OPUS 2

Scottish Covid-19 Inquiry

Day 3

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(10.00 am)

THE CHAIR: Good morning everybody. Mr Gale.

MR GALE: Thank you, my Lord. The first witness to the Inquiry is Ms Jane Morrison.

THE CHAIR: Thank you very much indeed.

MS JANE MORRISON (called)

THE CHAIR: It is very kind of you to come. Thank you very much indeed. I am not sure if you are aware, but I don't propose to put people on oath in this Inquiry, so we will just go straight into questioning from Mr Gale. Can I say that if at any stage of your examination you become upset or you feel you need a break for any reason at all, just indicate to me and let me know and we will accommodate that with no difficulty whatsoever. Thank you. Mr Gale.

Questions from MR GALE

MR GALE: Thank you, my Lord.

Before I ask Ms Morrison to refer to any of her statements, can I you just give your Lordship and everybody else who is watching and listening just a few indications about Ms Morrison's evidence?

Ms Morrison is part of the COVID Bereaved Scotland group. She has provided the Inquiry with three statements, which I intend to call her personal

statement, her organisational statement and then her statement regarding grief and bereavement during a pandemic, and my intention very much is to lead her through her evidence under reference to those statements in that order.

The personal statement and her organisational statement will be largely —— if I can use this term —— "read—throughs". They are quite detailed and we think that it would be appropriate that she be given the opportunity to say everything that is within those statements without much interruption, particularly from me. So that is my intention with that.

The grief and bereavement statement is a statement that she has provided the Inquiry with quite recently, after she and I discussed certain academic research that had been carried out, and I asked Ms Morrison if she would provide us with some information on that.

So there will be some more interruptions at that point, but I thought it useful to give the Inquiry that introduction.

I should also say Ms Morrison has given evidence to the UK Inquiry, and for the reference it is in the transcript of the UKI on 18 July of this year between pages 25 and 34 of the transcript.

So with that, Ms Morrison, your full name please?

A. Jane Morrison.

Q. Your date of birth is known to the Inquiry, and for present purposes I think it is sufficient to say that you are 65?

A. Correct.

Q. Again your address is known to the Inquiry, and again it is sufficient to say that you live in Perthshire?

A. Correct, yes.

Q. Again, for present purposes, I don't intend to take you through your career. That is set out in your statements and I think it probably suffices to say that you have had a distinguished and varied career and you are now retired?

A. Correct.

Q. Right. As I have mentioned, you provided three statements to the Inquiry and, as you are aware, you are the first witness to give evidence to this Inquiry, and the purpose of you giving evidence, as with many other witnesses, will be so that we can hear your accounts of the impacts that you suffered during the Inquiry and hear those accounts in some detail.

So, with that, I think I can, again with a small introduction, say that what has brought you to this Inquiry is the tragedy of the death of your wife, Jacky, in October 2020 from COVID in Ninewells Hospital.

I think you are all right with me and indeed everyone else referring to your wife as "Jacky"?

A. Correct.

Q. Lord Brailsford has already said this and I will simply reiterate because it may be that I am asking you a question or something. If you do feel that you would like a break at any point in our proceedings, you only have to say ——

A. Thank you.

Q. —— and that will be I am sure granted to you. So could you go, please, Ms Morrison, to your personal statement in relation to Jacky? If you could go to paragraph 3 of what is in your personal statement and I would like you to begin reading from there, please.

A. Yes. I wish to give a statement to the Inquiry about my wife. Her name is "Jacky" and, as I say, she was better known as "Jacky". Her date of birth was 26 January 1971, so she was only 49 when she died on 24 October 2020. She was in Ninewells Hospital in Tayside Health Board and the local authority being Perth and Kinross.

We had been together for 20 years. We had a lot of fun and a lot of laughter, and she was registered blind. She had only 2% vision and her eyesight was gradually getting worse, and it was a genetic condition that she

had. But she didn't let it stop her. She was well known in wild swimming circles, but also known as the "blind swimmer". She climbed Sydney Harbour Bridge, she did a trek to Everest base camp with a group of other visually impaired people, she ran the London Marathon, did the Edinburgh Moonwalk and she even went up in a microlight, although I do hasten to add not as pilot.

She was an occupational therapist until she had to give up work when her eyesight got too bad for that, and she worked in quite a lot of hospitals because she preferred to to do locum work rather than just being in one place all the time.

It might sound strange for someone who is blind, but we had a love of books and a love of reading and that is what got us in touch with each other, when we started talking about different books. Obviously it was quite a challenge for Jacky to read, but she did it, and we later went on to audio books because they were a lot easier.

She had several guide dogs over that time and she was an ambassador for Guide Dogs at one stage, talking to local schools, and she appeared on TV for them. Unfortunately none of her guide dogs liked to swim so they would not go into the water with her and would be

dancing on the shore, saying "Where are you?".

She stopped work as an occupational therapist because, as I said before, when her eyesight was getting too bad and she did a course in massage and reflexology and alternative therapies, and she felt these were treatments she could do because she had poor vision. She also did a course in counselling and, funnily enough, specifically in bereavement counselling, but people found it easy to talk to her. Possibly that was because of her visual impairment, but it was probably because they got to pet her guide dog while they were talking.

MR GALE: Can I stop you there? The bereavement counselling that she did a course in and that she was interested in, was that something -- obviously prior to the events that took place -- was that something you talked to her about?

A. Yes, yes.

Q. Do I take it from that that you had something of an interest or vicariously had something of an interest in that yourself?

A. Yes. She went into bereavement counselling after her father died very young, he was only 60 when he died, and she found it quite difficult to deal with that, given the circumstances. She went for bereavement counselling

herself and got a lot out of it and she felt she wanted to give something back, and because she had been through it herself, she felt it was something she could genuinely understand when people spoke to her about it, so she did the course.

Q. Did that experience of discussing that with her assist you when you came to look at some of the research that you had been asked to look at and make informed comments on it?

A. Yes, it did.

Q. Right. Thank you. Can you continue at paragraph 9, please.

A. Yes.

She did try to set up a business doing that. It went for a while, but with her eyesight it was letting her down again because it was really getting quite bad. She also ran a pet shop for a while. Again, the eyesight let her down because, in addition to having the visual impairment, she was in chronic pain all the time because the eye condition, it basically put hundreds of wee blisters over the surface of her eye, which was, as you can imagine, quite agonising. It was like loads of grain of sand in her eye. And she had about 20 operations at Ninewells Hospital. They were fantastic with her and eventually she had to have her

right eye removed completely because she had no useful vision in it at all, not even light and dark, and it was the most painful of the two eyes, so it was agreed to remove that and give her a prosthetic eye.

But we did also have some laughs with that because she used to keep her spare eyes on the fridge, on top of her chocolate, saying she was just keeping an eye on her chocolate. We had that sort of relationship, lots of laughter, lots of fun, not taking life too seriously, but not being stupid about it either.

One time when we were away, we had a motorhome and we were going up the east coast, and she stopped to pop into the shops and I went and filled up with fuel, and when I got back her new eye was pointing the wrong way.

Q. I assumes that was in her socket?

A. Yes, way over here (Indicates), because she hadn't it very long and she was a bit wary of it.

She did say, "I wondered why all those people were looking at me", and it was the first time she had had a problem and we were, neither of us, quite sure what to do. There was a little bit of to-ing and fro-ing and, "Shall we try this and try that?". But in the end she poured herself a large glass of wine and they gave her like a wee plunger that she put it on a managed to get the eye in the right position. But, as I say, we took

the attitude you have to laugh at life otherwise it's just miserable.

I didn't appreciate or truly appreciate how much she was liked and admired until she died because, between the cards, the emails, messages, Facebook comments and so on, I had about 600 expressions of condolence, showing what she meant to people and how much she inspired them because she just got on with it.

Q. I presume that getting those messages in the period after her death would have been very important for you because there were limited people that you could associate with?

A. Exactly, yes. Yes, it meant a lot. It was good to see that so many people saw in her what I saw in her as well.

We had a house extension and we put in an AGA cooker because that was originally developed by a blind man so you don't have to worry about controls, and she loved cooking, although we did have one or two interesting dishes sometimes. But she was great at baking. It didn't do much good for my waistline but it was lovely stuff. And she was so brave. She wouldn't let her visual impairment stop her, she wouldn't let pain stop her and she wouldn't let people know when she was in pain.

We were just in the process of organising with the farmer up road to have a bit of land and had applied for planning permission, but it was all done in respect of Jacky's lack of vision because it was green belt land and you could only have a house if it was adapted for a disability, so it was going to be a smart house so she could operate everything by voice and different textures to tell when you are moving from one area to the next and so on. Sadly I had to withdraw that after she died because of the modifications being for her, so I couldn't proceed.

Q. You go on now to talk about the events that led to Jacky going into hospital. Again I would like you to just provide us with that background please.

A. Certainly, yes. It was actually on 4 October. I had taken the dogs out and she was fine when I left the house, and I came back about an hour later and I asked if she was all right because she looked like she had jaundice, and then I thought, well maybe it's just the lights. I sat there a bit longer, looking at her, and then I said, "Let me have a look at your eyes", and one was indeed yellow and the prosthetic one was white, so I said, "You've definitely got jaundice".

It was a Sunday. I phoned NHS 24 to find out what to do. They were very good. The nurse said she would

have to get the doctor to call us back. I think she said something like two hours, but they actually called back within half an hour, and we went through everything with the doctor and she said she'd have to go to hospital because of it. And they arranged for a COVID test before she went in —— we had to go a different place in Dundee for that —— and it was simply because she'd had a bit of a cough for a few weeks. We were pretty sure it wasn't COVID because she didn't have any other symptoms.

We went to Kings Cross Hospital in Dundee, they did the COVID test. We even had a wee laugh about that because Jacky had quite a strong gag reflex and she told me, "You have never seen a doctor jump back so fast", when he did the throat swab and she started gagging. The test came back negative so we know she definitely did not have COVID at that stage.

When we went to Ninewells after that and the nurse came down, she met us at the door and explained that I couldn't go in and everything else, and she was taking Jacky up to the ward, which she did. I can't remember if she was put in a side room or not until they got the result through because at that time it was taking several hours to get results off the tests, but that was a general problem with the pandemic, everything was

taking longer. If you went for an MRI scan, normally they could do quite a few people in a couple of days, but it took much longer because after everybody had been in, they had to thoroughly disinfect the scanner and then leave it for 20 minutes at least before anyone could go in.

Q. I think, just to get the timeframe of this —— it may be that it needs to just be emphasised. Obviously the beginning of the pandemic was March ——

A. Correct.

Q. —— February/March of 2020, and Jacky went into hospital in October, so six/seven months later?

A. Yes, yes.

Q. Please go on.

A. So obviously I had to leave her. The nurse took her in. I went home. There was clearly a problem with the liver. They didn't know what it was because, unless she was having to reposition her eye, she was not a drinker so it wasn't anything like that. They checked it wasn't cancer and we did find out afterwards that a couple of relatives had the same eye condition, which was a mutation of a mutation of the eye disease and there is only three other families in the UK that are known to have that.

So, as I say, some of her older relatives had had

liver problems and died of it, but we only found this out literally when she was in hospital, doing the tests, and the consultant thought, because her eye condition was destroying the epithelium of her eye, it was possibly destroying the epithelium of her internal organs.

If I may bring in a bit, I didn't have in my statement there that about COVID, everybody just refers to it as a respiratory virus and it is actually a respiratory and vascular virus ——

Q. Yes.

A. —— and the vascular element of it, when it's the endothelium, it destroys all the blood vessels and that is what causes all the blood to get sticky and clot and so on and does the organ damage in people.

Yes, so about two years before she had had symptoms of diabetes and she became insulin—dependent, but they were minuscule doses of insulin that she needed, they couldn't quite understand why, and seemingly there are six types of diabetes, but she didn't tick all the boxes on any of then so there was something weird going on. With hindsight we think it was possibly the eye condition attacking the pancreas and it was intermittent because sometimes it worked and sometimes it didn't. Again, it didn't stop her. She just did whatever she

had to do and got on with what it. But they were doing lots of tests and biopsies and things like that while she was in Ninewells. When she was in 12 days, that is when they did the main biopsy.

Q. I know you are going to come to this, but in those 12 days that she was in Ninewells, what sort of contact were you able to have with her?

A. I am —— visiting was allowed. It was by appointment only so they didn't have everybody turning up at the same time and you had to wear masks and a pinny and I am pretty sure gloves as well. In theory I could have gone up every day, but it was over an hour's drive each way, so Jacky said, "Just come up every second day". But there was only once I was turned back, when they had someone who was possibly positive for COVID so no visitors were allowed in.

Q. Okay. Thank you. Please continue.

A. We can go back up because just ... yes, sorry, they were monitoring her bilirubin levels very carefully, and they seemingly get concerned if they go over 30, and in the time that Jacky was in hospital, they went from 230 to 650. They just couldn't get them under control. So there was something serious going on. The medical staff said if she hadn't got COVID and lived, she may very well have needed a transplant and they drained fluid

from her abdomen, again which happens when the liver is not working properly.

I did ask the doctor how serious it was, and he said, "Again, we may get to the stage of needing a transplant, but we're not there yet". They were thinking of: would it be you're talking a year, two years, in the future and they said there were still things they could do.

She was moved around the hospital a few times simply because of bed space. We had a joke when we were going into the hospital for the first time. Because she had been in hospital so often, with all her operations over the 20 years, I said to her, "The only part of hospital you have not been in is the maternity unit". However, because of the bed shortage, she was moved there for a few days at one stage so she got the full hat—trick.

Q. She had that experience.

A. Yes, as I said, you had to make an appointment to visit her. In fact there was a couple of times I couldn't go in because they might have a COVID patient. No visitors were allowed until that that was sorted and, yes, I had to wear the PPE.

Q. Was that provided to you ——

A. Yes.

Q. —— or did you bring your own, as it were?

A. I actually —— I actually took my own mask because it was a higher—quality mask than the surgical masks ——

Q. Okay.

A. —— but, yes, it was all there and provided. I usually stayed maximum of an hour. If Jacky was looking tired, then I would just go. The one thing was throughout all this time patients didn't have to wear masks and she had been in hospital ten days, I think, and I was waiting one time for her to come back from tests and a woman's husband turned up with the kids and the ward sister came out and quite rightly said that no children were allowed in, it was only one adult visitor, so they would to go outside. And immediately the wife followed them outside, kind of defeating the whole purpose of it. I watched her come back in. She didn't even use the alcohol gel. And it expands on one thing I have mentioned here before: every time I went to visit, there were patients in the car parks with no masks, no social distancing, getting round the one visitor rule by meeting friends and families out there and then walking back into the hospital.

We do have one woman in our group who is a nurse, and when the pandemic started, she was put at the front door of the hospital she worked at, and she said she was trying to stop people going out and doing that and she

was just getting verbal abuse and threats and everything else, so it's a mentality that we have to figure out how to deal with for the future.
Q. Yes.
A. As I say, I had to wear the PPE and Jacky didn't have to wear any. I did raise this with the hospital when I was talking to the consultants about it, when I was waiting for them to take Jacky off all the machines so they could take her into a side room and I could be with her when she died. There were faults in the hospital, but I also mentioned to them about the patients going outside, and I made a couple of observations, "If you are moving the patient around the hospital, why aren't they wearing masks?". And, in addition, some wards had different levels of PPE for the visitors. The maternity unit, for example, had lower levels of PPE because, when I went in, I asked, "Where is the mask PPE?", and they said, "Oh just wear the mask you've got and don't worry about anything else".

So the doctor I was speaking to, the consultant, she listened to me and she said it was very useful because she was in infection control and she said they were having an enquiry into why they had a COVID outbreak in the hospital and that the information I had given her was very useful.

I did get given the name of a consultant —— I think it was sort of the head of the department —— who I could contact not just for that but if I had any questions about anything or wanted more information about Jacky's infection and death. She was very good. I did raise all the points about the masks and other things and she did contact me.

I think it would have been about January 2021 when she contacted me and said they had concluded their investigation and asked if I would like to come up and speak to them and go through it all with them. I said "No" at the time because I just wasn't up to doing it, but I know they produced a report because when they had their unannounced hospital visit, inspection visit, in February 2021, it was mentioned.
Q. If I can pause you there. One of the things that you mentioned subsequently in your personal statement and then in your organisational statement and indeed in your final statement is the importance of communication.
A. Absolutely.
Q. I think what you are saying there and have said there is that your experience particularly during Jacky's illness was that the communication that you received was very good.
A. It was, for me, yes. I was very lucky compared with

many in the group where the communication was dreadful.
Q. Yes. I think that is one of the benefits, I suppose, of you being involved in the care and the Covid Bereaved group is that you have the perspectives of others who you can juxtapose to the experience that you had, which was not the same experience?
A. Yes, yes. As I mention later on, I take the view, if one hospital can get it right in my situation, then surely all of them can get it right.
Q. Yes. Okay. Can you continue on. I think you were at paragraph 42.
A. Yes. I was just going to say that in the report done of the inspection visit, it is actually paragraph 53 of that report that refers to the investigation done by Ninewells Hospital, just for your reference.
Q. Thank you for that reference. We will look at that. Thank you.
A. They were monitoring Jacky very carefully and it was about 3 am on the 15th day —— because they were taking obs every two hours —— that they noticed a spike in temperature and they thought it might have been an infection starting from either the biopsy or the drains, so they immediately put her on antibiotics. As the morning progressed, they saw it didn't make any difference at all and the temperature was still going

up. So they did a whole raft of tests, including a COVID test, which they were only able to do because she had a temperature. If she hadn't had a temperature, they couldn't have done the COVID test at that time.
THE CHAIR: Why not?
A. Because you could only have a COVID test if you had one of the three cardinal symptoms, which was cough, fever or loss of taste and smell.
THE CHAIR: I was going to ask actually, before you told me that, that she had been in hospital 15 days by that time ——
A. Yes.
THE CHAIR: —— had a battery of tests, by the look of it, about other things, but they hadn't given her a COVID test, but that is the explanation for that?
A. That is the explanation, yes.
THE CHAIR: Sorry, Mr Gale.
MR GALE: Not at all, my Lord. Thank you.
A. Yes, as the morning progressed, they saw it wasn't making any difference so they did all the tests. It came back positive. They honestly weren't expecting it to come back positive, but it did, and then she was moved straight into the COVID ward. They had quite a good set—up in Ninewells. They had made a hospital within the hospital, so they had taken over one area

where they had made a COVID ward, a COVID high-dependency unit and COVID intensive care all in the one area.

What was lucky was it was just at the start of the second wave, which it probably did mean they had more time to give to me than they might have done previously in the first wave or in the chaos of the second wave, and, as I mentioned before, the communication was very good. They phoned me regularly and they said I could phone at any time to check on Jacky's condition. When she had been in the ordinary ward, the ordinary COVID ward, and was just on support of oxygen, she had been able to FaceTime me and that sort of thing.

So on the Wednesday evening she was moved to the high-dependency unit because her oxygen levels were going down and she was put on the CPAP, the continuous positive airway pressure. Once that is on, you can't really talk. We did try a couple of phone calls but all I could hear was the air.

Q. The machine?

A. Yes. But they did keep me very well informed and they told me everything they were doing as they were doing it; for example, when they put in an artery monitor for getting detailed right blood oxygen levels, they told me when they did that, and the other machines that were

involved.

At that stage they were still planning that, if they had to, to take her into intensive care, they could do so. However, when her kidneys failed and then her liver failed and in addition to the maximum CPAP oxygen, they couldn't get her oxygen levels above 60%. And they had a meeting with the consultant of the high-dependency unit, the consultant of intensive care, the renal consultant and the liver consultant, and that was decided there was nothing they could do because of the organ failure and especially with the liver, because once that was gone, they couldn't do anything about that other than a transplant and obviously they wouldn't give a COVID patient a transplant.

Jacky was fully aware of everything that was going on.

Q. Was that important for her?

A. It is, yes.

Q. It was important for her; was it important for you?

A. It was, but not necessarily in the way everybody expects because by that stage she was -- she knew she was dying and I couldn't be with her when she was told she was dying, and, you know, to be sort of there on your own, thinking about it, and the realisation that that is going on, it provides its own trauma.

But Jacky actually decided that -- as there was nothing more they could do, she said, "I'm ready. Take me off all the machines", and they asked her that if she could hang on, they would try and do it so that I could get there, which she said she would do. But ... sorry I have just dotted about a wee bit.

Q. No, no. I think you go on to tell us that not having a drink that night was probably a benefit for you.

A. Oh, definitely, yes. What it was, I thought I wasn't going to be there with her when she died and the hospital at that stage had indicated I couldn't be with her when she died, and so I was talking to some friends on the phone and I thought, "What do you do, sitting there ...", and I actually poured myself a large drink. And I think my guardian angel smacked me up the back of the head and, thank goodness, I didn't touch it at all because the hospital rang half an hour later and said, "Look, we've managed to find a side room in the COVID ward. You can go in there and you can be with her at the end", which was wonderful to be able to do that.

