already been explored by the Scottish Ministers. The Four Harms which are to be the subject matter of the Inquiry include direct health impacts of COVID—19 but also other non—COVID health impacts. The letter by the minister says that there will be a person—centred, human—rights approach and the submission for the group is that the scope and sequelae of vaccine injury would be encompassed by a person—centred, human—rights—based approach to a non—COVID health impact. So, in my submission, we fall squarely within the terms of the Inquiry.

Now, there has been correspondence with the Inquiry from which it appears that there is some concern that the group may think that it has a wider ambit in the Scottish Inquiry than it actually does. As I have made clear, it's a matter of primary legislation that matters of drug safety, regulation and approval are reserved matters. They are not —— even if the Scottish Inquiry had wanted to make those matters part of the subject matter, it could not do and the group is fully aware of

that. The group is also aware that excluded from the Scottish Inquiry are such other issues as the question of the delictual immunity which has been vested in the vaccine manufacturers. That is also a reserved matter.

As far as the Vaccine Damage Payment Scheme is concerned, that is a UK matter and questions such as the sufficiency of the level of the award or the fact that one has to establish a 60% level of disability before one qualifies for the award, that can't be dealt with by this Inquiry. However —— and that is of some interest incidentally to the group because a number of its members have received VDPS payments —— what is relevant here and a submission that will be made is that the Scottish Government ought to have publicised the existence of the VDPS and funded advice agencies to assist with the making of applications under the scheme. A submission which will be made is that the vaccine—injured have been let down by the Scottish legal profession, which has not shown an interest in taking up the issue of making VDPS claims.

The two core issues on the basis of which the application for leave to appear in relation to health and social impacts were made are to do with, first of all, the experience of systemic barriers to diagnosis. As set out anecdotally in the statement, there are

people who have been diagnosed with vaccine injury and other people with identical symptoms who have not and there is an experience by the vaccine—injured of resistance by the medical profession, by NHS Scotland, to identify their injuries.

The other issue of course is stigma, which I've already touched upon. There has been some notoriety when an MSP tweeted about vaccine injury in derogatory ways. Even those who have clear diagnoses of vaccine injury are afraid to talk about it in their social circles.

The Inquiry may be aware that the opening statement of Anna Morris KC to the UK Inquiry on behalf of the vaccine—injured was actually taken down from YouTube and there is still the experience of social media sites censoring groups set up for the vaccine—injured.

So what should have been done? The submission of the vaccine—injured is going to be this: the roll—out of the COVID—19 vaccine programme in Scotland, leaving aside the matters of drug safety and regulation —— those are clearly UK matters —— but the roll—out was a matter for the Scottish Ministers and I've set out in detail the legislation on the basis of which that was done. Critically, what that means is that the Scottish Government had sole control over the

advertising and information environment. The consequence of that is that it fell to or ought to have fallen to the Scottish Government to publicise because all vaccines produce adverse effects, it's only a matter of how much, and the Scottish Government should have prepared the public for the possibility of vaccine injury, not just to ensure that the medical system identified, recognised and responded to those, but that people themselves knew because some people knew straightaway when they received the vaccine but some people have taken a long time to realise. So our submission is that it was for the Scottish Government to have a publicity campaign during the roll-out to alert vaccine recipients to the possibility of vaccine injury.

The group's submission is that there should have been a media and professional awareness campaign simultaneously with the roll-out to raise awareness of vaccine injury. Medical professionals would then have been on the look-out for symptoms and the public would have been alerted to the possibility of injury and the need to seek appropriate treatment. Instead there was this stigma around vaccine injury.

Now, I want to say a word or two more about stigma before I turn to what I want principally to say about the evidence which we would like to develop for the

Inquiry. One of the consequences of the background of stigmatisation, first of all, the group's members are often told that their post-vaccination physical symptoms are actually psychosomatic. This stigma is sufficient to compound other problems because people who have got vaccine injury can have challenges with mobility, living arrangements, relationships and career, and that is compounded by it being said to them that the reason why they're not well is that they're not mentally well. This stigmatisation is such that members of the group have been providing informal counselling and support for members dealing with depression and even suicidal ideation.