Jacky said -- she told me she had had enough, so, as I say, they took her off everything. I had over an hour's drive to get there and, once I got there, the consultant came out to meet me and was sitting talking with me while they got Jacky sorted out because --

I don't know somewhere in there I said, for example, they tried dialysis but her blood was so sticky, it jammed the dialysis machine. But they got her all ready, took her into the side room and I was able to sit with her for 50 minutes before she died and I sat with her for a while afterwards.

The two young male nurses on the ward were lovely. They asked if I was going to be all right going home on my own and they gave me the direct number of the ward so, if I needed to talk to anybody, I could phone them up any time during the night because they were on nightshift obviously, and they would talk to me, and I thought that was very kind of them.

The consultant as well had gone through everything with me, told me what would happen and also explained about the documentation that -- when they do the death certificate and not to worry about that, they would email it direct to the registrar and the registrar would get in contact with me and sort everything out.

The registrar as well, she was lovely. When she phoned, she said, "Look, I have gone through your civil partnership and your marriage certificates. I have most of the information I need. I just need it confirm a couple of points", so I didn't have to go through all of Jacky's details and family details.

Q. I suppose in any circumstance that is important, but particularly in the circumstances you faced ——
A. Yes.
Q. —— that was particularly important?
A. Yes. Yes. COVID was given as the cause of death. In fact it was "pandemic COVID—19" that was the cause of death. The other conditions might have contributed but they wouldn't have caused her death at that time, and it was very peaceful. But she had gone in on 4 October, died on the 24th, so ... as I say, I have made the point about infection control, but with the treatment she got, I don't have any complaints about that at all. They did everything they could, and every time I phoned up, I got answers or, if the person was busy, they would ask if they could get a colleague to phone back because the other person was dealing with Jacky and that was fine.

The communication I got on the final day was superb, especially when I do hear what other people had to go through. As I say, Jacky was fully aware of what was going on and the consultant actually commented that it is one of the horrible things about COVID for someone in Jacky's position because they are fully compos mentis and knew exactly what was happening throughout because obviously they couldn't be sedated because that would suppress the breathing.

As I mentioned earlier, my Lord, the only testing that was done at that time was if you had one or more of the three cardinal symptoms. That was the only reason she got the COVID test, otherwise she wouldn't have had it.
Q. You go on in the next section of your statement to talk about infection control and some of these points I think you have hinted at already: the incidents of people coming out of the hospital, meeting their families out of the hospital without PPE and then being able to go back into the hospital. Just take us through your thoughts on that, please, at paragraph 58 and following.
A. Yes. Within the hospital, the cleanliness and the PPE available for visitors, I actually thought it was pretty good from what I did see. If we want to nitpick, there were a couple of things, like when I went in with some fresh clothes and they said, "Oh, we tried to contact you to tell you not to visit today because of possibly COVID", they didn't know whether I could leave the clean clothes or not in a bag. In the end they did take them in, which I think was the right thing to do, so Jacky could be comfortable. And in maternity unit there was an elderly lady who was in and her daughter brought the lady's husband with her, but he had Alzheimer's so he wouldn't be able to remember what was said and the

daughter was allowed to go in with him as well. At the time I thought maybe it was a breach of infection control, but I felt it was the compassionate and right thing to do and I actually subsequently found out that —— I think it was July 2020 —— they brought in a rule where people could go in with someone who had Alzheimer's or special needs in those circumstances.
Q. I think one of the points that we are going to hear a good deal of is the possible conflict between strict infection control and what might otherwise be seen as compassionate access to people, whether they are in hospital or in care homes, so I think that —— what you are saying there is perhaps an example of what could be done, perhaps shouldn't have been done but was done?
A. Yes. It's a very difficult thing to get right and I do appreciate that it was all new territory with the pandemic. I do also believe quite a lot of it was put down to problems with PPE. If there had been an abundant supply of PPE, I suspect more people might have been allowed in in more circumstances to visit, particularly in care homes.
Q. I think you can probably just go on to the section on the funeral, if you like, Ms Morrison.
A. Yes. As I say, not wanting to be the same as everybody else, Jacky had already decided that she wanted to be

cremated but she didn't want a funeral because she didn't want that to be the last thing that people remembered about her —— this was decided way before COVID and that —— and she just wanted to be taken off on her own for the cremation so that is what I arranged. As it was, it worked out well because I was still in quarantine at that time because obviously she was still infectious at the end. And her family didn't live in Scotland and I spoke to them on the phone and told everybody what was happening and what time to think about her.

It made it much easier for me, I must admit, being selfish, because how the heck do you choose who the other five are going to be to go to a funeral? It would have been so difficult to have to do that. So that is what we did.
Q. You then go on to tell us about DNRs and I think this was something that was applicable, so could you just tell us your thoughts on that please?
A. Yes. Again, just talking about my situation, as you know, when we talk about within the group, I have got a lot more to say on it. But it's mainly on the final day that the —— because they hadn't asked me about DNRs before that, but the consultant and I had the discussion about DNRs. As I say, they thought she was going to be

all right before that, but because -- well, once her liver went, as you know, we couldn't do anything. As I said before, they couldn't do dialysis because her blood was too sticky with the COVID, and the consultant -- she was also speaking to Jacky at the same time, it was a three-way conversation going on, and she asked what our views on CPR were and was that something Jacky and I had spoken about before. We had -- again, thank goodness -- we decided that if nature decided the time was right, then that was it and not to do CPR. I think a lot of that was also down to the constant pain that Jacky was in with her eye condition and she also knew that she was going to be totally blind in the future, which she was dreading.

Also, with her occupational therapist background, she knew all about it and what it entailed and she said she didn't want it, which I agreed with, but I said if she had changed her mind and wants to do it, I would support her in whatever she wanted to do.

The consultant confirmed that that is what Jacky had said to her she wanted and I think she just wanted to make sure we were both saying the same thing, but she did add that Jacky still had her sense of humour because, when she asked her about it, Jacky did add, "Mind you, I hoped I would be in my 80s before you asked

me that", so a comic to the end.

Q. You did mention the consultant in paragraphs 69 and 70, and in paragraph 70 you do name the consultant. Can I ask you not to in your evidence because that would be subject to our order?

A. Yes. Yes, I have got to acknowledge in some ways it might be a little bit different for me compared with some people because I do come from a medical family and I knew what the consultant was talking about, so she didn't have to go down to the real basics of explaining to me what CPR meant and what it entailed and I did know what she was talking about and, yes, the DNR was put in place. But I would also like to acknowledge in particular the level of communication between myself and the consultant on that final day. She was excellent and answered all my questions and she -- as I say, even came out of the high-dependency unit to talk to me while we were waiting to take Jacky off all the machines and explained what would happen next.

Q. With all that background, Ms Morrison, you are in this personal statement -- and I know you go on in your organisational statement to do the same thing -- but you are going to tell us what you see are some of the lessons to be learned and also your hopes for the Inquiry. I would like you just to read through those

parts of your statement, please.

A. Yes. From my perspective the main lesson to be learned is on infection control. What is the point of having all these rules of what has got to be done in the hospital and all the medical staff have to do if patients are just going to walk outside, break all the rules and come back in, potentially bringing COVID in with them? It's just totally defeats the object of infection control, in my view.

The next lesson is, if you are moving patients around the hospital, they must wear PPE and they must be protected by wearing PPE, and if you are moving someone around the hospital, you must have the same level of protection on all wards.

The other massive issue is we must be in a position to do a significant number of tests as quickly as possible and give consideration for increased testing irrespective of symptoms or lack of symptoms in healthcare environments.

The other one, which is a biggie for me, is communication. I -- if you can talk about someone's death being a positive experience, in that context for myself it was a positive experience, but, as I say, there are so many who haven't had that and don't have good communication, so if one person can do it, they can

all do it.

Q. Hopes for the Inquiry?

A. Yes, that we can get infection control right. As I said, my personal hobby horse is communication because I got excellent communication, but I have listened to so many stories from people in our group who have had such a dreadful time, and this is why I think something like nicely done leaflets, not childish leaflets, just explaining each thing, "What does CPR involve and why are we saying we are not going to do it", and that sort of thing. I would suggest it needs some palliative care specialists and doctors and nurses to get together and say, "What are the main questions we are asked and how can we translate that into something that can be handed out to people generally to help them understand what is going on?", because you also don't take in everything when you are stressed and in that situation.

But the biggest thing of all, though, is we must have proper plans and procedures in place across the board so that, when the next pandemic hits us -- everyone knows it will do -- and from the outset we want people to know what needs to be done.

Q. Thank you, Ms Morrison. You have signed your statement and dated it and you confirm that that is your statement for the purposes of the Inquiry?

A. Correct.
MR GALE: My Lord, I wonder if we can take a few minutes.
THE CHAIR: Of course. How long do you want, Mr Gale?
MR GALE: Just ten minutes.
THE CHAIR: Ten minutes.
Do you want to actually take the -- let's call it "the coffee break", although that is probably the wrong term. Do you want to take that now?
MR GALE: We can do, yes.
THE CHAIR: Yes, that is the sensible thing. As it happens, it is 10 minutes to so why don't we just come back at 10 minutes past? Thank you very much.
(10.50 am)
(A short break)
(11.10 am)
THE CHAIR: Right now. Good morning again, Ms Morrison.
Mr Gale, when you are ready.
MR GALE: Thank you, my Lord. Ms Morrison, may we look at your witness statement, which is described as your "organisational statement". It's a longer statement.
A. Yes.
Q. There is a lot of material in it that to a certain extent you have already touched upon when you have spoken about your own personal perspective so there will be sections that I will perhaps skim over a little bit.

A. Yes.
Q. So I should say that everything that is within your statement will be considered -- every word of it will be considered by the Inquiry, so if -- simply because it hasn't been read out, it is not disregarded. Again you set out your background, and at paragraph 3 you explain that you are a part of the Scottish Covid Bereaved Group and in paragraph 4 you said that you had a meeting with the former First Minister in March 2021 as it had become clear that you and others of like mind needed to be an autonomous group to deal with Scottish issues, and you originally started off as a Scottish branch of the wider group of COVID Families for Justice.
A. Correct.
Q. There were some differences of opinion which for present purposes I don't think we need to go through, but at paragraph 6 you say:
"Everybody in the group has been bereaved."
And you refer to that as being a sort of qualification for membership of the group, I suppose --
A. Yes.
Q. -- putting in bluntly. You then say -- and I hope you don't mind but I took that next quote and I did attribute it to you so I didn't pass it off as my own -- but I did take that quote in the opening statement that

I made and I think it is probably better that it comes from you. So if you could just read paragraph 6, just to explain the background for that please.
A. Yes. So everybody in the group has been bereaved, and yes, we do, for want of a better expression, use the word -- it's a qualification for joining the group. Originally it was just that people wanted someone else who understood what they were feeling because I think we have all found out that bereavement during a pandemic is a very different thing from, for want of a better expression, "normal" bereavement.
Q. I think also you go on to indicate that your membership of the group had diverse backgrounds and that eventually you had a meeting with the former First Minister, as we have mentioned, in March 2021, and that was I think in part at least because you wanted a Scottish public inquiry.
A. Correct.
Q. I understand and obviously we understand that there was a positive response to that.
A. Yes.
Q. I think you say at paragraph 10 that:
"As a group, we have managed, I hope, to take a positive approach to all of this."
You want answers but you also want to be

constructive in getting those answers?
A. Yes.
Q. I think you particularly are aware that there are certain matters that this Inquiry can't give you answers about, regrettably --
A. Yes.
Q. -- and I am sure for many people, but there are matters obviously that we will endeavour to provide context and information for you. You also say at paragraph 10 that you have experiences of both good and bad practices.
A. Correct.
Q. I think these are matters you want to share with the Inquiry. You then go on to talk to us about the type of services that -- the service that Scottish Covid Bereaved provides and continues to provide, and I think it began, in part at least, with a Facebook page, but I think it is also -- you also recognise that some people, looking at myself, are not particularly adept at social media and therefore you had provision for other people to join who weren't -- didn't have that approach. I think you have also indicated in that section the difference between care home deaths and what is called "nosocomial death".
A. That is right.
Q. Perhaps for the benefit of everybody, can you explain

what that is?
A. Yes. Obviously the care home deaths, which accounts for about 9% of the deaths in our group, which actually matches the national statistics as well; the nosocomial deaths, which is hospital—acquired infection, and I just checked the latest figures well and it's 25% of our members have lost someone to nosocomial COVID, so that is three times the death rate than it is for care homes, nosocomial. Do you want me to explain the definitions of ——
Q. I think it is probably useful if you explain what it is.
A. When someone goes into hospital, if they have COVID in day one or day two, it is deemed they caught it in the community before they went into hospital. If it is day three to seven, it is indeterminate where they caught it. If it is day eight to day 14, it is probably caught in hospital and day 15 onwards it has definitely been caught in hospital.
Q. Thank you. You do go on to talk in this section of your statement about the interaction with other members of your group. At the bottom of paragraph 14 you give I think probably an anecdotal and general quote, when you say, "Ohh, that's what happened to me", and that is something that brought you and other members of your group together?

A. Yes, yes.
Q. Then I think you give a slightly more difficult aspect of what was said in paragraph 15. Perhaps you could just read that, please.
A. Yes. It is talking about the monthly Zoom meetings we do for any members who want to come along, we can just share their stories and nobody is mocking them because, when you actually say in public, "I lost someone to COVID", you are immediately getting the response from people, "Oh, there must have been something else wrong with them" or "They were very old". It's all those sports of stupid things. So a lot of people actually don't say in public how they lost someone.
Obviously within the group we understand what it's like and we don't have any of that stupidity, so people can talk from a place of —— I wouldn't say "comfort", but a place of knowing that the rest of people genuinely understand.
Q. Okay. Can I now just take you on and again remind you that we are —— we have all that you have said there. Can I take you on to the section on people represented by Scottish Covid Bereaved? I think what you say there is, as I mentioned earlier, it's of wide and diverse backgrounds.
A. Very much so, yes, because obviously we just got

together because someone had been bereaved, but as the group grew and the membership grew and we spoke to more people and you find out what they do —— we have people from all walks of life and all sorts of jobs and professions. You know, we've got medical people, nursing people, teachers, retired, scientists, cleaners, everything, we've got it, and it's —— it doesn't matter what background is, they are all there because they have lost someone to COVID.
Q. At paragraph 25 you mention the interaction of the group with the Inquiry's listening project, Let's Be Heard, and I think what you are indicating there is that that has been quite positive.
A. Yes. When the Let's Be Heard was being developed, we had some volunteers who worked with the team to give some thoughts and input and views, and then, once that was sorted out and how it was going to be, we were giving people ideas on how to get prepared for doing it online. We did a few posts and talking to people about it, so it was really getting the message home that, "This is a good platform to tell your story".
Q. I think on behalf of the Inquiry and particularly on behalf of Let's Be Heard, we are very grateful for that.
A. Thank you.
Q. Just going to paragraph 26, you say that the Facebook

page is the group's main focal point, and just to get an idea of the size of the group, towards the end of that paragraph you say that:
"We represent families of over 200 bereaved individuals who are signed up on the legal side."
A. Yes.
Q. Just explain what that is, what being "signed up on the legal side" is.
A. We do have members who just want to be members of the group and they didn't want to get involved in the legal side and the Inquiry side early, they would find it too traumatic. They just wanted to try and cope but know they had people they could talk to. So we never forced anyone to sign up if they are not comfortable with it. They get the choice. They can sign up with Aamer Anwar's team to be represented in the Inquiries.
Q. You touch on the geographical area covered and I think you indicate that this is across Scotland. Much of your communication is done remotely by Zoom ——
A. Correct.
Q. —— and other platforms, I suppose. You then go on to talk about the roles within Scottish Covid Bereaved and I think there were effectively —— I don't know whether I'd call it a "committee", but there were five of you who spoke to the former First Minister?

A. Yes.
Q. How did that group come about?
A. We put our hands up at the wrong time! No, it came about really because, when we knew we would have a meeting with the First Minister, Alan Wightman, who was putting it all together, he asked if there was anybody who particularly wanted to speak to the First Minister and we all said "Yes". And just sort of from there the wee group we started was —— we called it the "First Minister's speaker group" and then we became what would be called the "Lead group" and we said our aim was to get the Inquiry and to get legal representation for the group.

We formally disbanded as a lead team a few weeks ago (a) because we met our commitments but also to fit in with the UK Inquiry. Because of the modular approach taken, it seemed silly to have people who were involved just because they were on the lead team for that specific topic but they didn't have personal experience of it. So what we will actually do for each topic is have a wee group who will be the lead group for that topic. That is how it is going to work.
Q. Can I take you on in your statement to paragraph 45? Taking a bit of a leap, you there look at the approaches taken by this Inquiry and the UK Inquiry, and we know

what you say and we are well aware of what you say in paragraph 49 in particular ——
A. Yes.
Q. —— and we take that on board. In paragraph 50 you say that we are taking in this Inquiry something that is quite different an approach to what is being taken in the UKI. Obviously you have heard my opening statement and you have heard me say this before, that this was a considered decision and we have a particular view on that. I suppose from your point of view and indeed from many people's point of view, if I can put it this way, the jury is out on whether or not this is the correct approach?
A. Yes, I actually —— I find it a very interesting approach and I think it works well. Whether the difference is because we are a smaller country so there is —— we are not going to have hundreds of thousands of people speaking at the Inquiry that you can do it like that. I mean, the UK one, it would be a far bigger task to do that. But, no, I totally understand the logic of it.

The other thing is that for those who are called to speak at the Inquiry, no disrespect to the Inquiry, but you have got it out of the way at the beginning and to a certain extent don't have to keep re—living the experience, so from that point of view I think it is

very positive.
Q. Thank you. From paragraph 51 onwards —— and it's a lengthy section in your statement and that is not a criticism —— but what you do is you set out various matters that you want this Inquiry to take notice of. Some of these you have already talked about. DNACPR, you've talked about, communication, you have talked about, infection control, you have talked about, but now you are giving it more from the perspective of the group rather than from your own personal perspective, albeit that is informed by your own personal perspective?
A. Yes.
Q. I think probably paragraph 51 is important, albeit it is in general terms. It is important for this to be said and I would like to you say it, please, what is in paragraph 51.
A. Yes. As a group we are saying please listen to us because we have so much information and we really don't want anyone to ever go through what we went through. As I said before, we have examples of good practice as well as bad practice, and if some places can get it right, everybody can get it right.
Q. Can you go on in 52, please?
A. Yes. What we are finding is we have different health boards who are acting slightly differently or the ethos

within the health board is different. Sadly, if someone comes to me and says that they have had such and such a problem, in my mind I am thinking of particular hospitals, particular health boards, and very often it is the case when they eventually name the hospital. So we are already seeing clear trends of areas that don't do it as well as other areas, shall we say? Sometimes you are getting differences between hospitals within one health board and even between wards in one hospital there is a lack of consistency across the board.
Q. Thank you. Again, you go on to talk about CPR and I think really you have made that point: the need for that to be properly communicated so it can be properly understood by the recipients?
A. Correct, yes.
Q. And again you go on to talk about communication in general terms, I think.
A. Yes.
Q. You again praise Jacky's consultant for her level of communication and I suppose also one of the things that comes across from your particular experience is that do not resuscitate and CPR is something that you and Jacky had talked about.
A. Yes.
Q. Could you go to paragraph 63, please? You've said there

that you think that the organisation will be asking more questions than giving answers, and, "if the purpose of the organisation with regards to the Inquiry is to point in the direction ... [that] the Inquiry should be speaking to, to get information that the Inquiry is looking for".

Can you just then go on to read perhaps the next few paragraphs so we can have the context of that introductory remark?

A. Yes, it's —— as a group, as I have mentioned before, we want answers and we want to know why things went wrong, why wasn't there appropriate plans in place. But we have a load of issues we want to raise with the Inquiry and we want answers, but, again, as I have said before, we want to help by sharing our experiences and our knowledge. Obviously a lot of it is going to be political because that's the structure of the nation, but we hope that the politicians, the scientists, the chief medical officers and so on are big enough to put politics aside and just tell it like it was; you know, what issues did they have and how can we make it easier in the future —— how can they make it easier in the future to make decisions and that sort of thing. Basically we are asking for a full and frank discussion, if you will, on it.

Q. I think you are directing that particularly at decision—makers and possibly also implementers and, putting it in a particular term, you are looking for candour?

A. Yes. Yes. I think, as well, if I may say that we are hoping that within the Scottish Inquiry that it will go down to the level of individual health boards, possibly in some instances individual hospitals as more information becomes available, and perhaps ask Social Services a question, "Were you aware of any issues in a care home during that time and, if so, what did you do?", rather than just talk about care homes generally.