Another of the principal submissions which the group would wish to make to the Inquiry is that it should not fall to a voluntary group to deal with issues such as that. The issue around suicide risk is one on which NHS Scotland or the mental health charities should be giving specific training to deal with the vaccine-injured who have got those symptoms.

So if I may turn to the evidence which the group hopes to develop for the Inquiry. It's at page 7 of my statement. The group has had internal discussions amongst its own members and also discussions with its legal team. We've attempted to develop a proposal which

balances the restrictions on the jurisdiction with the substance of the subject matter which the group would wish the Inquiry to consider. It is thought we can get this down to about five witness statements.

Now, I was greatly heartened when Mr Gale, this morning, mentioned that it was hoped to reach the evidential part of the vaccine-injured evidence by February. I would just like to flag up that if we are to do even this modest programme that I'm proposing, it will take quite a bit of time and I'm laying this out now in the hope that we can have a dialogue with the Inquiry as to what can be done and the programme -- the time within which it can be done.

What we propose, five witnesses: broadly speaking, somebody who has got a clear diagnosis of vaccine injury and possibly also an award from the VDPS scheme. The only reason that that might be relevant would be to support that the person concerned does have vaccine injury; another member of the group with similar symptoms but who has not been able to obtain diagnosis, so that we can pull out this question of why some people get diagnoses and why some people do not; thirdly, a person of skill to illuminate the systemic barriers to diagnosis; we would also like, fourthly, evidence to be led from a bereaved family member of a person whose

death has been clearly attributed to vaccine injury; and lastly, because it is a matter to which the group attaches particular significance, a witness to the prevalence of suicidal ideation amongst persons suffering from or bereaved by vaccine injury and to the support needs of such persons.

As far as the person of skill is concerned, I have set out that the group has informal contacts with a number of medically skilled people actually throughout the world, some of whom are known to provide advice in litigations pro bono, but there is a question perhaps as to what value the Inquiry would attach to such a skilled witness, so I set out that as a matter in which dialogue with the Inquiry would be grateful appreciated.

There is one last matter which does not fall squarely within the health and safety impacts but does have a -- does touch upon it and is going to be relevant, in my submission, at some point during the Inquiry. It is this: that although there have been a number of coroners' inquests in England where vaccine injury has been found to be established by coroners, there has, as far as I can found out -- and I'm making enquiries -- been not a single fatal accident inquiry. Now, while this Inquiry has restrictions on it, jurisdictional restrictions on it, in terms of subject

matter such as, for example, drug safety and regulation, I do not think a fatal accident inquiry would be subject to such restrictions and it is a matter which I would seek to have canvassed in the Inquiry as to why there hasn't been a fatal accident inquiry so far in Scotland. That may not fall within these impacts. I simply flag it up as something which, in my submission, is of relevance to the Inquiry overall.

THE CHAIR: Thank you, Mr Bryce. Can I say —— and I'm sure I'm not speaking out of turn —— that Mr Gale or a member of his team will be more than happy to discuss all these matters with you, including the scheduling of any evidence you might wish to offer us.

MR GALE: I think, my Lord, perhaps just to be clear for Mr Bryce, I did indicate that it was anticipated and hoped that his group, if I can put it that way, would be accommodated within the period between February and Easter. I cannot offer a precise timing for that and if it requires further preparation and further discussions, it may be pushed back in that period, but we hope to do it in that period.

MR BRYCE: I'm extremely grateful to hear that and all I'm really flagging up is that it will be a time—consuming exercise and the time needs to be used. I'm very much obliged.

THE CHAIR: Thank you. Very good.

Now, next, the penultimate core participant today is the Scottish Healthcare Workers' Association, Mr Webster KC.

Mr Webster, thank you.