Q. Could you go to paragraph 72, please? You are talking there —— I think immediately prior to that you have drawn the description between a nursing home and a care home ——

A. Correct, yes.

Q. —— which sometimes gets blurred ——

A. Yes.

Q. —— or possibly not understood, so that is quite important to make that distinction. You then refer to the guidance given by the British Geriatric Society, in March 2020 and, for your information, we will be hearing from a representative of the British Geriatric

Society in a much wider response, but you have a particular issue that you want to raise under reference to that information?

A. Yes. Just emphasise the point because a nursing home will have a qualified nurse in it and a care home is personal care, helping them get up, get dressed, feeding people, that sort of thing. So basically you are suddenly asking care home staff, who have no experience whatsoever, things like, "What is the correct way to take a temperature?", and while they may have taken temperatures before and they might have done readings, would they know what to do them, what had they recorded? Did they understand what different readings meant in the context of COVID? Because they didn't have that knowledge and experience to do that and to some extent you feel sorry for them because they were chucked in at the firing line with no preparation for dealing with that.

Q. At paragraph 73 you talk about PPE. I am interested just to have your comments in 73 and 74 on that, please.

A. Yes, with PPE —— and the UK sent a lot of PPE to China at the start of the pandemic, I think it was actually in February 2020, and there's other things. The army used to be the custodian of the UK PPE stockpiles, in fact for all the stockpiles. They had the

Green Goddess fire engines and so on and they looked after all that. They had very good systems in place and they were careful to rotate stock, so if something was getting towards the end of its life, it would be sent out to the hospitals so it was used in time and you didn't end up with out—of—date stock on the shelves.

I think the privatisation of PPE has been —— I don't actually use the word in my statement, but I think it was a disaster. There is evidence of at least one privatised company who put a lot of PPE in a leaky warehouse which had asbestos problems and everything else and it was just sitting there in the warehouse not even on shelves. There was another one that has just fairly recently been exposed, where somewhere in the New Forest they found tonnes of PPE dumped in the open.

Q. Paragraph 76 is, as you put it, your bugbear —— I think you call it your "biggie" in your other statement —— and that is testing. Can you just go through that section, if you would, please?

A. Yes. As I mentioned before, originally tests were only available if you had —— at that stage it was two symptoms, it was temperature and cough. And then following information from the ZOE Health Study, which identified the lack of taste and smell, it went up to only those three symptoms. Yet the same paper referred

to earlier on from the British Geriatric Society and in plenty of other papers just referencing the BGS one, which was right at the beginning of the pandemic, it was already recognised that elderly people would not have those symptoms, they would have completely different symptoms, and I can't remember the exact figure off the top of my head, but I think it is something very low. It's either less than 10% or less than 20% would even present with a fever and they wouldn't have coughs, so they would have completely different symptoms, but they weren't eligible for tests because they were not those three symptoms.

Q. Just an observation, if I may. You reference the BGS paper and that was obviously very early in the pandemic. Am I right in thinking that you have educated yourself very much in what was the pandemic and its circumstances and a lot of very detailed information?

A. Yes, it was one of the ways that I coped. I wanted to know everything and anything all about it, so I have well over 1,000 documents I had acquired. I also did a timeline for the first year for UK Government and Scottish Government and other items which comes to nearly 100 pages of detail. So, yes, I did a lot of research into it.

Q. Thank you. If we just go to paragraph 79, please.

Perhaps you just read that out because I think we are talking there about testing.

A. Yes. The Government, UK Government, they made quite a big thing of they were the first ones to develop a COVID test, which, yes, they did, but they didn't go on and take the opportunity of having it mass-manufactured. They were offered a chance to go in with Roche in Germany to do a joint manufacturing thing and it was turned down by the UK Government because their stance was, "We've left Europe. We can manage on our own", and Germany were producing, by the end of February -- it says there "2021", but that's actually an error. It should be "February 2020" -- they were producing 4 million tests -- I can't remember off the top of my whether it was either a week or a month, but they were producing millions of tests and we weren't.

Q. Paragraph 80, you talk about I suppose the devolved element that this Inquiry is investigating and you say at 81 that the Inquiries are intertwined and the remit particularly of the Scottish Inquiry.

At 82 you make an interesting point, and again I would like you to read that out, please.

A. Before I do that, would you like a little bit of the historical background to it?

Q. Please do.

A. After the Swine flu pandemic in 2009, the governments of the four nations got together and they agreed they would go on a unified approach and they produced a document in 2011 for a flu pandemic -- I think the devolved nations had two paragraphs in it -- and in 2012 there was another document produced for a communication strategy between the four nations. But overall in the preparation, Scotland seems to have done a lot more preparation than the rest of the UK and they have been in the process of doing their Let's Prepare Scotland leaflet system, and this has done a whole series of documents on different events that they have to prepare for and plan for. As I mentioned to you earlier, one of the ways I coped with Jacky's death was looking at all of those plans and the local authority plans and so on. But there is a series of them dating from 2016 through to 2018. John Swinney was the man responsible for that aspect of it all.

But they were public documents for people to read and local authorities to look at and use to prepare their plans, but it covers all emergencies, so it does cover flooding, bad weather and so on. The structure in Scotland, it seems to be more simplified and there is one document that showed the difference in the UK Inquiry and Module 1, where they were showing the

structures for the four nations, and if we say the UK England one was actually called the "Spaghetti chart", including by the legals there as well --

Q. I think I have seen that, yes.

A. Yes, it's so complex, "Spaghetti chart" is the best description you can give. So the Scottish one was much more simplified.

Q. Thank you. You say at paragraph 88 that what you are telling the Inquiry is second-hand, but you also obviously have first-hand experience.

A. Yes, yes.

Q. I should indicate that the Inquiry is very interested in receiving information particularly from people like yourselves of what you term "second-hand", anecdotal --

A. When I am telling it, yes.

Q. -- and we are not -- we emphasise we are not a court, we are not hidebound by rules on the admissibility of evidence, so we are very interested in hearing this. Again you make the point at 89 that you represent -- your group represents 200 families.

A. Yes.

Q. At paragraph 92 you say that you do have a lot of stories and, "at a high level, it would be more appropriate to focus on the issues arising further down the chain ... which confronted our members, loved ones,

ultimately leading to their deaths". Can you just explain what you mean by that?
A. Yes, for example, we know that every health board had infection control plans in place, which incidentally only ever say in them that reference to patients —— the only reference to patients and visitors is they can use alcohol hand gel. There is no other reference. But how did those plans come down through the organisations? Did they go, the same plan, to each hospital or did hospitals tailor their own plans to sort out their own needs and then how was that translated down to the front—line staff? Because I know many organisations, they would write a document and say, "Yes, we've got one", and it was put on the shelf, so we need to know was that properly communicated to all the people on the front—line.
Q. Paragraphs 93 and 94 you get a bit political, put simply. Perhaps you can just read that out please?
A. Yes. It doesn't matter if the plans in place are the best in the world or not if the political comprehension of the coming storm is lacking and it's partly driven by pandering —— and I do say, sorry, this was directed to the UK side —— to the loudest MPs in Government, irrespective of the science, rather than doing what is in the best interests of the people. Then more people

would die than would otherwise be the case.
Many times during the pandemic, it appeared there was a culture of contempt for the ordinary people and, as I said before, hubris does not stop a pandemic and I think this attitude has been confirmed by the investigation into the so—called Partygate scandal.
Q. Thank you. I don't wish to cut out large sections of your statement but I think a lot of what you go on to say are matters that you have already touched upon so I would like to skip on a little bit, if I may. Paragraph 111, if you could just read from there on a little bit down in that section please.
A. Yes. This is in the context of lockdowns and the whole dealing with the pandemic. We do know that it did have a tremendous negative effect on individuals, particularly in care homes, particularly those with dementia who couldn't understand what was going on. Also, if you had dementia patients who were known as "wanderers", the ones who need to wander, what could you do? You can't lock them in their room.
This issue with not allowing people to visit and so on wasn't because of a lack of PPE. Could loved ones have put PPE on and come on in and —— you know, at the same time you are getting care home workers saying, "We're owned by a big group. We've a shortage of staff

here", and they're bringing people in from other areas of the country. So you've got people coming up from Birmingham, which was a COVID hotspot at that time, to to work in a care home, yet you're not letting the nearest and dearest in; and you might have people who are doing a shift in one care home and then moving to a different care home to do another shift. So, as I think other groups have said, if the loved one came in and had PPE to do that, it would be of tremendous benefit not only to the individuals in the care home but also to the organisation of the care home with the assistance they could give.
Q. You continue on in your statement to look at a number of other countries and the approaches that were taken in other countries. I can tell you and indeed the wider Inquiry that this is an area that this Inquiry will be looking at and we will be obtaining comparative evidence so that it can inform our view. So this is something that we will look at and we take on board all that you say in that part of your statement.
Just going towards the end of this part of the statement, could you go to paragraph 130, please?
A. Yes.
Q. You are talking there about the concept of lockdown.
A. Yes.

Q. We understand what that is, you have explained what that is. Can you just read on from 130 to the bottom of that section, please?
A. Yes. I think no one had considered the concept of lockdown. I think it was too little, too late, and I mean that in the context of, if something had been done earlier and if it could have been managed better, we wouldn't have perhaps had the long lockdowns that we did, but there was absolutely no plan for it and, let's be honest, they were winging it. Personally I didn't have a problem with lockdown, it didn't cause Jacky and I an issue, it kept her safe, but I know that some people did find it very difficult and very traumatic, particularly families whose older loved ones who lived on their own and the family used to pop in several times a day to look after them and that is what enabled them to live on their own in their own home. With all that being stopped, I think it was incredibly damaging and I think, if people had been treated more like adults and had it explained to them, "This is what we've got to do to stop the virus. We need you to do this and do that", I think that would have helped.
When masks were brought in, I don't think it was handled as well as it could be. I know —— I didn't have this witness statement —— I know that from the UK lead

on this, they were quite adamant that they didn't want masks because they didn't have masks stockpiled to deal with it. But it's said, "If you wear a mask, you stop other people getting COVID", and there is a lot of truth in that, but it all does depend on the mask. If I may just expand on that slightly.

Q. Yes, please do.

A. If you just make your own mask or just buy a mask in the shop that has no filtering material in it, then it is pretty ineffective. If you then go on and use the surgical-type mask, that is designed to stop people -- the germs coming out of someone's mouth and going to the person they are talking to, but naturally they don't fit very well, and then you are getting into the more important masks for dealing with an illness like COVID, when you've got -- the main European Standard is FFP2, and that prevents 94% of the particles coming into the lungs of the person who is wearing it. The American version of that is the N95 mask, which actually stops 95%. And then you've got the one which is really important, particularly for healthcare workers, people who are dealing up close and personal --

Q. In a clinical setting.

A. Yes -- and that stops 99.8% of particles coming in. But it was sort of "Wear a mask and that's it", whereas in

Portugal, for example, masks were called "freedom masks" and enforced the concept of everybody wearing a mask because it would free the country from COVID faster, so they turned into a much more positive thing and brought people on board with it.

I personally am a fairly risk-averse person and I actually ordered masks in January 2020. I am a reasonably, I think, intelligent member of the population, probably more risk-averse than many, but I'd seen the tweet from Devi Sridar, Chair of Public Health at Edinburgh University, on 16 January, when she said people were asking her, "Is this something we should be worried about?", and she said, "Yes, we should be", so I thought I would just play safe and do it, but that is me.

Q. Right. I don't want to go through in any great detail your observations on the supply and distribution and use of PPE. I think we have got a flavour of what you are saying about that and obviously we can read what is in your statement on that; also the section on do not resuscitate, paragraphs 143 and following.

I think perhaps it is perhaps important that you go to 151 in the statement. I think you explain there where some of your information comes from, which is very helpful. Your father was a doctor, your mother was

a nurse?

A. Yes.

Q. You explain from that perspective you were able to understand the rationale behind the advice and discussion of do not resuscitate.

A. Yes.

Q. I think you go on at 152 and following to reiterate the point that you made in the context of your personal statement this morning about the need to have information conveyed both directly and also in writing in an intelligible and easily understood manner.

A. Yes.

Q. You touch on in this section, the next section of your statement, on prolonged grief disorder and I am going to ask you to defer that until we look at your specific statement on that. Then you go on to the guidance that was handed out by the group. This is your group, I take it, you are referring to?

A. Which ...

Q. Sorry at paragraph 160, "Guidances handed out by the group".

A. Oh, yes, that was the title of question. We didn't hand out official guidances, but if people asked us for information or were trying to discuss it, then from my perspective I would say what I knew or send an email to

them to explain what was happening. We did do updates and let people know where we were at and what was happening, but we didn't do guidance as such. We did say things, "If you want someone's medical notes to find out what treatment they were given, you can request that from the hospital. Contact this person", that sort of thing, or, "If you feel your complaint hasn't been dealt with properly, you can go to the Ombudsman", that sort of thing.

Q. Lessons to be learned. Again this is something you have touched on in your own personal statement. Is there anything in particular from a wider group point of view that you would like to emphasise?

A. The one thing I would say prior to the views of the group, that we were actually -- the world was actually incredibly lucky, again for want of a better word, with COVID, that the case fatality rate was only around 1%. If it had been a flu pandemic, it would have been more in the region of 3% to 5%, something like SARS it would be 10% and if it was MERS you would up at 30% fatality rate. So as scary and horrible and frightening as the death rate was, we were incredibly lucky, given the lack of preparing, that it wasn't significantly worse.

Q. Also in "Lessons to be learned", at 168 of your statement, you talk about dealing with the aftermath and

counselling. What do you want to tell us about that?
A. People in the group, from the feedback that they've given me, they have not found it that helpful. A lot of counselling groups are volunteer groups and they are not able to deal with the complexities that arise from a death in a pandemic. This is why we let people -- not let people -- we encourage people to talk in the group, but I am very aware that I am not a counsellor, that I'm not trained in it, so I worry that, if I say something wrong, I could do more harm than good. So we do need to have some form of counselling service that can step in in adequate numbers, and even if it ends up doing group counselling rather than one-to-one counselling -- we have had people where they have gone for counselling and they have walked away because they felt the counsellor has not understood where they are coming from with grief in a pandemic.
Q. A phrase I have heard you say, both in reading your statement and I think I have seen you on television on a number of occasions, you often say that people "don't get it".
A. Mm-hmm.
Q. Does that encapsulate --
A. Yes.
Q. -- some of the views that you are expressing?

A. Very much so, yes.
Q. Could we move on to funerals because I know this is something you had to encounter --
A. Yes.
Q. -- after Jacky's death and obviously a lot of your members had to encounter after the deaths of loved ones. So perhaps we you could just take us through from 172 onwards, please.
A. Yes. Some of our members were told when -- well, they were given a choice, "You can either be with your loved one when they die or at the funeral. You cannot do both", and that was incredibly difficult for those individual who were put in that situation. People have to make -- people make decisions in different ways. For some people a funeral is a very, very important ritual; for other people, it is not so much. They want to be with the person as they pass away. But people did find the whole process so traumatic, starting off with many didn't realise that their loved one was double-bagged in a sealed body bag which could not be opened, could not be unlocked, so they couldn't have viewings, they couldn't go and see them quietly in the funeral home afterwards and they couldn't have their loved ones dress appropriately.
Those sorts of things were very difficult because,

if you couldn't be with them at the end, you would have quite liked to have gone and just sat quietly with them in the chapel of rest or whatever, and they couldn't do that. And then of course deciding -- how do you choose who goes to the funeral when it was only six people allowed to attend? You can't have singing because that produces aerosols and that sort of thing.
And one of the things that I think was the most difficult was the lack of physical contact after bereavement or at a funeral, and if another family member was there and you didn't live together, they couldn't come up and give you a hug and I think it was wrong to stop that. I mean, it was seven months after Jacky died before I got a hug, and that is just not right, you know. It's so important, it's such a comforting thing and not to do that ... and, of course, on the subject of people wearing masks at that time, at funerals you can understand why they had to put restrictions on and a lot of crematoriums and churches did act very quickly in putting video links in, but it is a very difficult situation to deal with.
The only blessing we did have was, thank goodness, people were still able to have personal funerals and the death rate wasn't at the size that it had to be mass burials. But some funeral directors were very good when

they said, "I am sorry, we can't unseal the body bag, we can't dress your loved in appropriate clothes, but then, if you give us what you would have wanted them to wear or their favourite clothes or something, we will put them in the coffin with them", and things are like that. And they did that and that was a comfort to people, but some places were almost cruel.
I can't remember who it was, but someone said that at their burial they were not allowed to even leave the cars in the car park until the undertakers were ready with the coffin at the graveside and then they were told, "Come on, you can come over now", and then, as soon as the coffin was in the ground, they were told, "You've got to go now. You can't hang around over the grave". We have to -- as a society we have to find a better way. I can understand why you wouldn't have 200 people at a funeral like that, but we've got to find a better way.
Q. Thank you Ms Morrison. Paragraph 182 and following, you repeat your observation that as a group you want answers and want to understand what went wrong --
A. Mm-hmm.
Q. -- and why it went wrong and, "we want to see better procedures and systems and more humanity in place for the next pandemic because there will be one", and you

say, "Hopefully it won't be until after the Inquiry and people have had a chance to learn lessons, so I hope that people are going [to] be already learning lessons and put new things in place".

So do I take it from that observation that you would want those who are taking decisions in the event that there is a future pandemic to be listening to what is being said at these Inquiries?

A. Absolutely, yes.

Q. You also say in 183 -- would you read out 183, please?

A. Yes. I said I think we've got to think outside the box more because I am sure a lot of things can be improved dramatically just by thinking outside the box and I think authorities have not to underestimate the people that they were dealing with.

Q. Carry on, please.

A. Yes. As I said before, we've got a range of educated people to people who might have learning difficulties and that sort of thing, but if things are explained properly and we really understand what is going on and we see everybody else going through the same, it does make it much easier to comply. And the big thing we've got to do is get a grip on social media in a pandemic and they've got to stop all these ridiculous conspiracy theories going on and it has to stop because, apart from

the fact that some people do fall for some of these stories, it is so hurtful to those who have been bereaved to hear the naysayers saying, "It's a load of rubbish. It is not happening. It's just flu", and so on.

Q. I think you conclude by saying that freedom of speech is acceptable if it cannot be allowed to hurt other people.

A. Correct. Yes.

Q. Again you have signed that statement, Ms Morrison, and dated it, and again this is your evidence to the Inquiry on the organisational aspect.

A. Yes.

MR GALE: My Lord, I wonder if we could again take five or ten minutes before the next statement, which will be shorter.

THE CHAIR: Shall we say 12.20 pm?

MR GALE: Thank you, my Lord.

(12.07 pm)

(A short break)

(12.20 pm)

THE CHAIR: Right. Now, Mr Gale, when you are ready.

MR GALE: Thank you, my Lord. Ms Morrison, thank you again for coming back. I would like to move to the final statement that you have given. This is relatively brief but there is a lot of important information in it that

I would like to discuss with you.

It's entitled "Grief and bereavement during a pandemic", and I think in the first paragraph you mention something that you think that needs to be looked at, and that is what is called "prolonged grief disorder", also known as "traumatic bereavement", and you give some data from an American report that says levels may be as high as over 60%.

A. Correct.

Q. You then were asked to look at a report prepared by Dr Emily Harrop and her teams from Cardiff and Bristol Universities. This was published last month and it is entitled "Prolonged grief during and beyond the pandemic: factors associated with levels of grief in a four time-point longitudinal survey of people bereaved in the first year of the COVID-19 pandemic". I think you have looked at that.

A. Yes.

Q. I think also you have indicated that there are certain points within that statement, that paper, that you haven't considered or indeed commented on and in particular the socio-economic status of some of the people who were surveyed for the purposes of that work. So you have made no comment on that.

A. Mm-hmm.

Q. You say at paragraph 4 that there is one issue that you think needs stressing, and I wonder if you could just read on from there and then we will come to look at various sections of the paper at a later stage.

A. Yes. One issue that I thought needed to be stressed is the report says you have different levels of PGD depending upon all the factors they have looked at. For our purposes as a group, we have never got into the realms of, "Your grief is worse than their grief because of X, Y and Z", and we have simply taken the approach that some members are really struggling to deal with their grief.

Q. I think what you then set out at (a) to (d) are various factors that the authors of the report identify --

A. Correct.

Q. -- and you make comment on that when you come to it.

A. Yes.

Q. So we can just take those as read, and if you carry on at paragraph 5, please.

A. Yes, so the four things we looked at is the relationship with the person who died -- that is a significant factor -- the cause, expectedness and the place of death -- these are the criteria within the report -- the circumstances of the death and the disruption to grieving, coping and the support process. There are

other considerations not fully examined, but obviously I can only speak as a lay person and base my view on talking to other members in Scottish Covid Bereaved and I think -- during the pandemic I think the trauma starts before the death of the loved one.