Opening statement by MR WEBSTER

for the Scottish Healthcare Workers' Coalition

MR WEBSTER: My Lord, Scotland's healthcare workers have served the people of Scotland with courage and conviction. As it was for many of Scotland's key workers during the acute phase of the pandemic, they were the people who placed themselves at risk for the benefit of others. We recall how they worked tirelessly to protect and care for others. We recall them trying to manage the constraints and inadequacies of resources available to them, both for those in their care and to care for and protect themselves. We recall them physically and emotionally exhausted by the work they did for us.

The acute phase of the COVID—19 pandemic may be behind us but the disease and its consequences are not. COVID—19 continues to be an ongoing and very real threat to the health of individuals and to Scottish society. Sadly, people are still dying of COVID and they are still suffering from the disabling effects of

long COVID. There are many who continue to suffer long—lasting effects of the disease without adequate recognition or support, without any clear understanding of when, if ever, their symptoms may abate and not knowing whether they will ever return to anything resembling their former lives and careers.

For many, future uncertainty of care and support, both medically in terms of symptoms and rehabilitation and financially in terms of employment security and state—assisted welfare, are a further crippling burden. They are the ongoing victims of the pandemic.

This Inquiry must now repay a nation's indebtedness to these individuals by investigating and reporting with similar courage and conviction to that shown by them as they faced the virus. Scotland's healthcare workers seek truth, accountability and recognition for the harms that they have suffered and continue to suffer and reassurance that their suffering is not an inevitable fate to be repeated in future pandemics.

The Scottish Healthcare Workers' Coalition is a grass roots organisation comprising healthcare workers of all types, doctors, nurses, those in professions allied to medicine and hospital and social care staff concerned as to the long—term effects of COVID—19. They have coalesced in seeking information and support as to

not only the physical effects of the virus but also in respect of what became apparent as an all too common, woeful and discriminatory response by Government, healthcare providers and employers to their circumstances.

They look to this Inquiry to record their experiences. The Inquiry has determined to make this its first endeavour. So let us recognise and acknowledge widely and fully the sacrifices made, the risks taken and the exhaustion and the fear that was endured. This Inquiry needs to identify, record and chronicle the broad—reaching emotional consequences of the pandemic, including those arising from long COVID for these workers. The Inquiry must also ascertain and preserve evidence of the economic impacts for these workers and the effect of the virus on societal infrastructure, including again the effect of long COVID. But then the Inquiry must turn to our decision—makers, then and now. It must show no fear or favour in ascertaining the facts of what decisions were taken and why they were taken and to understand the analysis or lack of analysis that was undertaken.

It must discover whether our elected Scottish representatives and their offices truly followed the science, both in the early stages of the pandemic and as

our knowledge increased. Did they reflect upon and reasonably weigh the risks and advantages? Did they put public money to good and effective use and did they take reasonable steps to protect the workforce that they sent out to do battle with the disease?

Now, long-term post-viral illness was known before COVID-19, so the question must be posed: was that risk recognised at all and, if it was, was it reasonably balanced in the decision-making that occurred in the early stages of the pandemic? How prepared was Scotland in its distinct preparations for the arrival of the virus to meet the needs of its population? Were unnecessary lives lost or blighted amongst Scotland's healthcare and social care workers? Were, as a consequence, unnecessary lives lost amongst those they strove to care for? These are the overarching issues for this party to the Inquiry.

How has Scotland responded to the sequelae of the disease in economic and social terms, both for society at large and for those front-line workers we placed our trust in? The Inquiry must look at what our Scottish elected representatives and public bodies have left us with as a long-term response to the consequences of the pandemic in employment, health and social security terms. Are they continuing to gather information,

collate, analyse and plan in the light of ongoing long-term illness? Have they put in place protocols and funding to manage future risks of long-term illness? Have they considered the effect on healthcare and key workers of long-term disease? Have they done so to inform the state's response to not only those who continue to suffer but also future generations? Have they taken appropriate steps to care for, provide for and support those who continue to suffer? I ask: have they learnt anything? I ask: have they learnt enough? The legacy left by the state and the resilience of the state to provide for the future of those still suffering from the disease are the other overarching concerns for this party.