Q. Yes. Please continue on and I will come back to look at various aspects of the report as you come to the specific items in paragraphs 14 and following, but if just carry on reading what you are saying.

A. For example, if someone's loved one was in a care home, I believe there was a little -- an initial low level of constant fear. People were hearing all the dreadful stories in the press, initially from the horrendous things that were happening in Italy and Spain, so they are fearful that their loved ones will get COVID and die. Then, when there was the decision to discharge all of those elderly and, to use the official words, "bed-blockers", from hospitals untested into care homes, it soon became apparent that this was a problem in care homes and some of those discharged were bringing COVID with them, which, as an added bit there, it occurred to me the other day that if they are bringing COVID with them, then it will be nosocomial COVID that they have got.

But naturally it ramps up the anxiety levels of the

families; some care workers, as we mentioned before, who did shifts in more than one care home and some larger care home groups sent staff up from places like Birmingham, as I said before. So the families all see these things going on and they feel quite helpless and they couldn't go in and see how their loved one was doing, to check if they are all right, because they were banned from visiting, and that in itself is also traumatic. And then, if their loved ones caught COVID, the whole thing is ramped up tenfold, the helplessness and so on, and some care homes were being told, "We don't take care home residents to hospital. Order the end-of-life pack".

We even have one group member who had a legal arrangement in place that she could take her mother out of care at any time, and when her mother got COVID and I believe was only getting end-of-life care, she wanted to take her mother home to nurse her and she was threatened with action by Social Services. As it was, she did remove her mother from the home and nursed her in her final days. Imagine the trauma of coping with your worst fear realised. Your mother has COVID and is dying and on top of that you're having to battle the system and cope with threats and so on, when all she wanted to do was enable her mother's final days to be

the daughter who loves her and has time to properly care for her.

So many more had the trauma of just, if they were lucky, looking through a window, trying to shout messages of love, knowing full well that nobody has helped put their loved ones' hearing aids in so they can't be heard. You had the trauma of those who were sitting by the phone waiting for updates, if they were lucky, once a day from the hospital to find out how their loved one was doing.

I know from my own experience, those days are so long and your stress levels are going through the roof, you are praying, hoping for the best, at the same time you are fearing the worst, and the guilt and helplessness that you feel is unimaginable. Promises you have made to each other that you would always look after each other and be there when times are tough, here it was the toughest of times and breaking those promises through no fault of our own.

So the point I am trying to make is there has actually been a significant build-up of trauma before we even get to the actual death. As you know, some of us were fortunate enough to be there at the end, even when we were wearing gloves and masks, but even the final holding of hands is tainted because you are wearing

gloves, you know, and you couldn't even kiss them goodbye. You were there trying your best to comfort them and even then you couldn't do it properly.

For those who could not be there, I think it was even worse. Again this total helplessness, that the brain runs riot with all these questions, "Do they know they are dying? Are they in pain? Are they gasping for breath? Are they completely alone or is the nurse holding their hand? Do they know I'd be there if I could be?", and so on. And if you're in lockdown and you're on your own, it's even worse. You don't even want to talk to anyone else on the telephone just in case the hospital phones during that time. And, again, if your loved one had a pre-existing health condition, you are living on tenterhooks for much of the time, worrying about them, because of the risk they are at. All these factors are traumatic, but I think they may be a significant contribution to the subsequent PGD.

Q. If I can just stop you there and ask that you be shown the paper by Dr Harrop and her teams. The reference is at SCI-WT0730-000002. This paper was produced in September so it's very, very recent. I will take some of the burden off you having to talk all the time, if I can read out certain passages from this paper.

The background in the abstract at the beginning

is -- it begins:

"The COVID-19 pandemic has been a devastating and enduring mass-bereavement event, with uniquely difficult sets of circumstances experienced by people bereaved at this time. However, little is known about the long-term consequences of these experiences, including the prevalence of Prolonged Grief Disorder (PGD) and other conditions in pandemic-bereaved populations."

Then there are details of the methods and the results, and going on to the next page, there is in the rubric, the "Conclusion":

"[The] Results [these] suggest higher than expected levels of PGD compared with pre-pandemic times, with important implications for bereavement policy, provision and practice now ([for example], strengthening of social and specialist support) and in preparedness for future pandemics and mass-bereavement events ([for example], guidance on infection control measures and rapid support responses)."

Again taking matters very briefly, there is a lengthy but very informed background section which those who wish can read. Then if one goes on within the document to the section ... if we go on to the section 4.1 -- it's at page 20 within the document itself -- there is a section entitled "Grief levels and

the effects of time". I think again this is something that you have looked at and you make some comments on. I think we see from the report that the writers say:

"We found relatively high levels of indicated PGD and grief vulnerability overall and across time. As in other studies, time since death was negatively associated with overall levels of PGD symptoms and to a lesser extent levels of grief vulnerability, with a pattern of improvement and 'normal' grief trajectories for many. However, there are also patterns of worsening grief and grief which remained relatively static over time."

The writers then go on to consider the person who died, and I think this is the obvious one, the relationship with that person, and I don't think I need to go through that in any detail. I think we can understand that. They then go on to consider, in 4.3, the "Cause, expectedness and place of death", and obviously again that's something that is of significance, and probably related to that, at 4.4, the circumstances of death.

Then the other element of this report that you gave consideration to was the disruption to grieving, coping and support processes.

A. Yes.

Q. If I can take you also to the discussion -- I'm sorry, not the discussion section -- the conclusion section at section 5, and this is probably worthy of lengthy read-through and I will do that. The authors say:

"We found relatively high levels of indicated PGD at [circa] 8, 13, and 25 months post-bereavement when with compared with similar non-pandemic studies of bereaved populations ..."

And skipping on, if I may, to the paragraph towards the end of that right-hand column:

"Based on these findings we make the following recommendations: to inform bereavement support and policy at the present time and in future pandemics, many of which resonate with the recent report by the UK Commission on Bereavement ...

"1. In view of the higher proportion of people experiencing or at risk of PGD following the pandemic, bereavement support services require increased investment to ensure adequate levels of specialist provision which can effectively cater for those with more complex needs, as well as robust methods of identifying and reaching people most in need of more intensive support. Bereaved people are more likely to require such support include those grieving children, partners and siblings and following unexpected deaths,

as well as people who are isolated and have limited social support, health conditions and low levels of formal education.

"[Secondly] Opportunities for informal emotional and social support should be strengthened through provision of peer-support groups as well as compassionate community initiatives and educational programs which seek to improve grief literacy and the support available to people within existing social and community networks. Communities worst affected by COVID-19 and structural inequalities should be prioritized in such initiatives."

Then:

"Policies and training should be implemented to ensure compassionate and supportive communication and behaviors from healthcare professionals at the end of life, especially in acute and care home settings. 'Follow-up' contact should be consistently delivered by care providers following the death and enable meaningful discussion and reflection on difficult and troubling experiences, with signposting to locally and nationally available bereavement support services."

I would stop there, if I may, Ms Morrison. Can we go back to your statement, having looked at those various passages? If we can go back to paragraph 14, where you deal with the first of the significant factors

as it was put. If you could just read from there, please.

A. Yes, the first one is the relationship to the person who had died, and to me this seems obvious. The closer you were to the deceased, the more grief you will have to deal with. But within that I think again the level of —— for want of better expression —— the responsibility the bereaved had for that individual is a big factor; for example, if it's a parent, you have lost your child, even if they are grown up and have their own life. In addition to the natural shock and trauma, there is also an element of guilt that you should have been there to protect their child and I think it is also true when your partner is lost to COVID.

I can only reflect on my personal situation, but I know every time and day in relation to Jacky's death, yet my mother died not from COVID but the following year and I couldn't even tell you date she died or when her funeral was. I mean, I went to it, but I couldn't tell the dates. There's just no room in my psyche to take any more information like that on board.

Q. Then the cause, expectedness and place of death?

A. Yes, although the reports looked at this as separate topic, I think it links in very much with the next

point, point 3, and I do not think it is appropriate for me to comment on whether dying in one location, eg, a care home, is better or worse than dying in a hospital.

Q. Yes, and the circumstances of death, which is obviously the connect with what you have just said.

A. Yes, the report says, for example, that hospital deaths from COVID were the most traumatic. To me there is a certain logic to that because the individual has obviously become so ill that, unless it was nosocomial COVID and they were already in hospital, they were being rushed to hospital for treatment.

So you imagine the scenario where you have seen your loved one decline rapidly in health, you have been worried about them, looking after them, and then you think, "It's bad. I have to phone for the ambulance", and they decide hospital admission is the correct course of action. So you are dashing around, putting things together with them to take to hospital, trying to think of everything because you won't be able to take anything in if you forget later on. The ambulance crew have your loved one in the ambulance by now, you hand over the bag, a quick masked kiss and off they go, and then suddenly you are left standing there and it hits you that you have just probably seen them for the last time.

So you are thinking that did you remember to tell them you loved them, did you remember to take a phone charger. You know, all these things are whirling around in your head and you can't ask your best friend to come over to support you. You are literally on your own. And I have already described what it's like waiting to know what was happening.

But when we consider the death itself in relation to PGD, this can be summed up as poor end—of—life care, whether actual or perceived, with poor communication and support immediately after death, and I particularly welcome that recommendation at point 3 in the report about improved communication and training.

Many of our members have concerns about the death of their loved one and I believe much of it is down to poor communication during the time leading up to death, as I have previously outlined. They are left feeling that their loved one was not being properly looked after or cared for, and I used the word "cared" quite deliberately as some people who were getting little or poor communication felt that this was because the medical staff didn't care, and I was particularly pleased the report recognised that communication has to be better.

Of particular concern was the withdrawal of fluids

and nutrition from elderly patients and the issue of DNRs, as we have previously discussed. Particularly I think for those who couldn't be with their loved one at this time, because they are haunted with what happened to their loved ones; were they just left to die on their own? They didn't know if the death was peaceful or traumatic and, when you are not there, your imagination runs riot. I know that many hospitals and care homes try to have someone with the person at this time, but even then it's not a family member, it's not someone who knew and loved them. Again, many people feel guilt because of this. It's just a natural reaction, "I wasn't there for them".

Q. The final part of Dr Harrop's work so far as your commenting on is "Disruption to grieving, coping and support processes", which obviously include funerals.

A. Yes.

Q. Again, I would be grateful if you would just read what you say there, from paragraph 21 onwards.

A. Sadly for some people this impact came on immediately. We have one member who lost her father. She was with him at the end, but immediately after he died she was taken into a side room where she was sprayed down with something by a nurse. She doesn't know what it was, assumes it was some type of disinfectant and she was

told to go home. And she was unable to go and tell her mother, who was in the same hospital, that her husband had died and her mother died a few days after this.

We have other members who were able to be with their loved one at the end but not offered a chance to sit with them for a while after they died and they felt they were being rushed out of the hospital. And depending on the timing of the death and the relevant restrictions, we had people going back on their own to an empty house and unable to have even their own adult children around to come over and support them and help organise the funeral.

I have already mentioned not being able to view and dress the deceased and the issues of socially distanced funerals have been well reported and desperately difficult to choose who can attend. A funeral, as we know, is normally a time to celebrate the life of a person, to bring people together from all areas of a person's life and hear all the stories about them, to share the happy stories as well as the sad and to reaffirm that that individual made a difference in people lives, and to have that human contact with hugs as well as tears, and so many families were denied this opportunity.

There was also the difficulty in trying to sort out

someone's belongings or indeed clear their house during a pandemic. Charities would not accept clothing, house clearance firms were significantly reduced and only a few firms would take it on because of all the additional steps required, such as PPE and so on. There was also the difficulty for next of kins if they stayed in a different area or even abroad, dependent upon the restrictions at the time, but even when the restrictions were eased, there were still moments that appeared to add insult to injury.

We have a member who lives outside Scotland who came back home when her parents were ill, her father died in hospital with COVID with her mother dying a week later and another family member was in intensive care at the time, so she had to stay at her parents' home while she organised and paid for the funerals, cleared the house out and sort out all the other admin that comes along with bereavement, but, in addition to dealing with all that, she received a bill of £500 from the council for staying in the property after her parents' deaths. Many people didn't even get a call from the GPs' practice just to see how they were doing and the expression "cast adrift" comes to mind.

However, even with all that trauma going on, there was the massive impact of being bereaved simply from the

point of view that everywhere we went, every time we switched on the news, picked up a paper, COVID was in the headlines, actually day after day, week after week. Then, as time went by and the conspiracy theorists seemed to gain more ground and the COVID deniers were becoming more vocal, it was incredibly distressing. But I think the ultimate insult came when all of the so-called Partygate stories came out. People became so angry and felt they had been punished for following the rules, they felt they had been treated with absolute contempt and they felt they had been taken for a ride and treated as mugs, and that produced so much anger it is difficult to find the words to adequately describe it. But all of those factors contribute, in my view.

Q. Again, Ms Morrison, you have signed that statement, dated it and again that constitutes your evidence to the Inquiry?

A. Yes.

MR GALE: Ms Morrison, that is all that I need to ask you about. Can I thank you on behalf of the counsel team and the Inquiry team more widely for the obvious care you have put into putting together your statements. We are very grateful to you. Thank you.

THE CHAIR: Thank you very much, Ms Morrison.

Mr Gale, it's 12.45 pm. Is it possible to start at

1.45 pm?

MR GALE: Yes, my Lord. I think the witnesses will be here.

THE CHAIR: I suspect they will be here. If, by any chance, it is impossible, that doesn't matter, but if I could ask everyone to be here for 1.45 pm. Thank you.

(12.49 pm)

(The short adjournment)

(1.45 pm)

(Delay in proceedings)

(2.00 pm)

THE CHAIR: Good afternoon. Mr Gale.

MR GALE: Thank you, my Lord.

My Lord, the next witnesses are four members of the Care Home Relatives Scotland group. They are Catherine Russell, Sheila Hall, Alison Leitch and Natasha Hamilton.

Care Home Relatives Scotland (called)

MR GALE: They have asked if they can give evidence together in this way. They are used doing that, I think, from various occasions on which they have given presentations to -- including parliamentary committees and other groups. I have exhorted them not to talk over each other and I think they are accepting of that.

Questions from MR GALE

MR GALE: If we can just go through so that everybody in the

room and those watching know who is who.
(Introductions made)
MR GALE: Mrs Russell.
MS RUSSELL: Cathie Russell, yes.
MR GALE: I think we know you were born in 1955, we don't need your precise date of birth, which means that you are probably the same age as me in that case, you are 68. The Inquiry is aware of your address. For present purposes, I think the group is designed care of your solicitors, Thompsons.
Mrs Hall.
MS HALL: That's myself.
MR GALE: Yes, and you were born in 1995.
MS HALL: Correct.
MR GALE: Again, your address is known to the Inquiry.
Ms Leitch ——
MS LEITCH: Yes.
MR GALE: —— you were born in 1977 and, Ms Hamilton, you were born in 1986.
MS HAMILTON: Yes.
MR GALE: This is probably not something you actually need to answer to, but you are four of the core members of the Care Home Relatives Scotland group, CHRS, as it is known, and you have indicated a willingness to provide a statement to the Inquiry in the form of what we are

terming an "organisational statement", in which you talk about the way in which CHRS has acted and campaigned over the past few years.
You are in agreement that your statement is published and is available to be considered.
For the reference, my Lord, the Inquiry reference to the statement is SCI—WT0731—000001.
Looking at your statement, if we could go to paragraph 3, it will either be in front of you or be on the screen in front of you, I think you indicate there that you are prepared to provide the statement and you wish to all speak to it and you can each speak to different parts of the statement, and while you indicated when the statement was written that you thought it may not be possible, we have done our best to accommodate your wish on that matter.
You have also provided the Inquiry with a lot of documents, some of which we will be referring to today, but a lot of documents you have given to us and, as with all witnesses, I will indicate that all documents that have been provided will be considered and analysed by the Inquiry team and taken account of.
At paragraph 5 you talk about the group and you set out the name, the aims and objectives of the group, which were written in September 2020. I wonder if

somebody from the group —— I think it is probably Mrs Russell —— would you like it read out what are the aims and objectives of the group?
MS RUSSELL: Yes. We set out very early on exactly what we were trying to achieve, and that was to enhance the quality of life of our loved ones in care homes by resuming essential family contact by working to introduce the concept of essential care—giver status within the Scottish visiting guidelines for care homes, to encourage a person—centred approach, enhancing and supporting emotional well—being and avoiding further social isolation, and, thirdly, to develop lines of communication with policy—makers and represent the views of relatives with loved ones in care homes.
We did this because we were very conscious that, when we set up the group, there was a huge outpouring of emotions. We were absolutely —— we had all been struggling individually dealing with the fact that we had been cut off from our relatives for so long, some visiting guidance had been published but it didn't vaguely resemble how we would normally have spent time with our loved ones and we were starting to see pictures of people sitting two metres/three metres away behind police tape and so on, and we thought we really wanted to work positively with the Scottish Government to try

and get some common sense back into this because we felt that the measures being taken were so detrimental to our loved ones.
MR GALE: You say at paragraph 6 that the group does not and has never received any funding.
MS RUSSELL: That is correct. We were set up essentially as a Facebook group so we didn't need funding to run that, and we have really just kept it —— we have found there have been advantages in not being funded by anyone.
MR GALE: You have over 2,000 members.
MS RUSSELL: That is correct.
MR GALE: What you say in paragraph 8 is that the group was brought together out of sheer desperation and desperation to get access to loved ones in care homes. You then go on to say when you were founded, which was on 12 August 2020, and can you just explain how you all came together?
MS RUSSELL: I think I had noticed people on Facebook. I had also been aware there were petitions going around. One of those petitions had been founded by Natasha and there was another petition by another lady that I had signed and I had met a few people on Facebook who were making the same observations as myself. And so I just messaged people and very quickly the group grew really, really quickly. I think people were desperate to find

somewhere they could coalesce and take this forward.
MR GALE: I think in paragraph 9 of your statement you do individually set out the connections that you each had with somebody in a care home. Again, it's not necessary to go through those in detail. We are aware of that information and have obviously have noted it.
There is also a mention of a lady who had a daughter in a care home and she became part of your team. I don't want you to mention her name or the daughter's name, but that was a slightly different situation, where you had a person whose daughter was in a care home rather than somebody, if I can put it this way, elderly.
MS RUSSELL: That is right.
MR GALE: At the bottom of paragraph 9 you say that you were all concerned about visiting guidance and the lack of contact with their loved ones in care. We are talking about when your group was established in August 2020, so what was the nature of your concern?
MS LEITCH: I think at that point things were opening up in society for the general public. You could Eat Out to Help Out, there were travel corridors, but there was nothing meaningful changing for care homes. It was as if residents had just been forgotten about. And that was really the driver. I could see my friends going for lunch with their mum, they could go on holiday with

their mum, but I couldn't have any meaningful contact with my mum, and that was really where the frustration came from, that nothing was changing for residents.
MR GALE: If I can put it this way, was there perhaps a feeling of unfairness? Was that something that you experienced when you saw others who were able to interact with their loved ones?
MS HAMILTON: Yes, I think that's the basis behind also why the group was set up and that is certainly why, in paragraph 9, the petition was set up. I found it very unfair in July 2020, yes.
MR GALE: Ms Hamilton, you are the daughter of Anne Duke and the concept that we will come to look at of what is called "Anne's Law" is named after your mother.
MS HAMILTON: Yes, that is correct.
MR GALE: Going back to paragraph 10, your Facebook group -- who is the originator of the Facebook group?
MS RUSSELL: I was the one who physically set up the group, but, as I say, I was already in touch with people who could immediately join it and we shared it around community organisations and so on so that people would be aware of it.
MR GALE: It appears that that group started to expand quite considerably.
MS RUSSELL: Yes, it did. There was a huge -- it was like

a pressure cooker really. I think people had been very distressed at being cut off from people who were a huge part of their lives. Once the group opened, you realised particularly husbands and wives -- we had a lot of husbands and wives who had been together for 40 or 50 or more years and they were no longer being allowed to see each other. They could just look through a window. And this was at a time where, had their husband or wife been in hospital, they could have sat and held hands with them for an hour every day because hospital visiting had been re-established indoors but it hadn't been re-established in care homes, and people felt very -- people normally, when they go into hospital, it's only a short time, but we had been cut off since March and were not being allowed to establish any kind of reasonable contact or meaningful contact with our loved ones. We were left standing -- in my case, even when open visiting started, like outdoor visiting, my mother was kept in the home and I would be stood several metres away shouting at her through open patio doors. That wasn't how we spent time together and that was the case with I think everyone in the group, that they just -- they couldn't do the things for their loved one and provide the companionship and love and the touch that they had always done.

MR GALE: Was that something that resonates with all of you?
MS LEITCH: I think there is a misconception about who lives in care homes. It seems that people think it's 90-year-old bed-bound severely demented people that are in care homes that don't know if they get a visitor, whereas that's not true. There's a huge population from the age of 18 right the way up that are in care homes and they can have very fulfilling lives that are still involved with the community, they can be very active. They can still have fulfilling lives. And I think the members all felt quite isolated.
You don't know what it is like to live with a loved one in care home unless you actually live it, and I know from my own experience a lot of people just kept telling me, "But your mum is safe". Nobody else was taking account of the other harms that were happening, of her being isolated. So by Cathie starting the group, it brought everybody together and it was a sense of relief that you were no longer alone in feeling like this because, if you don't know somebody else that is living that life, then you are very isolated.
MS HALL: I think it is kind of important to emphasise how, once we all came together, we appreciated how we had all been in the same situation, that feeling of isolation and frustration, and we had all been individually just

desperately trying to find someone in authority to write to or question or find out why the guidance wasn't improving, and it was almost when we came together it gave a sense of community and power and momentum when we started then contacting the different bodies.

MR GALE: What you say in paragraph 10 of your statement, mid-way down that paragraph you indicate people you got in contact with. That included the Scottish Government, Scottish Government officials and other bodies, including campaigning groups, and you contacted MSPs from each political party, Scottish Human Rights Commission, the Mental Welfare Commission, Human Rights Consortium Scotland, Scottish Care, care home providers, Public Health and the Care Inspectorate and Alzheimer Scotland. So you became very active in putting out your case to a wide variety of Government agencies and other agencies which had an interest in care homes.

MS HALL: And we very quickly formed a logo and kind of presented ourselves in a professional and official way so that ...

MR GALE: I think somebody has -- or had some involvement in PR, so you were able to utilise that experience.

MS RUSSELL: I had certainly worked in corporate communications but also Natasha was heavily involved in

marketing and so on, and I think throughout the group, not just the core team but all the members, we did have a lot of people who brought a lot of skills that we could use; for example, in developing all the surveys and in carrying out research and so on.

MR GALE: In paragraph 11 you say that the group started to think about how they could progress matters and bring the plight of care home resident to the public's attention and there's the reference to the background in PR, and you thought that a demonstration would further the profile of your group; is that right?

MS RUSSELL: Yes. We had been sending lots of letters but we weren't getting lots of replies, and not so much as when we were a group, but certainly individually, you know, I had started sending letters in March, and to say, you know, "This situation is going to go on for more than a year. You can't stop me seeing my mum for more than a year", basically. So I think we knew that simply letters weren't getting us anywhere, whereas a demonstration with placards and so on would generate press attention and that might ensure that politicians would pay more attention.

MR GALE: Were your letters just being ignored or were they responded to in particular ways?

MS HALL: Certainly I can remember sitting with Cathie and

making a list of all the directors of Public Health -- there were 14 in Scotland -- and writing to them all and very few did we get replies from. We would send the letters by email and we would possibly get an acknowledgement, "Oh, yes, we hear you", but nothing really concrete came out of that. So, yes, we didn't get anything ...

MR GALE: Substantive, would that be the way to put it?

MS HALL: Substantive.

MS LEITCH: I think also it is important to remember at this time there was nobody speaking out for care home residents at all. There was no voice for them.

MR GALE: You managed to organise a demonstration which you tell us about in the section "Next Steps" of your statement at paragraph 12. Perhaps somebody would read out what actually happened at that time.

MS HAMILTON: Paragraph 12. So a demonstration was planned outside the Scottish Parliament for 16 September 2020, marking six months from the start of lockdown restrictions and the last meaningful contact with the relatives in care homes. The group's aim for the demonstration was to highlight the issue and get into conversation with the Scottish Government team, who were issuing the guidance.

MR GALE: Carry on please.

MS HAMILTON: So the police at the Scottish Parliament were notified in advance by CHRS of the planned demonstration. The group asked those attending to follow social distancing guidance and to wear face masks. The media became aware of the planned demonstration and the group were invited to speak on the Kaye Adams BBC Radio show on the morning of 16 September 2020. Members of the group also appeared on Politics Scotland that evening to put forward their position and featured on Reporting Scotland. Sheila and Alison were interviewed on BBC Radio Scotland Drivetime and the demo was covered on many local radio stations.

At the demonstration, the group used posters and placards to try and bring attention to the forgotten community of those in care homes. There was a very good media turnout. Members of the CHRS core group have featured in the press and media on numerous occasions.

MR GALE: Can I just stop you there? That was obviously on 16 September and it appears from what happened thereafter that you got the attention of at least some politicians. In particular, you got attention of Jeane Freeman, the Cabinet Secretary for Health, and I think you then were invited to a meeting with her and you met her online on 18 September, so just two days later.

MS RUSSELL: Yes.
MR GALE: So what you tried with your demonstration at least to that extent had a successful outcome.
MS RUSSELL: Yes, we got a call on the day of the 16th. I was contacted by someone just trying to check my phone number and Jeane Freeman phoned that day.
MR GALE: So was it the four of you who went to the meeting with Jeane Freeman?
MS RUSSELL: At that time we had just met Alison for the first time at the demonstration and there was a lot of people there, but -- so it was three of us that went and one other person who was in the core team. She was an interesting lady in that she, throughout the pandemic from April, had always been able to have contact with her mum in the care home, so in a way she was the perfect demonstration of what we were trying to show could happen, could be achieved, quite safely.
MR GALE: So what was the outcome of this meeting with Jeane Freeman on 18 September?
MS RUSSELL: Well, the outcome was like the outcome of most meetings, another meeting, but what they said was they would go away and they would look again at the guidance. She said she could hear what we were saying, that we wanted to meet in a relative's own room rather than outside, that we wanted touch. She summarised

everything that we were looking for and said that we would meet again, and I think it was probably nearer two weeks later that we met, and that is when we heard that the new guidance was coming forward that would gives us four hours with touch.
MR GALE: So to an extent you had achieved something through that contact with Ms Freeman?
MS RUSSELL: Yes, I think we were all really happy that day. Alison was at that meeting too and we were just delighted that we had made progress.
MR GALE: Ms Freeman I think did continue to meet you on regular occasions and you communicated with her and sent her in particular surveys --
MS RUSSELL: Yes.
MR GALE: -- of the impacts that you and your loved ones were experiencing and others.
So far as the improvement that you were made aware of by Ms Freeman in October 2020, did the advantage in that last?
MS RUSSELL: Not at all because on the day that we were given advance notice of what might be in the guidance, we were really delighted, but by the time the guidance came out, I knew, for example, that it would make absolutely no difference to me because Glasgow had gone into a different tier, which excluded care home

visiting, so there wasn't going to be any in Glasgow and there wasn't going to be any in Lanarkshire or Greater Glasgow, and immediately a number of care home groups were saying that they would be implementing it. So Alison and Natasha did a great deal of work really to establish how well that was going down.
MR GALE: Can you explain what work you did and the results of that work?
MS LEITCH: Yes. I think after the initial reaction from some care providers about what was being proposed and them saying they wouldn't implement it, we gave -- we decided -- we had already done one survey at the end of September just to try and quantify what the situation was --
MR GALE: Can I just pause you there? Can you tell me how you did your surveys?
MS HAMILTON: We did it through Google Drive, it just emphasising how much we actually were just family members using like what we had at our hands to try and prove to Government bodies that the guidance they had put out wasn't working. So we felt that we could sit in meetings and talk about it, but we might just come across as bunch of families that are just getting angry, but if we could actually show them physically that we went to our members and we've taken information from

them, "Here's the feedback", then we felt like that's something that could really give us the upper hand I guess in these meetings and prove what we were saying was actually true.
MR GALE: What was the reaction to that, to the information that you were providing?
MS LEITCH: I think on the survey -- we carried out a survey from 27 October to 3 November, so we gave the October guidance a couple of weeks to be embedded. I think that was the biggest response to any survey that we have had and that we had 347 respondents and only 10% reported an improvement in visiting arrangements. So when we were able to feed this back, I think Jeane Freeman was quite shocked as to how poorly it was being implemented. 33% of respondents reported that the visiting had actually worsened in the period since the new guidance had been -- and 7% reported having a visit that included touch in the three weeks that followed the guidance coming out.
MS HAMILTON: Can I just add, on the back of -- if we -- we strongly believe that, if we hadn't have done these surveys, no families would have had their -- or care home residents would have had their voices heard how the guidance was being implemented. It was purely asking the care homes, "Is this guidance working?", and

they were giving the feedback, so it was only care homes that would have had their official voice heard unless we had given this information to the Government.
MR GALE: So far as reasons as to why this wasn't working, what did you become aware of?
MS HALL: I think something that we very quickly became aware of was the confusion with guidance. There was guidance coming from so many different places, and so the Scottish Government were doing their guidance but they were dependent on Public Health guidance. There was guidance coming from CPAP groups, there was guidance coming from infection control groups and there wasn't -- there didn't appear to be one person, one concrete voice, giving clear guidance. And we kept saying that to Jeane Freeman, "We need clear simple guidance", but we were trying to plough through this plethora of 32 page documentation that kept coming out, so there was a definite lack of clarity that caused confusion and difficulty .
MS RUSSELL: There was also an implication that the reason care homes were so reluctant to let us in was that they weren't indemnified and --
MR GALE: I will come to that in a moment, if I may. So far as confusion with guidance is concerned, obviously you would be people who were interested in the terms of the

guidance so that you could inform yourselves and indeed other members within your group as to what the guidance was at any particular time. Now, you clearly were having difficulty in assimilating all the guidance that was being passed around. Did you find that that was a difficulty that was being shared by those who were caring for your relatives ?
MS HALL: Without a doubt. Absolutely. I had a very good -- well, speaking for myself, I had a very good relationship with the manager in mum's care home and she used to be tearing her hair out and would say, "Oh, for goodness' sake, what does this mean? What do I do here? I am getting this from this and this from this". And, you know, I used to sit with her and we used to chat about it and I would say, "Actually, we can do this", and she'd go, "All right . Okay. Yes". It was very difficult to follow.
MR GALE: I think one of the indications that was mentioned was the question of indemnity.
MS RUSSELL: Yes.
MR GALE: Can you just explain that, please?
MS RUSSELL: Well, in one of the letters that I'd sent to Dr Macaskill at Scottish Care, I had said to him -- he had mentioned -- I had said that Macron, President Macron, had given -- just instructed the

French care homes to open in May, and he said, yes, but he was able to do that because the French care homes were indemnified against prosecution and that didn't happen in the UK and that care homes were finding it very difficult to even get insurance.
MR GALE: Paragraph 21 of your statement, there you mention the former First Minister and you say that she did not meet with the group despite many requests to do so. What was your reaction to that?
MS LEITCH: I think we were all very disappointed. The First Minister seemed to me -- or sent messages out to certain demographics. There was a message to children that Santa was still a key worker. She met with the group that gave evidence this morning. There was the message to students, telling them to go home for Christmas one year. It just always felt that our residents were just not on her radar. This was enforced by care home residents never being included in the daily briefings or, when there were updates for the general public, care home residents were never mentioned in this .
We would raise it time and time again and we raised it at a meeting with Kevin Stewart, when he came into post. It was quite a fraught meeting, that one, and at the next update care home residents were mentioned in

with the general public for the first time.
MS HAMILTON: Can I just add on the back of that that one of the only times that care home residents were actually mentioned was in Christmas 2020, when the whole country was going to go into a lockdown on Boxing Day and everybody was told you could have a family bubble on Christmas Day because Boxing Day we'd be having lockdowns. But the former First Minister stood up and said, "Unless you are visiting someone in a care home, do not create a bubble". She didn't tell staff not to create a bubble. She told families , "If you are visiting someone, do not create a bubble", and that had a major impact on how people viewed care homes and visitors .
MR GALE: You did seem, however, to have the ear of Jeane Freeman, and I think at paragraph 22 you make reference to another meeting with her, where you explain to her what was going on at grass-roots level in care homes. You say in your statement:
"For people who did not have a loved one in a care home they simply did not know what it was like 'on the ground'."
So was it your impression that there was a difficulty in the wider public in understanding what the position was in care homes?

MS RUSSELL: I think they were —— I think in a sense they were almost believing their own PR. I mean, very early on, when they brought in visits with touch, there were a number of press things done, you know, photo calls done of people meeting and greeting in care homes, but for vast majority that never happened. I was still sitting behind closed windows and that was the case of virtually everyone in Greater Glasgow and Lanarkshire, and lots of other parts of the country were simply not getting that type of access to relatives and it was very much outdoor visiting only. There were very few places doing any indoor visiting, although there were a few examples, like Kelso House, and there were a couple around the country that did a good job, but not many.

MR GALE: Paragraph 23 of your statement is only a single sentence and it's very brief, but it contains, I think, what you would see as being a very important observation, and that is that you saw yourselves as "essential care—givers". Do I take it that for many of you prior to the pandemic you were actively involved in the care of your loved ones, wherever they may have been, whether they were at home, whether in care homes?

MS HALL: Absolutely and absolutely, and I think from the very first meeting we kept saying, "We are not visitors". They kept talking about us as "visitors" and

over the years that kind of filtered through and that was appreciated. But, yes, we were not just visitors. We weren't just popping in on a Sunday afternoon once a month. We had been in virtually every day and for many of our members, they would have been going in every day to help with mobility, to help with feeding, to help with touch, to help with just general care and companionship.

We keep coming back to the fact that we should have been —— anyone in a care home is looked after by a team of people, from the laundry ladies, the cleaners, the carers, the nurses. There is a team that have to look after them and we are part of that team, as the visceral husband, wife, daughter, son, and that's what was never ever and still is not being fully recognised, and that's what we mean by being "essential care—givers" or "essential partners" or "essential contacts".

MR GALE: Also you come to the, if I can put it this way, exercise of trying to see your loved ones from the standpoint of being a relative, being a friend in many cases, a partner who loves the person who is in the care home, so it would be rather odd if you were negligent or unconcerned about the way in which you conducted yourselves in that situation.

MS RUSSELL: Yes, we felt that they really just didn't ——

I don't know if it was a lack of trust or what the problem was, but to us, as Sheila has said, our relatives needed a lot of support around them and we always recognised that COVID was extremely dangerous to our loved ones, but stopping relatives getting in was not stopping COVID getting in. And one of the other things that used to upset me at the daily briefings, when Nicola would announce the number of people that had died of COVID, she wasn't announcing the number of people that died in care homes that had never seen their relatives since March.

We were getting people on the group every single day announcing that their loved one had died and by the end of —— after 12 months, more than 15,000 of them had died and only one in five of COVID. I am not saying "only", I am not underestimating in any way COVID deaths, but the point was that a great many people —— although the care home population is very diverse and there are young people and there are people with all sorts of different conditions, there's a very large majority of people who are approaching the end of life, and this is known to be the case. And so people were just completely distraught, and those whose loved ones died before they were in any way reunited with them are finding it extremely hard to cope with that loss.

MR GALE: Did you feel that there was an appreciation either on the part of decision—makers or those who were implementing decisions as to the detrimental effect on your relatives of isolation?

MS HAMILTON: I don't think anyone took that into any sort of consideration. Everybody was just concentrating on COVID. And although they were talking about us getting in, all the restrictions and the guidance that were put in place never put in favour for the residents who were shut off from everything that they'd ever known. I was shut off from seeing my mum, but I could still speak to my husband, I could still make phone calls, I could still go to the shops, but my —— or people in care homes —— but people in care homes didn't have that option.

So the isolation just heightened that and I don't think anyone took that into consideration. They didn't take any pre—existing conditions, reasons why anyone was in care home. All they were thinking of doing was protecting them from COVID and didn't listen to any of us when we said the reasons why they are in care homes are worsening because of isolation.

MS LEITCH: And the alternatives that were offered, such as a window visit or an iPad —— and I think it is a large percentage of people in care homes have a cognitive

impairment. That is not going to work for anybody in that —— we probably never used iPads to communicate in care homes prior to this, so suddenly you've got a voice coming out of somewhere that —— if the person can concentrate on the iPad, you are lucky, but if they're not used to that, it could well cause distress.

We had people —— sometimes the window could be open, sometimes the window could be closed. You could be stood at a closed window with a mask on trying to communicate with somebody with a cognitive impairment. It just didn't feel like anybody had thought this through of how any kind of meaningful contact could be maintained.

MR GALE: Going back to your statement because I think some of what you have said is really anticipated in some of the next paragraphs of your statement, at 24 you say you were not campaigning for open door access and you make the point that many of those in your positions were people who had cared for their loved ones prior to them being in care homes. You also refer to the "essential care—giver" status and we will come to that in a little. And I think really in 26 you encapsulate what is —— has been said. Perhaps somebody would just read that out so we can have it from one of you. Paragraph 26.

MS RUSSELL: CHRS were concerned that Scottish Government

and their Public Health Advisers saw COVID—19 as the only harm. They did not consider the trauma and the effect on mental health that enforced separation from loved ones would cause.

MR GALE: Thank you. At paragraphs 27 you go on to indicate some of the work that your group has been engaged in since the start of the pandemic, and again it's perhaps useful just if somebody reads this out.

MS HALL: Since the start of the COVID—19 pandemic, CHRS have had in excess of 130 meetings with Scottish Government and decision—makers. Following the initial meeting with Jeane Freeman, these then took place at regular intervals via Teams on the computer. After the Scottish Parliament elections in 2021, contact continued through Kevin Stewart, Minister for Mental Well—being and Social Care, and still continues with Marie Todd, Minister for Social Care, Mental Well—Being and Sport. The meetings have also been held with the Care Inspectorate and Scottish Care as well as other organisations which are detailed on a spreadsheet provided to you.

MR GALE: You have provided that to the Inquiry and we were aware of it. You also gained some awards for your campaigning work.

MS LEITCH: We have not won any yet. We were nominated.

MR GALE: Sorry, I am anticipating what may happen. You have been recognised ——

MS RUSSELL: We were finalists.

MR GALE: I apologise for that, and you list those for us there. You have also been active in giving presentations at events to a very wide range of bodies and you list them as NHS Lothian, Scottish Care, TUC, Infection Prevention Society and the organisation, TIDE, Together in Dementia Everyday.

The next section in your statement is on inconsistencies and this is something we have probably already touched on briefly, but again I would like you to take us through that, and given that Ms Leitch is the person mentioned in paragraph 30, perhaps you would just read that section so that we have it.

MS LEITCH: Sure. Following the improved guidance in October 2020, I was asked it take part in a trial involving visits with touch. Three of these visits took place prior to them being halted by the care home provider. The reason that was given was that the provider felt that these types of visits were too risky and that the Government had made the wrong decision.

One major concern of CHRS was that the guidance —— when the guidance was published, it was the responsibility of the individual care home managers to

interpret and implement it. The guidance was not clear and individual care home managers would often err on the side of caution and CHRS heard reports of some Scottish care homes applying English guidance.

MR GALE: Continue please.

MS LEITCH: The group was concerned that care home managers and Public Health Scotland were giving insufficient reasons as to why relatives were being excluded from care homes, often simply citing "infection control measures" as reasons for refusing visits. Relatives had no right of appeal to these decisions.

The group was often asked for their views on the guidance. They played an extensive role, including commenting on and suggesting edits for all versions of the Open with Care documents. The group has also reviewed guidance produced by Public Health. In order to clarify the confusing guidance, the group often produced their open summary documents to provide clarifications for our members.

MR GALE: Can I just stop you there? From this section of your statement, again did you take —— did you gain the impression that inconsistencies and confusion were inherent in the way in which you saw the guidance being operated but also was inherent in the way in which it was actually being operated?

MS HAMILTON: Yes, I think —— certainly from our members' point of view there was an inconsistency across the country, we would call it a "postcode lottery", so that played a big part on the frustration that relatives felt that, just because your relative was in South Lanarkshire, you are getting different access to someone that was maybe in North Lanarkshire, and that added a lot of confusion within members as well, so, like, "Why are they getting in differently than I am?" So, yes, that is always a big thing I think was inconsistent was between different Public Health bodies and it depended on where the care home was, it depended on the access you got, or depending on who the provider was as well depended on the type of access you got, so the guidance was interpreted sometimes to possibly benefit the care homes.

MR GALE: Just to go back to paragraph 34, the observation is made there that relatives have no right of appeal to the —— to or of these decisions that were made by individual care homes, and that I think is in the context of decisions often being said that access would not be permitted for infection control reasons. Throughout the pandemic did you ever find or get the view that any decisions were being personally framed or had regard to the personal rights of your loved ones?

MS RUSSELL: No we felt the rights of our loved ones had been completely trashed from day one and we felt our rights had been completely trashed from day one.

MR GALE: It wasn't just your loved ones, it was yours.