The long-term effects of COVID-19 are many and varied. Long COVID is a multi-system illness. There are over 200 documented symptoms for long COVID. Severe fatigue, shortness of breath, loss of smell, muscle ache, memory loss, chest pain, insomnia, cardio-vascular irregularities, dizziness, paraesthesia and joint pain are just some of the many recognised symptoms. To narrate the same is to lay the basis for an understanding for the potential for and reality of long COVID having a significant impact not only on day-to-day functioning but also on a worker's ability to

remain in or return to employment.

As much as long-term post-viral illness was recognised before the world had heard of COVID-19, the existence of long COVID as a common descriptor for prolonged symptoms and disability after the acute phase, that is to say following infection, is now well recognised. But it was not always so and regrettably the Inquiry is likely to hear of professional ignorance, if not antipathy, to the needs of those with long COVID.

So it's against that background that the Scottish Healthcare Workers' Coalition come to this Inquiry in the expectation that the Inquiry will throw a searing light on the actions, practices and feelings of health and social care providers as employers and the Scottish Government as the policy lead and directing force in the management of the challenges of the COVID-19 infection and long COVID in particular.

We trust that this Inquiry will hear from witnesses who will speak to the debilitating effect of acute and chronic symptoms in COVID and long COVID in health and professional terms. If so, the Inquiry will hear of the frustration of this workforce at the inappropriate protective equipment provided to them and the inadequate protection afforded to them in the workplace. They will speak to the financial and economic consequences for

them as they have struggled and continue to struggle with the constraints of COVID and long COVID. They will speak to their frustration and despair of seeing professional careers falter and end as a result.

Concerningly and really as a matter of national shame, they will speak to sceptical, unsympathetic and unaccommodating employers with poor employment practices and lamentable state financial protection for long COVID sufferers. They will speak to employers in the health and social care sector, who frankly ought to have known better, not responding to the individual needs of their workforce as those with long COVID wrestled to manage the particular effects for them and their own personal circumstances, and to employers unappreciative of long COVID, inappropriately pressurising staff suffering from long COVID to return to work to meet the need demanded by the pandemic and then being unsympathetic in their approach to symptom-induced desires for shorter hours of working and prolonged periods of ill health absence after returning to the workplace. They will speak to loss of earnings and loss of employment.

Our health and social care workers have worked tirelessly at exceptional risk to themselves to save lives and provide care. What they deserve is an investigation that will look to see whether the

Scottish Government, health boards and other health and social care providers have proper regard to their safety and welfare when planning for and responding to the pandemic, both as regards the protection of health and well-being of those individuals and also the protection of their ability to remain healthy to care for others.

So we ask a number of legitimate questions. Firstly, was proper consideration given by the Scottish Government and Scottish health boards to the risks for health and social care workers in the workplace? Was there independence of thought and analysis from Westminster and the UK Government? More specifically, as long-term post-viral illness was known before the pandemic, it was a foreseeable consequence of COVID-19, so we ask: was it foreseen? Were the likely long-term consequences identified, weighed and acted upon appropriately in the assessment of the conditions of which health and social care workers would have to work. If not, why not?

Did NHS Scotland, individual health boards and employers recognise and respond to the distinct needs of their workers with long COVID as knowledge expanded? Long COVID was being reported as early in the pandemic as mid-2020, so what steps were taken in Scotland to re-assess risk and identify appropriate precautionary

steps once empirical evidence emerged?

Was the prevalence of risk of long COVID in the health and social care workforce separately assessed here or was an opportunity missed at the early stage of the pandemic to warn healthcare and social care workers and the public at large of the risks of long COVID and the importance of appropriate and adequate protective measures?