MS RUSSELL: Yes, and we think that, even if you look at the existing care standards which were in place before the most recent care standards, all of those were breached. No one asked my mother would she —— what would her preference be, would she rather take a risk with a virus and see her family, and I can absolutely 100% guarantee what she would have chosen.

Also people in care homes had actually been incarcerated. This is —— I remember absolutely rage in September 2020, when the poor students were —— and I did —— I do feel sorry for the students, but the student were absolutely up in arms that they had been closed in halls for a week. Our relatives had been banged up since March and there didn't seem to be anyone in the human rights community, anyone anywhere, actually, calling this out. This was including young people. It wasn't all —— the likes of my mum, we —— every time I went to the home, I took her out in her wheelchair, but all of that was gone, and yet everyone else was encouraged to go out on their daily walk.

I actually had a call from one care home, from

a relative in —— of a care home, where they said a gentleman had committed suicide because he normally walked the promenade near his home every day and that had been stopped, and six months in that man took his own life, and this is what we were up against. And I did tell Jeane Freeman about that and gave her the details, but ... it was ... it was a dreadful way to treat people.

MR GALE: Paragraph 36 makes reference to an open letter which was published in the Nursing Times in October 2020, signed by a number of infection prevention control specialists and consultants, and I think this is something —— this letter came to your attention; is that correct?

MS HALL: Yes, this —— we were busy saying, "Look, with the same infection prevention control measures as the staff, why can we not get in to see our relatives?" This was our plea. Then I was made aware of this letter —— I have a nursing background and it had been placed in the Nursing Times. They published it by this consultant called Jules Storr, who is a specialist in infection prevention and control, with a nursing background, and it was signed by many prominent members of that community.

It turned out I knew one of the authors, and so

I got in touch with Jules and the other main author, and it was like a light bulb moment because they were saying, with their professional hats on, exactly what we were saying, that surely we could have contact with our loved ones using good IPC, and Jules' mantra was that IPC should be used with compassion to enable meaningful contact and not as a barrier.

So as a group we worked with them, with a web designer, who gave her time free of charge, with a graphics person from the World Health Organisation, whom Jules had done a lot of work with. She did consultancy work for the World Health Organisation. So we worked really hard to bring together documents, and a website which we called "Enable Safe Care" which still holds it domain name and is up there that anybody can look at. We produced documents to say, "This is how you can use infection prevention control measures and be able to visit your loved one safely. This is how you could safely take them out in a car. This is how you can safely go to their room". And it received really very positive feedback.

We sent it to the IPC consultants in Public Health Scotland, we gave it to Scottish Government, and people would say, "Oh, yes, it's very good", but it was never formally recognised or adopted. It did get recognition

interestingly from the National Library of Scotland, who very soon after it was published contacted us and said, "We would like to use this as part of our COVID collection", or whatever it is called.

MR GALE: Can we have look at that letter, please? That is the letter open letter in the Nursing Times. The reference is SCI—CHRS—00014, and that will be brought up in front of you on the screen. As I think we can see at the end of the letter, it was signed by Jules Storr and a number of other past presidents of IPS —— what is "IPS"?

MS HALL: "Infection Prevention Society".

MR GALE: —— and also a considerable number of others, as you have said, who have, at least on the face of it, a lot of experience in these matters and expertise.

MS HALL: Yes. I don't know if this is relevant, but just a couple of week ago I collaborated with Jules at a conference for infection prevention control, a national conference in Manchester, with her saying —— coming back to saying that IPC should be used as an enabler and with compassion, and I was there speaking about what had happened in care homes.

MR GALE: Looking at the terms of the letter, at the beginning we see the writers saying that:

"Restrictions are being imposed in relation to

COVID—19 across too many nursing, care and residential homes in the UK and beyond, in the name of infection prevention and control."

And then:

"As experts in this field, and together with interested and concerned individuals and organisations, we summarise why infection prevention and control should be an enabler [and] not a barrier to ... compassionate human interaction in nursing, care and residential homes."

As a broad concept, is that something with which you are all in agreement?

MS HALL: Yes, absolutely.

MR GALE: I think the writers go on to say:

"It is almost impossible to underestimate the harm and mental anguish that barring entry to nursing, care and residential homes has caused to thousands of residents, their families and significant others. Such action also supports the dangerous narrative that elderly and vulnerable people mattered less."

Is that the impression you had?

MS HALL: Yes.

MR GALE: Then the writers going on to say that there is an appreciation of the seriousness of the disease. They then say that those —— they put it:

"... from a scientific perspective ... it is possible to both protect people from infectious disease through infection prevention and control while enabling safe compassion, human interaction, including physical contact between loved ones."

So this would have been manna from heaven for you.

MS HALL: Absolutely, yes. It was a huge incentive. Perhaps we will come on to this, but unfortunately that's the way of thinking that Public Health have never adopted. They have never taken a positive approach, saying, "Okay, let's use the infection prevention control measures to work with you to enable you to see your loved ones". It was always, "No, you cannot".

MS RUSSELL: I think we also have issues with the way guidance was written generally in that it always included a kind of Sword of Damocles which dangled over the manager's head because it always said in the end, "At the end of the day it is entirely up to a manager to ensure it's safe", and so very often you were having managers —— we've got huge compassion for the staff in care homes and we were extremely grateful for the love and affection that they gave our loved ones —— you know, a lot of them were absolutely brilliant —— but I think that the way —— I think they could have done —— I think they would rather have been told, "You do these things

and we've got your back", whereas they were between a rock and a hard place. If they did what we would think was the right thing and anything went wrong, then they were going to get hammered. There were would be —— Operation Koper would be knocking on their door to interview them. There was all these things going on and we just felt that, although the Government was in a way looking like the good guys in the guidance by saying, "We will allow all of this", they were then just putting all the onus on people and so in some ways we weren't overly surprised that we didn't always get the —— that they were quite reticent about enabling contact.

MR GALE: I mentioned in my opening statement to the Inquiry on Tuesday that I had read a statement in which —— I can't remember the precise words, but a health professional who also had experience of knowing somebody in a care home said that there was too much emphasis on what she called "the hard stuff", and not enough on the soft stuff, which —— she mentioned spiritual and compassionate. I take it that is something that you would agree with?

MS RUSSELL: Yes, very much so. You have to, at the end of the day, think, "What is life for?" That is —— if you were 90 and you were in a nursing home, would you want to see your family? We were only asking for one person

who could then try to —— you know, who would stimulate their memory and show them photographs of their grandchildren and their great—grandchildren, how they were all doing. That's all we were wanting. We weren't demanding that people come in with a cast of thousands. And yet they just didn't ever seem to recognise that love is —— and affection of your family is as much to you as food and drink. It's every bit as important.

MR GALE: I suppose then in many ways the writers of this letter put it probably better than many could in the final paragraph on that first page, where they say:

"We know that in a lot of cases, people are simply trying to do their best within the resources and circumstances they face, and we would like to help them. Therefore we now call for urgent action to end what we perceive to be incorrect application of infection prevention and control, often disproportionate to the realities of nursing."

Again, that reflects the position that you have taken and are taking today before this Inquiry.

My Lord, 3 o'clock.

THE CHAIR: We will come back at 3.15 pm. Thank you.

(3.01 pm)

(A short break)

(3.15 pm)

THE CHAIR: Yes, Mr Gale.

MR GALE: Thank you, my Lord.

Can we go back to your statement, please, and we were looking at the letter in the Nursing Times and I think that document is and has been in front of you. Obviously we can all read the document, but I think we can see in the document that the writers draw specific attention to certain matters, and while again we can read them, there are one or two that I would just like to highlight with you because I think you have really made reference to these but I just want to obtain your views on it.

The second bullet point:

"Infection prevention and control should instead be used as an enabler and a supporter of safe entry to homes."

That is the basis of all your respective views?

MS HAMILTON: Yes, if staff can go in the same way, then we should be able to go in the same way.

MR GALE: The third bullet point is quite interesting. It says:

"The longer the current situation prevails, the more likely it is to become routinized and de—implementation could become a concern in the future."

Is that something you've found?

MS RUSSELL: Very much so. From day one we kind of realised that how long is this going to go on because you couldn't see what the strategy was. You know, you couldn't work out what are they waiting for. Are they waiting on a vaccine? Are they waiting on treatments are they waiting on better infection ... you know, you just couldn't work out what it was going to take to get us back in. And in the end, for many of us, particularly those in Greater Glasgow and Lanarkshire, it did take a year to get back in and, by that time, we had been double—vaccinated and there was testing, so —— but if that hadn't came along, would I ever have got back in? I don't know.

So to us infection control was the only thing that would work because we always knew that there could be changes to the virus, that things might not work, the injections might not work and so on, vaccines might not work. You would get changes going on and so for us the key thing was always infection prevention and control.

MS HALL: And what is written there, we took this to the senior infection prevention control nurse in Public Health and she agreed with this. So they were agreeing with the concept and what was written in this letter, but to this day nobody grasped that concept, nobody seemed to have the authority to grasp that

concept and come along in a positive way and say, "Here we are. This is how we can help you become that essential contact person". And to our mind that was perfectly simple, but there was a —— that person was lacking, that authority was lacking, from Public Health, from wherever.

MR GALE: Did you feel that the force of what was being said in this letter was being understood by some of the officials, the people with whom you were discussing it?

MS HALL: I have email correspondence or we, the group, have email correspondence with the senior infection prevention control nurse at the time, in Public Health, and she said, "Yes", you know —— she agreed with the letter and she agreed with our work that we had done as Enable Safe Care.

MR GALE: The two other bullet points on that page I think are really, from what you have, said self—evident.

"Infection prevention and control and compassionate care are not mutually exclusive ..."

And also:

"... infection prevention and control should be applied as a source for good."

MS RUSSELL: Correct.

MR GALE: The letter then goes on to address, I suppose, a number of potential recipients of the letter. It

begins with the nursing, care and residential homes, and I think what we can see there is that the suggestion is to:

"Allow normal family interactions by stopping restrictions and instead continuing to inform and support families on the steps to take for safe contact in a spirit of trust and cooperation."

Again, I think you have already mentioned this, but the impression that I have from your evidence is that those with whom you were dealing did not subscribe to the idea that effectively you could be trusted.

MS RUSSELL: I think that's it in a nutshell. They didn't trust relatives and, in fact, on one occasion, it was said to me, "It would be all right if they were all like you", in other words, you know, "if we felt everyone could be trusted", and in fact it's in recent guidance as well, isn't it?

MS HALL: Yes. We are a bit concerned because the current Public Health guidance states that they will restrict visiting during a pandemic if relatives are not adhering to infection prevention and control measures, which we find completely unfair. We are interpreting it if one person breached a rule, then they would ——

MS RUSSELL: —— just shut down.

MS HALL: —— close visiting.

MR GALE: The other potential recipients of this letter, of the directions in this letter, number 2, the Government, local authorities, Public Health departments, and the essence of what is being said there is:

"Remove ... statements that may be seen to justify 'blanket bans' on visiting."

Again that is, I understand, something you are very much in favour of?

MS HALL: Yes, the problem with blanket bans was a constant really.

MS HAMILTON: There was no consideration given to everyone's individual reason why they were in a care home. You resided in a care home, you weren't seeing your family. That is blanket ban.

MR GALE: Then number 5, families, so directed against your cohort, it says:

Understand, respect and adhere to the infection prevention and control recommendations recommended of you to support the safety of yourself, your loved ones and care home staff."

Any problems with that?

MS RUSSELL: No, I think everyone would have been more than happy to do that.

MR GALE: Thank you. Can we go back to your statement —— because we then go on to Anne's Law in the statement at

paragraph 37. Ms Hamilton, this is really your project and I wondered if you would just read on from paragraph 37 so we have that in the transcript of the Inquiry.

MS HAMILTON: So prior to joining CHRS, Natasha Hamilton started a petition on change.org in July 2020. (PE1841 refers). She publicised this on social media and was directed to CHRS in August by Rights for Residents, a campaign for care home residents in England.

This petition sought to ensure that people who live in adult care homes have the right to see and spend time with people who are important to them.

Natasha had been unable to see her mother for prolonged periods and the petition called for a designated visitor to be allowed into care homes to support loved ones.

The position now has more than 97,000 signatures.

It was placed before the Scottish Parliament Petition Committee in November 2020.

It received a lot of media coverage, particularly from the Sunday Mail, which coined the name "Anne's Law", named after my mum, Anne Duke.

Anne's Law was added to the SNP manifesto during their election campaign in 2021. It was also included by Labour, Liberal Democrats and the Green Party in

their manifestos.

Anne's Law has not yet been enacted in legislation. It has been taken forward as part of the National Care Service Bill, however CHRS believe the bill does not go far enough.

Section 40 of the National Care Service Bill does not give residents the right to have a designated carer or visitor but gives ministers, in consultation with Public Health, the power to make directions to allow people into care homes or indeed to keep people out of care homes.

CHRS believes a stronger statement is needed to ensure that at least one essential care—giver/visitor will always be allowed into care homes if there are any visiting restrictions imposed.

In the meantime, two new Health and Social Care Standards were introduced in March 2022, reinforcing the rights of people in care home to see and get support from people close to them. All registered adult care homes are expected to meet these standards and they are used by the Care Inspectorate during inspections.

The group are concerned, however, that because Anne's Law is not yet enacted in legislation, there are no guarantees that another prolonged lockdown that would imprison care home residents and deny them any access to

their loved ones could not happen again. For example, in December last year, Public Health Fife took a decision on Christmas Eve to stop all visits to a care home. This decision was reversed after 48 hours and later admitted the decision was wrong, but families live with the constant fear that they can be locked out.

MR GALE: Clause 40 of the National Care Service Bill is still before Parliament; that is correct?

MS HAMILTON: Yes.

MR GALE: It has not been enacted and as yet there is no indication as to when it will be enacted?

MS HAMILTON: No.

MR GALE: I think you have a concern about it and you have expressed that concern. Do you feel that what is contained within clause 40 goes far enough?

MS HAMILTON: I will hand over to Cathie in a second, but -- sorry -- I just want to add something about the base of Anne's Law. The reason why I -- if we are talking about impacts in these hearings, the reason that I personally set up that petition was, when my mum moved into a care home, she was told that was a home that -- our family had treat that as a home, and that goes for every single care home resident across the country, so that mirrors what they would have been told at the same time and that impact that happened to families during

lockdown, that they were kept out and care-givers were kept away from their family purely because the place they resided in played a huge impact on why this all had to happen.

But Cathie will be more able to speak about ...

MS RUSSELL: Yes, the problem we have with 40 is that it basically -- the National Care Service Bill is enabling legislation so that there is nothing which says what it does on the tin. It just -- what it does it gives a minister the right to instruct care homes. Now that doesn't fill us with confidence because we were locked out for a year because of the instructions of ministers on the advice of Public Health. So, in actual fact, I think when that happened to us the first time round, it may well not have been legal, what happened to us. I have grave doubts about whether or not it was and I am sure if we had managed to get a case to court, we would've won. But the problem was that this clause is --it's just not -- it doesn't guarantee us -- it doesn't guarantee us anything, and it would in fact make a situation, which I believe was illegal when it happened to us, legal because it would give ministers the power to lock us out or to let us in.

MR GALE: I think what is essentially in clause 40 is the issuing of what is termed a "visiting direction" --

MS RUSSELL: Yes.

MR GALE: -- and that would enable, in those particular circumstances, for people get into care homes.

MS RUSSELL: That is right. Part the National Care Service Bill is involved with -- as you say, is underpinned by directions and they are depending on a lot of co-production and, to be fair, we have been involved in the discussions around the directions.

We keep pushing on this to try and get nearer to this idea of an essential care-giver, essential care companion -- they seem to have a lot of problems with the language -- but to give people the right to someone getting in. We are getting closer, but the problem with it only being directions is that the directions can be changed.

MR GALE: Yes. There is no mention in clause 40, as I read it, of the concept of an essential care-giver; is that right.

MS RUSSELL: There is no mention of that, no.

MR GALE: And as you have just indicated, there is a power to ministers to vary or revoke a visiting direction.

MS RUSSELL: That is correct.

MR GALE: Is that something that you are particularly concerned about?

MS HAMILTON: Yes, that is not Anne's Law, and I will stand

up. It is named after my mum and the only way we will allow Anne's Law to go ahead is unless it ensures that anyone resides in a care home has access to at least one person. Anything that says anything bar that will not go through as Anne's Law and we will make sure of that.

MS RUSSELL: This isn't a revolutionary idea. It has already been accepted in a lot of hospitals as part of John's campaign, that when a vulnerable person comes into hospital, that their care companion -- their carer, the person who looks after them, usually their husband or wife or daughter, can be there with them and -- you know, as they are admitted and so on, and that is all we are asking for in a care home, that people will be able to maintain that contact.

THE CHAIR: Do I understand your evidence to be that in the discussions around the drafting of this bill you have had some involvement?

MS RUSSELL: We have had extensive involvement in the directions. We haven't had any involvement in the clause.

THE CHAIR: No.

MS RUSSELL: We have been told this week that they are looking again at the clause.

THE CHAIR: I understand that. Do I understand in the discussions that you have had that there has been

discussion about the concept, the idea, whatever you care to call it, of an essential care—giver?
MS HALL: Yes, and we have been involved in rewriting the direction and editing them. Our perception is that one of the problems is they have to defer to Public Health, and it's Public Health who are not keen to accept this concept of an essential contact person.
THE CHAIR: Is it the entire concept of an essential care—giver, so far as you understand —— I appreciate that you may not know this —— is it the entire concept of an essential care—giver that causes Public Health or the Government problems or is it simply the definition of that term?
MS HALL: No, it's a concept ——
MS HAMILTON: Sorry, there is definitely a definition because there's been many a time in meetings there's back and forth about what should we call it, and it seems like there's a lot of complications ——
THE CHAIR: Well, that's a good —— "what should we call it?" I take it that you couldn't care less what it was called as long as the concept ——
MS RUSSELL: A rose by any other name.
THE CHAIR: To be fair to parliamentary draftsmen, there may be —— I don't know —— there may be issues in relation to "essential care—giver" as a matter of language but that

wouldn't trouble you. It's the concept that is more important to you?
MS RUSSELL: Yes. Any words —— obviously there is also to do with family relationships. You know, we couldn't have "close relative" because they might not be related. So there are these problems, but "companion" ——
THE CHAIR: That is the sort of thing I was driving at. The language is plainly —— could be something that drafters could have concerns about.
MS HALL: At the moment the concept, whatever it is called, is only being acknowledged by Public Health as somebody that is brought in when there is a pandemic. They have made it essential only visiting and the person isn't actually end of life, and then they might allow an essential contact person in, whereas —— that is like at the end of the line, whereas we are looking for the person to be recognised as soon as someone goes into a care home because it will be the husband, the wife, the daughter, the son, and they were part of that team, pandemic or no pandemic, through thick and thin.
THE CHAIR: So that is the idea, the concept. What it's called is not particularly relevant to you?
MS HALL: Correct.
THE CHAIR: I understand that. Sorry, Mr Gale.
MR GALE: Thank you, my Lord. Very helpful. What I would

like to do is look at just one or two documents that perhaps inform some of the points that you have been making. You have provided these largely to the Inquiry, and can I ask you to look first of all at a letter that you made available to political candidates in the —— whatever year it was —— 2020 election?
MS HAMILTON: Sorry, could I just say one last thing on the back of what you'd said?
THE CHAIR: Of course.
MS HAMILTON: When Nicola Sturgeon stood up on 21 September and spoke about Anne's Law and their manifesto, she did say that family members would be —— they would work to make sure that Anne's Law was that family members would be allowed the same access to care homes as staff. And, again, so that goes into the conversations we were having; there's a lot of talk around the name of it, but the SNP manifesto spoke about it being the same as staff. So that just highlights what we were talking about there. Sorry.
MR GALE: Not at all. I wonder if you could look and be shown a document, which is SCI—CHRS—000039. I think that is a draft letter that could be sent to election candidates. Sorry, have I got the wrong reference?
MS HALL: Reference 37.
MR GALE: It is indeed 37. I beg your pardon. That was

a letter that you sent as your group to potential election candidates.
MS LEITCH: We asked members to send it.
MR GALE: At the second page of that you set out what Anne's Law was asking for, and the principles of that are set out in the letter under five bullet points. Then the paragraph after that you say:
"People living in residential and nursing homes, for whatever reason, have been treated differently to the rest of society."
Then in the final paragraph you say:
"This situation is the biggest human rights catastrophe that this country has ever seen and I ask you to support Anne's Law during your election campaign."
You have mentioned on a number of occasions and mentioned here what you term a "human rights catastrophe". Can you give us some favour of what you mean by that?
MS HAMILTON: I think —— I'll speak for us and then let someone jump in —— human rights catastrophe, I sound like I am repeating myself, but all of this is because of where someone lived, and we have stated it. We have so much respect for the staff that had to get put through horrendous ordeals due to the guidance and

having to deal with families wanting to get in and they weren't allowed to let the families in, but the staff never had any infringements put on them and they could enter the care home and leave, but those who lived in the care home had -- were so heavily restricted in their lives, which could have been, for many people, the last couple of years of their lives, and that to me will always be the biggest injustice of what happened.