Let me say this on protective measures. The public may view the provision of personal protective equipment in the health and social care settings to be a story of privilege, profligacy and perfidy as to the needs of front-line staff. That is a perception that this Inquiry must address and expose. Were those who took personal risks to care for us placed at unnecessary risk due to inadequate assessment or the means of exposure and manners of protection, especially in the context of long COVID? Was the precautionary principle recognised and adhered to? If not, why not? And as our knowledge of the disease improved, was a change in guidance appropriate and was any such change effective? And if not, why not?

Looking beyond PPE, we now recognise COVID-19 as entailing airborne transmission, so did the Scottish Government, health boards and employers

appreciate the potential and the need for high-quality and effective air filtration and ventilation in health and social care settings to mitigate risk? And did they take steps to mitigate the risk and then meet the need? Did they, by the end of 2022, put in place appropriate standards for future air quality in such settings?

The only way to avoid long COVID is to avoid catching COVID-19 in the first place. Long-term morbidity was not only a factor that ought to have been part of the pre-pandemic planning, it must also have been part of the information-gathering and planning for the next pandemic.

So looking forward, have appropriate and adequate steps been taken to monitoring gathered data as to the long-term effects of the disease in order to better understand the needs of this essential part of our care workforce in the future and as to how the disease will continue to and how future viral pandemics may impact on the provision of healthcare and social care in Scotland in the future?

Has the Scottish Government set about and funded the gathering of relevant data to record, assess and weigh the effects of long COVID in individuals and the social and economic cost of workplace absenteeism and the cost of financial support for people with long COVID on sick

leave and, finally, also the extra demands of the social care sector to support people with this debilitating illness? Has the Scottish Government set about assessing the emotional and financial effect on individual well-being and finances for those with long COVID? Has that Government ensured that, in the light of what was known by the end of 2022, that NHS Scotland and Social Security Scotland is adequately informed, funded and resourced to provide the specialist help and support that this cohort of sufferers needs? Is the legacy fit for purpose?

Let me touch on one other matter at this point in time. We say this phase of the Inquiry is the appropriate stage to consider the issue of discrimination for it resonates in the extent to which proper and adequate care was offered to health and social care workers both during the pandemic's acute phase and subsequently; that's to say for those who are still suffering. We ask: was COVID-19 and long COVID recognised and responded to by Government, health boards and employers in a manner that looked to and adequately assessed discriminatory effect? Did they assess the need for protection in an informed, nuanced and equality-sensitive manner that avoided discrimination in the workplace? Looking forward, should long COVID be

recognised as a disability under the Equality Act and should long COVID be formally recognised as an occupational illness?

Most significantly for this group, the Inquiry must also recognise that the debilitating symptoms of long COVID have and have had a material effect on the ability of those suffering to retain employment and maintain a career. The Scottish Healthcare Workers' Coalition submits that the long-term burden of the pandemic has fallen disproportionately and in a discriminatory manner in that regard and it is expected that the Inquiry will address the question of whether Article 14 Convention rights against discrimination have been breached.

So as we embark upon the work of the Inquiry, I exhort you, sir, never to lose sight of the need to conclude the Inquiry with clear findings of fact. It will only be with an understanding of what was considered and what was ignored, what was weighed and what was discounted and what was done and what was not done that lessons can begin to be learnt for the future.

I admonish the Inquiry team that there therefore needs to be rigour in giving careful and discrete attention to the consequences for this particular cohort of society who risked so much for us all. This party

looks forward to and expects the Inquiry to produce background research specific to the risks undertaken by Scotland's healthcare and social care workforce and the interplay of long COVID in the assessment of and the response to those risks. There also needs to be understanding of the practical consequences of long-term COVID-related illness and the steps taken to avoid and mitigate the same and there needs to be accountability for failures, oversights and indifference.

This Inquiry must, without fear or favour, be seen to address the issues I have outlined and the related questions that for now time and space does not allow us to be stated before the Inquiry. And time must not be allowed to denude this Inquiry of effect. COVID-19 continues to reap its deadly consequences. People will die from COVID-19 during the period of this Inquiry. Many others will continue to suffer its consequences through long COVID. The Inquiry must report at intervals to ensure that lessons learnt can be implemented and suffering alleviated.

It would be all too easy, in the many disparate issues the Inquiry will have to consider and report upon, to lose sight of this cohort's concerns and fears. I offer no apology for pleading their case as a special case. For them the future is uncertain in so many ways.

They are, as I've said, the ongoing victims of the pandemic and they look to this Inquiry to provide some answers. Could and should the Scottish Government and health boards have done more and what they ask is: was their suffering unavoidable?

THE CHAIR: Thank you very much, Mr Webster. That brings us to the last core participant's submission for today. Refugees for Justice, Mr Kiddie.

MR KIDDIE: Somewhat ahead of schedule.

THE CHAIR: For the good, I imagine.

Opening statement by MR KIDDIE
for Refugees for Justice

MR KIDDIE: My Lord, Inquiry counsel, ladies and gentlemen, I appear here today as junior counsel for Refugees for Justice, as instructed by that group's solicitors, who are Birnberg Peirce. My learned senior, Hugh Southey, is also instructed.

I want to start by quoting some of our evidence so far. First, I'll quote Baroness Helena Kennedy KC, who chaired the independent Inquiry commissioned by Refugees for Justice, which also investigated similar issues as these public proceedings shall consider.

Speaking of the vulnerability of asylum seekers and refugees, she concluded in her report as follows, in her words:

"... it is the current systems of asylum determination and support that make them [vulnerable] ... it places people into marginalised social and economic situations, without adequate support, and leaves them there with ever-diminishing hope for the future."

And she says:

"For those who have experienced trauma, this same system can compound the problem."

We have heard almost countless stories of re-traumatisation and further trauma as a result of treatment.

I now also want to quote Manisha Keister, who is one of the co-ordinators of Refugees for Justice and herself an asylum seeker. Speaking of her own experience of lockdown during the coronavirus pandemic and of how she was treated at that time, she says:

"We weren't even allowed to talk to other people due to COVID. We had little understanding of what was happening. Why were we there? How long would we be there? When would we move? I felt like an animal. That's the way they made me feel, so I just complied."

These are just a few examples of evidence demonstrating how decisions of the Scottish Government about matters such as lockdown had a particular impact

on vulnerable asylum seekers. Lockdown was obviously challenging for us all, yet it was particularly challenging for victims of trauma who were marginalised and lacked support networks. In this context Refugees for Justice welcomes this Inquiry's particular focus on the position of refugees in these proceedings so far.

My purpose today is to introduce Refugees for Justice and then to highlight the following three principal points: first, that refugees individually and collectively are particularly vulnerable in society; secondly, that the Scottish Government should have taken account of the vulnerability of refugees; and, thirdly, that over the course of the material time in which this Inquiry is interested, being the years 2020, 2021 and 2022, it appears that the Scottish Government failed to take account of the vulnerability of refugees in its strategic decision-making in response to COVID-19.

By way of introduction, Refugees for Justice, also known as "R4J", is a core participant in these Inquiry proceedings, being a group that was founded over the course of said material time. R4J was founded by asylum seekers and refugees who were directly personally affected by the impacts of the Scottish Government's said failure and who therefore decided to establish

their group in reaction to that failure. Thus, in a very real sense R4J is a campaign group led by refugees and asylum seekers and for refugees and asylum seekers. It also has strong connections not only with the refugee and asylum seeker community at large but also with other groups and organisations which exist to help these people; for example, the Scottish Refugee Council and Refuweegee, both of which have produced witness statements for R4J for the purpose of these proceedings.

Here two points bear clarification. First, R4J represents the interests both of those who had by the material time already been recognised as refugees and also of those who had by then not yet been thus recognised so were considered asylum seekers. For brevity, moving forwards, in these proceedings at large the term "refugees" may be used for both.