MS LEITCH: I agree with Natasha completely. I think, from my perspective, my mum's human rights, her rights to family life, my rights to family life, they were ignored. My obligations under a power of attorney, those were ignored. The adults within the Incapacity Act -- every Act that was there to protect my mum was trashed, so that is why I believe that human rights have been trashed.

MR GALE: Again, just to get some more context, I wonder could you go to the document ending with the reference 000119? This is a letter regarding the National Care Service Bill in the consultation period that your group sent and it attached a submission on your behalf to that bill. Just looking at the context of it, you say:

"This submission summarises the views and experiences of our group members, focusing on Anne's Law and the importance of family contact. We remain

concerned that the right for a person in care to see their husband, wife or other essential care-giver, in the same way that they have contact with paid carers, is not stated as a 'right' -- but simply that the Minister has the right are right to direct."

That is the essential element of your complaint about what is in the bill?

MS HAMILTON: Yes.

MR GALE: Just looking at some of the concerns in the attached document, I think at the numbered page at the bottom, page 4 of your appendix to that letter, you express a number of concerns. The first is "Human and equality rights", then there is the "Option to Suspend Designated Visitors", and then you make certain comments in relation to "Adults with Incapacity"; is that right?

If we can go briefly to the "Summary", and this is perhaps something that you have in a way been discussing with his Lordship a moment ago. What you say there is:

"Whilst we welcome the ability of Directions giving powers of enforcement to Ministers, we continue to have grave concerns that within the Ministerial Directions for Anne's Law, the commitment to ensure care home residents will never again endure enforced separation and isolation could become diminished within the numerous caveats and possible changes to Directions.

"As we have stated on numerous occasions, being a care home resident necessitates regular and close human contact for personal care arrangements. That essential contact must also continue between husbands, wives, mothers, fathers, family members or close friends."

Then you emphasise:

"For clarify, we would request that the default position should be the resident's right to contact with their nominated relative/friend at all times, and if necessary, by following any recommended PPE precautions as per care staff. We must be recognised as a vital part of our loved one's care team."

Have you diluted any way from that?

MS RUSSELL: No that is spot on.

THE CHAIR: You require directions or you consider that you require directions and you would like recommendations in relation to directions. But I am not for a minute suggesting that was necessarily practical for you to do it, but you could have challenged directions that were made by judicial review when they were made. This is a lawyer speaking rather than possibly someone in practice, but if the directions are fundamentally in breach of someone's human rights, whether it be yours or the resident in the care home, they would have been

challengeable.

MS RUSSELL: Well, the directions themselves are just drafts at the moment so you might be giving us ideas for the future.

THE CHAIR: I am not suggesting that it's necessarily a particularly practical way to go about doing something because it takes time and costs money is the obvious reason against it, but it is something that could be done.

MS RUSSELL: We would rather it simply -- there was something simply enshrined there which said that, where people are --

THE CHAIR: I understand that. I suspect that this is a point that might be developed by your counsel in submissions rather than anything else, but ... yes.

MS HAMILTON: But it's a point that what happened on the run-up to this -- and my legal knowledge is -- I hate speaking about legalities, but the fact that we were locked out anyway was against human rights. So we shouldn't --

THE CHAIR: Well, that's extending this argument a little further, even though we have got so far, but you may have a point.

MS RUSSELL: There were so many -- even the cruel and unusual punishment -- honestly, when you see some of the

photographs going up on that group and stories of the way people were being treated, it was -- it was really, really inhumane --
THE CHAIR: Yes, I see that.
MS RUSSELL: -- and heart-breaking.
THE CHAIR: I suppose -- sorry.
MS RUSSELL: I think we do need to bring that element -- care is all about relationships and good relationships, and to me what they did just drove a coach and horses between relatives and staff which should never have happened. We were all batting for the same team. We just all wanted the best. And I think a lot of care home staff have been in contact with me, in fact, with the trade union and spoke to me on Monday about it, saying how they really supported us because that is what they felt too.
THE CHAIR: I understand. I understand your position entirely. As I said, I raised a rather legalistic point.
MS HALL: And for those in care homes who were physically frail but mentally had all their faculties, they were sitting reading newspapers and watching the television and seeing society going back to normal and they weren't allowed to put a foot over the front door of the care home, so I think they felt very strongly that their

human rights were being violated.
MR GALE: There are a number of other documents that you provided us with and they are attached, and these include your commentary on the discussion paper, there is also a literature review by Care Inspectorate and various other papers that make comment on Anne's Law. I would like to take you to a document entitled "Anne's Law Consultation: analysis of the responses". This is a final report. It's dated February 2022. I am just searching to find the reference to it. Yes, it's SCI-CHRS-000124. It's an analysis of the responses to Anne's Law and part 2 of that document contains the response, "Delivering Anne's Law".
Now, within that document there are a number of observations and if within the document you go to page 23, please -- the number in the bottom corner -- I think we can see -- these are recording responses that have been made to the proposal of Anne's Law and I think we can see in relation to question 1 the overall aim of Anne's Law:
"Nearly all participants agreed with the overall aim that people living in adult care homes should have the right to see those important to them to support their health and wellbeing. A total of 280 participants responded with 99% of individuals and 97% of

organisations [responding positively and in agreement with that]."
I think that certain of the respondents gave reasons for their response and that is set out under the table in that page. And the main reasons included:
"The mental and physical wellbeing of residents and their loved ones.
"Quality of life is paramount.
"The importance of familiarly connections.
"The need for residents in care homes to have the same human rights as other members of society.
"The specific negative impact of the restrictions on care home residents with dementia."
Again, I take it that those are all reasons with which you are in agreement?
MS HALL: I would also add the negative effect on not just the resident but their relative, the husband or the wife or anyone that was denied access.
MR GALE: Then on what is page 25 there is a response to question 2, to the opinions on the main aims of Anne's Law, and it says:
"Nearly all (278) of the respondents to Part 2 of the consultation provided a response to the question on the main aims ..."
And the issues raised -- and I will just deal with

the first one, if I may:
"The need to protect human rights and ensure that meaningful contact is enshrined in law."
Again, that is something with which you were thoroughly in agreement, I take it?
MS HAMILTON: Yes.
MR GALE: So looking at Anne's Law as it currently stands at the moment, are you optimistic or pessimistic about it?
MS HAMILTON: At the moment I would say I am pessimistic. I like to be optimistic about the interaction we are having to discuss about it. The reason why I am pessimistic is something this simple should not take this long to get put through in law. So we clearly have someone somewhere that's putting a barrier up for us and, if it's taking this long to get us to this point, I worry how much longer it is going to take, and that -- and bringing it back to impact, it's having a huge impact on us, having to continue to fight for this right for our loved ones, for everyone that is in care homes and for potentially -- any one of us in this room could end up in a care home for any sort of reason. So we're protecting the future rights for everybody as well. But I am optimistic about all the interaction we are having, but, if you asking about being pessimistic, why is it taking so long would be ...

MR GALE: Do you have any indication as to the progression of Anne's Law? Do you have any indication when it may be ——

MS RUSSELL: Well, it is tied to the National Care Service, which is currently paused, so hopefully they will bring the NCS back on. They have said that once the NCS is passed, it wouldn't take long to implement, but they are implementing something which, as it stands at the moment, isn't acceptable to us. So unless we get changes to the main legislation, I don't think we've achieved what we set out to do.

MS LEITCH: I think, whilst we have the new care standards in place, that we don't really hear of people being locked out anymore, but my concern is that, because of the short time that people live in care homes, that there is not many people in care homes today that lived through the height of the pandemic and that people don't know about their standards, so you are relying on families challenging decisions and being aware of these and we don't think at any point the guidance has been made fully available to families in a way that is meaningful to them.

It was my mum's care home that was shut down on Christmas Eve in December last year from a locum Public Health consultant making a decision, and there

was —— my mum's home is a 40—bed home and it was only her floor that was closed, so there's 20 beds. There was 19 families locked out that day and I got in because I knew the rules. And that just shows you who didn't know the rules and didn't know what they were entitled to, and we raised —— I wrote to Kevin Stewart and I have no doubt that he went through Public Health because of the decision, but he called it a "blip". I don't think it was a blip. I think that could be happening up and down the country quite easily, but people just don't know what they are entitled to, so it needs to be enshrined in law so that there isn't blips or there isn't locum health consultants making a decision on a whim.

MS RUSSELL: The reason that we would be unhappy to just settle for the care standards was that there were existing care standards during the pandemic and they didn't help us at all, and they did have lots of things there which should have ensured that your opinion —— if I am in care, that my views are always taken into account. There is a whole list of things there that, had they been applied, what happened to us and our loved ones wouldn't have happened.

MS HALL: I think since the day we started campaigning, we have highlighted the fact that there is actually no

place, no body, nowhere to go, if a relative is looking for advice or guidance. I mean, there is the Care Inspectorate, but they are kind of seen as the —— they police the standards, and we are having ongoing talks about this because they were keen for our group to take on this role and we are —— that is not what ——

MR GALE: Not your role.

MS HALL: No.

THE CHAIR: Just before you leave Anne's Law, can I ask a question which I admit is of detail but nevertheless it's quite interesting. Am I right in thinking that the way you envisage Anne's Law provides for an essential care—giver, one person?

MS HAMILTON: Yes.

THE CHAIR: Because in a different context we have heard evidence from the lady that gave evidence this morning, I think it was in the context of funerals; you know, if you've got six relatives —— ten relatives and you've got six at a funeral, how on earth do you pick them? It's invidious. I can envisage circumstances where a family, a person in care, has lots more than one relative who is a potential care—giver. You agree with that a matter of fact?

MS RUSSELL: Yes, that is right.

THE CHAIR: If what you tell me about infection control and

if what the lady that wrote the letter that we saw from the Nursing Times or to the Nursing Times is correct, then proper infection control, properly applied, should mean there is no reason to have simply one care—giver, essential care—giver. As long as they are provided with whatever the essential infection control measures were, then the whole family could be essential care—givers; is that not correct?

MS RUSSELL: There are two parts ——

THE CHAIR: Shouldn't you be modifying Anne's Law to say that?

MS RUSSELL: The first part of it is that during the pandemic their essential was for end of life, then more people would have been allowed in, where it was known about. In the early days of the pandemic nobody knew they could get essential, but later on, as people became more knowledgeable about the right to essential visiting for end of life, then that could have been larger numbers ——

THE CHAIR: Because you are actually proposing something that is going —— the minute someone goes into a care home, that right exists. But I am just wondering why you are trying to confine it to one person. It could be more.

MS RUSSELL: It is true for pandemics for major outbreaks

where Public Health are determined to reduce footfall, it is basically a plea to say: please do not reduce footfall below the one person. We weren't seen as husbands, wives, lifelong companions. We were seen as vectors of infection. That is all we were to Public Health and that is why we have said allow —— please God allow at least one person in.

MS HAMILTON: So on the back of what you are saying there, I totally understand what you are saying, but I think to highlight is it shows how worn down we are as families, that we are still, three years down the line, fighting for a law to allow one person. We are almost maybe scared to ... can we up it to two? Can we up it to three? So we can't even get the basics from people to back us to allow one person in. We don't want to push our luck.

THE CHAIR: The logic of what you are proposing would drive me to think that your argument would hold good, if it is good, if it is more than one person.

MS HALL: I think this is the thing we would have to convince Public Health. So we feel, well, at least if you will at least ——

THE CHAIR: You've convinced me in the first ——

MS HALL: In the worst, worst —— in the worst pandemic, the worst scenario, there will still be —— that husband will

be able to visit the wife; there will be that one important person so that it never drops completely that there is nobody going in, so it's like the safety net.

THE CHAIR: I am not sure you are quite getting me. I am not suggesting —— for example, say you have —— forget the husband and wife —— you have two sons or a son and a daughter, two daughters, two people, it's a bit invidious to pick one over the other. I am not suggesting both of them go at the same time ——

MS HALL: But common sense ——

THE CHAIR: Both of them could be nominated and they could go one at a time when they wanted.

MS HAMILTON: So that is part of what we have proposed as well, that although we are saying one person, there should be three people that are nominated. But that is what we proposed, but only one person —— like we are saying, because we are very understanding —— under extreme circumstances we need to try and protect everybody, but only one person goes in at a time, but there is the option for it to be three people that can be rotated on a basis, so we have ——

THE CHAIR: A number of people can be nominated as essential care—givers. Yes. Fair enough.

MR GALE: Thank you, my Lord. That is very interesting. To a certain extent restricting it to one person, did you

feel in the way in which you were campaigning that that was perhaps what you could get away with?

MS HAMILTON: I would also say that, on the back of restricting it to one person, we have to bring it back to the care home residents, so at the time we were possibly speaking about it, we were always talking about it impacting us, but care home residents were just locked away from all their family, so in our heads and minds we were thinking, well, if we could at least get care home residents to have one person, that allows that care home resident to have access to their family. They were shut off from everybody, so we were just starting from bare minimum to try and help all those residents.

MR GALE: The "bare minimum" I think encapsulates that, doesn't it? Just a few other points, if I may. I take the part of your statement on interaction with families as read because we can look at that. If you go to paragraph 57, in your statement you mention CHRS Lost Loved Ones group and you briefly explain the purpose of that. Can you just again explain why that group was set up?

MS RUSSELL: That group was set up because, when Open with Care came in in February 2021, in the March a lot of care homes did start for the first time in—person visiting and people were posting a lot of photographs or

selfies with their loved one for the first time and people in —— a lot of the people in the group by then —— as I say, by then, 15,200 people had died in care homes, of whom about a fifth were from COVID. So we had loads of people in the group who had already lost their relatives and they were finding these photos —— although they were really happy for people and they were really pleased to see it, they were finding it difficult as well and they asked if they could have a separate group.

MR GALE: Can I take you on to your concerns at paragraph 59 and onwards? I think it may be just useful if one or other of you reads that section from 59 onwards to the end of your statement.

MS LEITCH: The government failed to recognise the need for at least one key relative such as a husband, wife, mother or daughter to be given essential care—giver status. We believe that essential care—givers using all the same mitigations as staff, including PPE and infection control protocols, could have ensured their loved one was supported and kept in touch with their wider families throughout the pandemic. Close relatives desperate to see their loved ones were made to feel like the enemy when they should have been welcomed as part of the care team.

The Scottish Government failed to provide clear

direction to care homes and failed to insist that guidance was adopted and followed. This was despite the fact they laid down the rules in every other sector of society. They claimed they had no levers to do this in care homes, but this could have been achieved by amending the care standards much earlier or explaining that payment of fees or personal care allowances, which go direct to homes, would depend on them implementing the Scottish guidance.

The Government failed to ensure that care home residents benefitted from the route out of lockdown. Instead, they had no access to services such as opticians, podiatry, hairdressing, for more than a year and they were unable to get out in the fresh air. It was seven months after the Chancellor's Eat Out to Help Out before care home residents were even able to go for a walk or a run in the car.

As a group, we felt that we had no way to challenge these decisions, even though we were sure they were unlawful. When your rights are being challenged to this extent, there should be some way to access justice. We felt many others paid by the public purse to protect the interests of vulnerable people failed to speak out on behalf of those in care homes, such as directors of social work and the Office of the Public Guardian.

Imprisoning people for a year and isolating people in small rooms for weeks on end should have been challenged.

The Scottish Government and their Public Health advisers failed to recognise the huge impact their policies were having on older people who were approaching the end of life, even without COVID, and the impact that such long periods of isolation and confinement were having on the entire care home population, which includes a substantial number of young adults.

The Scottish Government were able to create an impression in the press and media that indoor visiting had restarted, but in huge areas of Scotland it continued to be heavily restricted with only closed windows visits or outdoor visits available. Many people in Greater Glasgow and Lanarkshire areas had no direct contact with their loved ones for a full year.

The Scottish Government have never said sorry for what relatives of those in care homes have been through. The needs of young adults in care homes were ignored. When Public Health Scotland produced a final set of COVID guidance in January this year, care home guidance had been amalgamated with the guidance for prisoners. This was only changed after complaints from our group.

Any one of us could end up in care and lessons must be learned so that this never, ever happens again.

MR GALE: Thank you very much, all of you, for engaging with the Inquiry and providing your statement and your evidence today. I will always ask or should always ask anyone who gives evidence to the Inquiry if there is anything you feel you want to add to what you have already said and also to say that, if at any time after you leave this room it occurs to you that there is something that you should have said or would have liked to have said, please let us know, contact the Inquiry team, and that information will be added to your body of evidence that you have provided. So is there anything further that any of you would like to add?

MS LEITCH: Yes, please. This session is on the impact, and the biggest impact we felt from our members was the survey that we carried out following the change of guidance in October 2020, which allowed four hours with touch. We surveyed our members to quantify how well these were being implemented. They included a free text section for people to include how the restrictions were impacting them and we received 322 impact statements, which include 165 mentions of stress, anxiety or depression, 100 mentions of guilt or worry, 59 mentions of sadness, abandonment or hopelessness,

49 mentions of heart—break, heartbroken and grief. It felt that every time there was progress in terms of access to care home residents, another obstacle appeared.

We would often hear, "We can't trust you to do your own tests"; "We can't facilitate visits with touch"; "We can't facility video calls"; "We can't have Christmas decorations"; "We can't accept Christmas presents unless they are quarantined for 72 hours"; "We can't have hairdressers"; "We can't use rapid testing as we haven't had training"; "We can't alternate visitors", "We can't give any extra visit even though visits are going unused"; "We can't let you push your wheelchair"; "We can't facilitate outside visits as we haven't bought any heaters for winter"; "We can't you give you an essential visit as we would have to give everyone one"; "We can't allow you to access your relative's room"; "We can't let you see your dying relatives for more than 15 minutes a day"; "We can't let you hold your dying relatives' hands"; "We don't trust the Scottish Government decisions"; "Guidance is only guidance. We don't have follow to it"; "Public Health say 'no', Care Inspectorate say 'no', social workers say 'no', the manager says 'no', head office says 'no', but we can test you, dress you up in PPE and make you sit

behind a screen 2 metres away from your hard of hearing non—verbal relative for 30 minutes once a week and then tell you your time is up".

In early 2021 we joined forces with family groups in England, Wales, Northern Ireland and the Republic of Ireland, calling on governments of the five nations to act and we still stand by this today. And we would like to mention our partners, Care Champions in Ireland and Rights for Residents in England because we know they are watching today, and they're campaigning for a law of care partner in Ireland and Gloria's Law in England.

After a year of fear, distress and countless separations, family members from our five nations want to re—assert the larger picture of what society should be. Over the months of the pandemic, the deepest ties of love, the things that make us glad to be alive, have been treated as unimportant. Spouses, life partners, parents and children have been treated as inessential to each other. Their wishes have not been considered; their voices have not been listened to. Residents of care homes have been shut in and those who love them have been shut out. People living in residential and nursing homes for whatever reason have been treated differently from the rest of society. They have had no

agency. Those who have been trusted to speak for them have been not been properly listened to. Their well—being has been compromised in the name of care.

This is not the society we wish to pass on to the next generation or grow old in ourselves. The test of a democracy is how it gives respect and choice to all of its members, young or old, in health or in sickness. Love is a bedrock of a good society. For hundreds of thousands of people, those bonds of love have been cruelly disregarded. As members of our individual nations and as fellow human beings ourselves, we call on our governments and everyone with influence to assert what is inalienable right for all of our sakes.

MR GALE: Thank you very much, Ms Leitch.

Thank you very much to all of you. We are very grateful to you. Thank you.

THE CHAIR: I share those sentiments. We will adjourn now.