The second point for clarification is that, while at the material time and indeed nowadays asylum was a reserved matter in terms of the Scotland Act 1998, nonetheless the Scottish Government was still responsible for the overall strategic response to COVID-19 in Scotland, including in respect of issues likely to affect the experience of refugees and asylum seekers for better or for worse. Therefore,

contextually, UK Home Office policy remains relevant for consideration, given it contributed to the particular needs and vulnerabilities of refugees in Scotland and the Scottish Government ought to have been aware of this and it also ought to have taken account of it.

So now moving on to R4J's first principal point for this Inquiry, it is that refugees are particularly vulnerable in society. By the very nature of their status, they are people who have been displaced from their home nations by reason of hostilities, persecution, oppression, discrimination, natural disaster, economic adversity and other similar causes. Therefore, they come to us out of disruption and dispossession and find themselves abroad in our country, which is foreign to them, in extremely disadvantaged circumstances, including past trauma and very often trauma-induced mental health difficulties, severance from home contacts, including family and loved ones, and uncertainty as to future outcome.

R4J's second principal point is that the Scottish Government should have taken account of this vulnerability of refugees. For example, as said, R4J commissioned its own Inquiry into asylum provision in Scotland which had particular reference to failures during COVID-19 and where I have already quoted that

Inquiry's Chair, Baroness Helena Kennedy KC, who said of the appropriate approach to vulnerability -- again her words:

"We have heard almost countless stories of re-traumatisation and further trauma as a result of treatment in the UK. It is very clear ... that trauma-informed approaches should be the norm in how we treat asylum seekers."

In R4J's written submissions, as already submitted to the Inquiry, public law, human rights law as well as good practice all require this vulnerability to be taken into account. Yet R4J's third principal point is that over the course of the material time it appears on the basis of available evidence that the Scottish Government failed to take account of the vulnerability of refugees in its strategic decision-making in response to COVID-19. In terms of the accounts of R4J members, their overall experience of lockdown included the Mears Group rounding people up to relocate them out of and away from safe homes and into overcrowded hostel-type accommodation, typically by summary means on little or no notice and at a time when more general advice to the populous at large was to isolate and to stay at home. And their experience also included removal or curtailment of financial provision, for

example, resulting in the effect that they could no longer top up their mobile phones in order to maintain contact with loved ones back home or indeed even with legal or other advisers, and inadequate access to medical, dental and mental health assistance and inadequate official communication in respect of vaccination, self-testing and self-isolation, including official guidance, and overall the Scottish Government failed to take account of this type of experience in its decision-making. Much of this is also reflected by the terms of Baroness Kennedy's said Inquiry, as already mentioned.

Whilst some of the matters above were not directly the responsibility of the Scottish Government, they had an impact on the way that refugees experience decisions of the Scottish Government, such as lockdown. For example, lockdown limited the opportunity of refugees to build support networks. However, so far there is no evidence that these matters were considered or that consideration was given to mitigating them.

Finally, therefore, in conclusion, R4J welcomes this opportunity for this official Scottish COVID Inquiry to find and to recommend as follows: first, that refugees are indeed particularly vulnerable in society; secondly, that the Scottish Government failed to take account of

this vulnerability in its strategic decision-making for COVID; and, thirdly, therefore, that the Scottish Government should take account of this vulnerability in relevant future such strategic decision-making. Indeed we would even go so far as to invite this Inquiry to consider recommending a statutory requirement to take account of the vulnerability of refugees going forwards.

That concludes the opening submission for Refugees for Justice and thank you for very much, my Lord, for this opportunity to make it.

THE CHAIR: Thank you very much indeed, Mr Kiddie. That's all. Well, as Mr Kiddie observed at the beginning of his submission, we are well ahead of schedule, for which I thank you all. We will adjourn now and reconvene at 10 o'clock tomorrow morning. Thank you.

(2.43 pm)

(The hearing adjourned until Wednesday, 25 October 2023 at 10.00 am)

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