(4.08 pm)

(The hearing adjourned until until 10.00 am on Tuesday, 31 October 2023)

INDEX

MS JANE MORRISON 1
(called)
Questions from MR GALE 1
Care Home Relatives 84
Scotland (called)
Questions from MR GALE 84

A

aamer (1) 40:16
abandonment (1) 155:25
abdomen (1) 15:1
ability (1) 138:19
able (25) 14:7 20:2 21:13 23:20 24:4 26:10,25 59:3 61:5 63:23 78:20 81:4,13 90:6 93:23 97:14 100:13 103:2 116:18 122:19 130:5 132:13 150:1 153:16 154:12
above (1) 22:6
abroad (1) 82:7
absolute (1) 83:10
absolutely (14) 18:20 56:9 65:9 87:17 98:24 102:8 105:23,23 114:10,13,16 118:13 119:7,23
abstract (1) 72:25
abundant (1) 27:19
abuse (1) 17:1
academic (1) 2:15
accept (3) 82:2 133:6 156:8
acceptable (2) 66:7 145:9
accepted (1) 132:7
accepting (1) 84:23
access (17) 27:11 88:14 105:10 109:17 113:6,13,14,21 128:25 132:3 135:14 143:18 151:11 153:12,21 156:3,17
accommodate (2) 1:15 86:16
account (3) 86:22 92:16 146:21
accounts (3) 3:19,21 37:2
achieve (1) 87:5
achieved (4) 97:17 98:6 145:11 153:5
acknowledge (2) 30:6,13
acknowledged (1) 134:11
acknowledgement (1) 95:5
acquired (1) 49:20
across (9) 32:19 40:18 44:10,21 74:5 99:23 113:2 118:1 129:23
acted (1) 86:2
acting (1) 43:25
action (4) 70:19 78:18 118:19 121:15
active (3) 92:9 93:15 111:5
actively (1) 105:20
actual (3) 71:22 79:10 130:13
actually (44) 10:15 11:2 13:9 16:1,1 19:13 20:9 23:1,14 25:20 26:14 27:4 33:6 37:3 38:8,12 41:20 42:14 47:22 48:8 50:12 52:2 57:19 58:7 60:15,15 71:21 83:3 85:21 92:13 95:16 99:18,24 100:4,16 102:15 104:3 112:25 114:12,20,25 134:14 146:25 148:20
acute (1) 76:16
adamant (1) 57:1
adams (1) 96:7
adapted (1) 10:5
add (10) 5:7 29:23,24 82:10 100:20 104:2 129:17 143:16 155:7,14
added (4) 69:21 113:8 127:23 155:12
addition (5) 7:18 17:14 22:5 77:11 82:18
additional (1) 82:5
address (4) 3:6 85:8,15 124:24
adept (1) 36:18
adequate (2) 61:12 75:19
adequately (1) 83:13
adhere (1) 126:17
adhering (1) 125:20
adjourn (1) 158:17
adjourned (1) 158:19
adjournment (1) 84:7
admin (1) 82:17
admired (1) 9:4
admissibility (1) 52:17
admission (1) 78:17
admit (2) 28:12 147:10
admitted (2) 129:5 132:12
adopted (3) 116:25 119:10 153:2
adrift (1) 82:23
adult (5) 16:12 81:10 127:11 128:19 142:22
adults (5) 56:19 137:13 138:15 154:11,21
advance (2) 96:2 98:21
advantage (1) 98:18
advantages (1) 88:9
advice (3) 59:4 130:13 147:2
advisers (2) 110:1 154:5
aerosols (1) 63:7
affected (1) 76:10
affection (2) 119:22 121:7
after (40) 2:15 6:22 9:10 10:9 11:18 12:3 48:2 51:1 56:16 62:5,6 63:9,13 65:1 71:17 78:15 79:11,18 80:22 81:3,6 82:20 83:3,3 90:14 99:9 106:10,13 107:14 110:14 117:2 127:22 129:4 132:1,10 136:7 153:15 154:25 155:8 157:13
aftermath (1) 60:25
afternoon (2) 84:11 106:3
afterwards (3) 12:20 24:6 62:23
aga (1) 9:16
again (58) 3:6,6,9,22 7:16,17 10:13 13:25 15:1,4 28:20 29:8 33:16 34:5 38:19 44:11,16,19 45:14 50:21 52:19 60:10,16 66:9,10,13,22 72:5,13 73:20 74:1,19 77:6 80:11,18 83:15,16 85:15 89:4 97:22 98:2 103:22 110:7 111:12 112:21 121:19 122:8 125:8 126:7 129:1 132:23 135:15 137:17 138:23 143:14 144:4 151:20 155:2
against (5) 103:3 115:5 126:15 140:8,19
age (2) 85:7 92:7
agencies (2) 93:17,17
agency (1) 158:1
ago (3) 41:14 117:17 138:18
agonising (1) 7:22
agree (3) 120:21 137:9 147:22
agreed (7) 8:3 29:17 51:2 123:22 124:13,14 142:21
agreeing (1) 123:23
agreement (5) 86:4 118:12 143:1,15 144:5
ahead (1) 132:2
aids (1) 71:6
aim (4) 41:12 95:21 142:19,21
aims (4) 86:24 87:3 143:20,24
air (2) 21:19 153:14
airway (1) 21:17
alan (1) 41:5
albeit (2) 43:10,13
alcohol (2) 16:16 53:7
alison (5) 84:15 96:11 97:9 98:9 99:5
alive (1) 157:17
allow (10) 120:9 125:4 128:9 132:2 134:14 149:6,7,12,15 156:17
allowances (1) 153:7
allowed (18) 14:8,16 15:21 16:11 27:1,20 63:6 64:9 66:7 91:6,15 127:15 128:14 135:14 137:2 141:24 148:14 155:18
allowing (1) 54:21
allows (1) 151:10
almost (5) 64:7 93:3 105:2 118:15 149:12
alone (2) 72:8 92:19
along (4) 38:6 82:17 123:12 124:1
already (19) 4:4 26:8 27:25 33:23 43:6 44:6 49:4 54:9 65:3 78:11 79:6 81:13 90:19 99:12 111:12 125:8 132:7 152:5 155:8
also (69) 2:21 5:2 6:7 7:17 8:5 17:11 24:15 27:17 29:5,11,12,15 30:13,24 32:16 35:12,25 36:9,17,17,21 41:15 44:20 46:2 49:20 52:9 54:18 55:11 58:20 59:10 60:24 65:10 67:6,19 70:8 74:10 75:1 77:12,14 81:25 82:6 86:17 88:19 89:7 90:8 93:25 95:10 96:8 101:20 106:18 109:20 110:18,23 111:5 112:15,24 114:12 117:13 118:19 119:14 120:16 124:20 127:24 134:3 139:4 142:5 143:16 151:3 155:8
alternate (1) 156:11
alternative (1) 6:5
alternatives (1) 108:23
although (10) 5:7 9:19 33:7 77:24 105:12 107:17 108:7 120:7 150:14 152:6
always (18) 71:16 91:25 97:14 103:16 107:4 113:10 119:13,15,17 120:11 123:15,19 128:14 137:8 146:20 151:6 155:5,5
alzheimer (1) 93:15
alzheimers (2) 26:24 27:7
amalgamated (1) 154:24
ambassador (1) 5:22
ambulance (3) 78:16,21,22
amending (1) 153:6
american (2) 57:18 67:7
analysed (1) 86:21
analysis (2) 142:8,11
anecdotal (2) 37:22 52:14
angel (1) 23:15
anger (1) 83:12
angry (2) 83:9 99:23
anguish (1) 118:16
anne (2) 90:12 127:22
annes (28) 90:14 126:25 127:22,23 128:2,23 129:18 131:25 132:2,5 135:11,13 136:5,14 137:24 138:22 142:6,8,12,13,18,20 143:21 144:7 145:2 147:9,12 148:10
announce (1) 107:8
announcing (2) 107:9,13
another (11) 48:13 51:6 55:7 63:10 82:14 88:21,21 97:21 104:17 128:24 156:3
answer (1) 85:22
answered (1) 30:16
answers (8) 25:14 35:25 36:1,4 45:2,11,14 64:20
antibiotics (1) 19:23
anticipated (1) 109:15
anticipating (1) 111:1
anwars (1) 40:16
anxiety (2) 69:25 155:24
anybody (5) 24:10 41:7 109:1,11 116:15
anymore (1) 145:14
anyone (14) 12:5 40:14 43:19 72:12 88:9 106:10 108:5,17,18 114:18,19 132:3 143:18 155:6
anything (16) 12:19 17:19 18:4 22:12 29:2 49:19 60:12 78:20 95:7 120:3 130:20 132:4,4 140:15 155:7,13
anyway (1) 140:19
anywhere (2) 94:19 114:19
apart (1) 65:25
apologise (1) 111:4
apparent (1) 69:19
appeal (2) 112:11 113:18
appear (1) 101:13
appeared (5) 5:23 54:2 82:9 96:8 156:4
appears (2) 90:23 96:19
appendix (1) 138:11
applicable (1) 28:18
application (1) 121:16
applied (4) 10:2 124:22 146:22 148:3
applying (1) 112:4
appointment (2) 14:8 15:18
appreciate (4) 9:3,3 27:16 133:9
appreciated (2) 92:23 106:2
appreciation (2) 108:1 118:24
approach (10) 35:24 36:20 41:16 42:6,13,14 51:3 68:10 87:10 119:10
approaches (2) 41:24 55:14
approaching (2) 107:21 154:7
appropriate (5) 2:9 45:12 52:24 64:2 78:1
appropriately (1) 62:24
april (1) 97:14
area (6) 10:8 20:25 21:3 40:17 55:16 82:7
areas (6) 44:6,7 55:1 81:18 154:14,17
arent (1) 17:13
argument (2) 140:21 149:18
arise (1) 61:5
arising (1) 52:24
arms (1) 114:16
army (1) 47:23
around (17) 15:9 17:13 31:11,13 60:17 64:14 78:18 79:3 81:10 88:19 90:20 102:5 105:14 107:3 131:8 132:16 135:16
arranged (2) 11:5 28:5
arrangement (1) 70:15
arrangements (2) 100:12 139:3
artery (1) 21:23
asbestos (1) 48:11
aside (1) 45:20
ask (16) 1:19 15:3 20:9 25:14 30:4 46:9 59:15 72:19 79:4 83:19 84:5 135:4 136:13 147:9 155:5,5
asked (22) 2:16 7:8 10:18 17:17 18:10 23:3 24:8 28:23 29:7,24,25 32:13 41:6 59:23 67:10 84:18 96:3 111:17 112:12 114:8 136:3 152:9
asking (10) 4:5 45:1,24 47:8 58:12 100:25 120:25 132:13 136:5 144:24
aspect (3) 38:2 51:18 66:11
aspects (1) 69:7
assert (1) 158:12
assimilating (1) 102:4
assist (1) 7:6
assistance (1) 55:12
associate (1) 9:12
associated (2) 67:14 74:7
assumes (2) 8:15 80:25
attached (3) 137:21 138:10 142:3
attacking (1) 13:23
attend (2) 63:6 81:16
attending (1) 96:3
attention (8) 94:9,21,22 96:14,20,21 115:13 122:8
attitude (2) 9:1 54:5
attorney (1) 137:12
attribute (1) 34:24
audio (1) 5:19
august (3) 88:16 89:17 127:8
author (1) 116:1
authorities (3) 51:20 65:14 126:3
authority (5) 4:20 51:15 93:1 123:25 124:5
authors (3) 68:14 75:4 115:25
autonomous (1) 34:11
available (9) 26:14 46:9 48:21 76:8,21 86:5 135:5 145:21 154:16
avoiding (1) 87:11
awards (1) 110:23
aware (19) 1:9 3:16 22:15 25:19 36:3 42:1 46:10 61:8 85:8 88:19 89:5 90:22 96:5 98:17 101:5,7 110:23 115:18 145:19
away (10) 8:11 61:15 62:17 87:23 91:20 97:22 130:2 151:2,8 157:1

B

back (50) 7:2 8:14 10:17 11:1,3,14,16 14:14,18 16:9,15,21 20:21,22 23:15 25:15 26:11 31:7 33:11 66:23 69:6 76:23,24 81:9 82:12 88:1 90:16 100:13,20 104:2 106:9 109:14 113:17 117:20 120:1 121:22 122:3 123:8,10,13 126:24 133:17 135:8 141:23 144:17 145:6 149:8,15 151:3,4
background (12) 10:14 29:15 30:20 34:6 35:3 39:8 50:24 72:25 73:21 94:9 115:19,22
backgrounds (2) 35:13 38:24
bad (7) 5:10 6:4 7:16 36:10 43:21 51:22 78:16
bag (4) 26:20 62:20 64:1 78:23
baking (1) 9:20
ban (1) 126:14
banged (1) 114:18
banned (1) 70:8
bans (2) 126:6,9
bar (1) 132:4
bare (2) 151:13,14
barrier (3) 116:7 118:8 144:14
barring (1) 118:16
base (3) 5:4 69:2 129:17
based (1) 75:11
basically (6) 7:20 45:24 47:7 94:18 130:7 149:2
basics (2) 30:10 149:14
basis (3) 90:8 122:17 150:21
battery (1) 20:13
batting (1) 141:11
battle (1) 70:23
bbc (2) 96:7,11
became (9) 13:17 41:10 69:19 83:8 89:8 93:15 96:5 101:6 148:16
become (8) 1:13 34:9 78:10 101:5 122:23,24 124:2 138:24
becomes (1) 46:9
becoming (1) 83:6
bed (2) 15:10,15
bedblockers (1) 69:18
bedbound (1) 92:4
bedrock (1) 158:8
beds (1) 146:2
before (38) 1:19 6:3 11:6 12:5 13:16 16:17 20:9 21:8 24:5 28:3,24 29:1,3,8,25 37:14 42:8 43:20 45:10,14 47:11 48:20 50:23 54:4 63:14 65:17 66:14 69:5 70:1,4 71:21 107:23 114:6 121:20 127:18 129:8 147:9 153:16
beg (1) 135:25
began (1) 36:16
begin (1) 4:14
beginning (5) 12:9 42:23 49:3 72:25 117:24
begins (2) 73:1 125:1
behalf (5) 39:22,23 83:20 137:21 153:24
behaviors (1) 76:15
behind (5) 59:4 87:23 90:8 105:7 157:1
being (60) 4:20 5:12 8:10 10:10 19:3 26:10 28:12 31:22 34:19 39:14 40:7 42:6 56:18 65:8 70:11 78:11 79:18 81:7,13 82:25 88:2,9 91:2,6,15 92:17 94:23 99:10 100:14,24 102:5,6 103:18 105:17 106:15,16,20,20 109:20 111:19 112:8,23,25 113:21,24 117:25 124:7,8 126:4 131:14 134:11 135:17 139:1 141:2 142:1 144:24 145:13,19 153:20 155:20
beings (1) 158:11
believe (9) 27:17 69:11 70:17 79:15 100:21 128:4 130:21 137:15 152:17
believes (1) 128:12
believing (1) 105:2
belongings (1) 82:1
below (1) 149:3
belt (1) 10:4
benefit (4) 23:8 36:25 55:10 113:16
benefits (1) 19:2
benefitted (1) 153:11
bereaved (18) 1:23 19:3 34:7,18 35:4 36:15 38:22 39:1 40:4,22 66:3 67:15 69:3 73:4 75:7,23 77:8 82:25
bereavement (17) 2:2,13 6:8,13,22,25 35:9,11 63:10 67:2,6 73:14 75:12,15,18 76:21 82:18
best (9) 52:5 53:20,25 71:13 72:2 79:4 86:15 121:13 141:12
better (14) 4:16 35:1,5,10 56:7 60:16 64:16,18,23 77:7 78:3 79:24 121:10 123:6
between (14) 2:23 9:4 27:9 30:14 36:22 44:8,9 46:16 51:7 113:11 119:5 120:1 139:4 141:10
beyond (2) 67:13 118:2
bgs (2) 49:2,13
big (7) 45:19 50:4 54:25 65:22 77:9 113:4,10
bigger (1) 42:19
biggest (5) 32:18 100:10 136:12 137:8 155:16
biggie (2) 31:20 48:17
bilirubin (1) 14:19
bill (11) 82:19 128:4,4,6 129:7 130:7 131:5 132:16 137:20,22 138:7
biopsies (1) 14:2
biopsy (2) 14:4 19:22
birmingham (2) 55:3 70:4
birth (3) 3:2 4:17 85:6
bit (18) 8:17,21 10:2,20 11:8 13:7 23:6 30:7 33:25 41:24 50:23 53:17 54:10,12 69:21 121:8 125:18 150:7
blanket (3) 126:6,9,14
blessing (1) 63:22
blind (5) 4:23 5:3,14 9:17 29:13
blip (2) 146:8,9
blips (1) 146:12
blisters (1) 7:21
blood (5) 13:13,14 21:24 24:2 29:4
bluntly (1) 34:22
blurred (1) 46:19
board (10) 4:20 32:20 42:4 44:1,9,10 53:3 55:19 58:5 77:22
boards (3) 43:25 44:4 46:7
bodies (5) 93:5,9 99:20 111:6 113:11
body (4) 62:20 64:1 147:1 155:12
bonds (1) 158:9
books (3) 5:15,17,19
born (4) 85:5,13,18,19
both (8) 29:22 36:10 59:10 61:18 62:12 119:2 150:9,11
bottom (5) 37:21 56:2 89:14 138:11 142:16
bought (1) 156:14
box (2) 65:11,13
boxes (1) 13:20
boxing (2) 104:5,7
brailsford (1) 4:4
brain (1) 72:6
branch (1) 34:12
brave (1) 9:22
breach (2) 27:2 139:24
breached (2) 114:8 125:23
break (7) 1:14 4:7 31:6 33:7,14 66:19 121:24
breaking (1) 71:18
breath (1) 72:8
breathing (1) 25:25
bridge (1) 5:3
brief (2) 66:24 105:16
briefings (2) 103:19 107:7
briefly (4) 73:20 111:12 138:16 151:19
brilliant (1) 119:23
bring (9) 13:7 15:25 81:18 94:7 96:14 116:13 141:7 145:5 151:4
bringing (5) 31:7 55:1 69:20,22 144:17
bristol (1) 67:11
british (3) 46:23,25 49:1
broad (1) 118:11
brought (12) 3:23 26:23 27:5 37:24 56:23 58:4 88:13 92:18 94:3 105:3 117:7 134:12
bubble (4) 104:6,10,11,12
bugbear (1) 48:16
buildup (1) 71:21
bulb (1) 116:2
bullet (4) 122:13,20 124:16 136:6
bunch (1) 99:23
burden (1) 72:23
burial (1) 64:9
burials (1) 63:25
business (1) 7:14
busy (2) 25:14 115:15
buy (1) 57:8

C

cabinet (1) 96:22
call (14) 1:25 11:1 33:6 40:24 48:17 82:21 97:4 113:3 114:25 121:15 133:2,17,19 158:11
called (22) 1:7 11:2 36:22 41:9,11 42:21 52:2 58:1 67:5 84:17 90:14 115:21 116:14 117:4 120:18 127:14 133:21 134:10,22 146:8 159:3,6

calling (2) 114:20 157:6
calls (4) 21:18 105:4 108:12 156:7
came (24) 7:7 10:17 11:16,19 16:10 20:21 23:24 30:16 41:3 55:8 80:20 82:11 83:7,8 88:17 90:3 92:23 93:3 95:6 98:23 103:23 115:13 123:12 151:23
camp (1) 5:4
campaign (4) 127:9,24 132:8 136:15
campaigned (1) 86:2
campaigning (6) 93:10 109:17 110:24 146:24 151:1 157:10
cancer (1) 12:20
candidates (3) 135:5,23 136:2
candour (1) 46:4
cannot (3) 62:11 66:7 119:13
cant (31) 11:21 21:17 36:4 49:6 50:14 54:20 63:6 64:1,2,8,14 71:7 79:4 94:17 120:15 149:14 156:5,6,7,7,8,9,10,11,11,13,14,15,17,18,19
car (4) 16:18 64:10 116:19 153:17
cardiff (1) 67:11
cardinal (2) 20:7 26:3
cards (1) 9:5
care (225) 19:3 21:2 22:3,8 27:12,21 32:11 36:22 37:2,8 46:11,12,17 47:5,6,8 54:16,24 55:4,6,7,10,11 69:10,18,20 70:1,2,3,11,12,16,17 71:1 76:16,18 78:3 79:9,22 80:9 82:14 83:21 84:14,17 85:9,23 87:6,9,14 88:14 89:4,8,11,16,22 91:12 92:3,5,7,13 93:13,13,14,18 94:8 95:11,21 96:15 97:15 98:25 99:3,10 100:23,25 101:1,21 102:10,23 103:1,2,4,18,20,25 104:3,9,13,19,21,25 105:5,21,22 106:7,10,22 107:10,18 108:14,14,19,21,25 109:3,20 110:16,17,19,19 111:7,19,25 112:2,4,6,9,15 113:12,16,20 114:6,7,12,25 115:1 116:14 117:22 118:1,9,16 119:21 120:17 124:15,19 125:1 126:12,13,20 127:9,11,15 128:3,6,10,11,14,16,18,20,21,25 129:3,7,21,23 130:7,10 131:3,4,10 132:3,9,13 133:2,20 134:18 135:14 137:4,5,19 138:1,22 139:2,3,12,13,25 141:8,13,20,25 142:5,22 143:10,13 144:19,21 145:4,12,15,16,23 146:16,17,20 147:3,21 148:22 151:5,7,10,11,23,24 152:3,24 153:1,5,6,7,10,16,24 154:9,20,21,23 155:1 156:3,23 157:8,11,22 158:3 159:5
cared (3) 79:19,19 109:19
career (2) 3:10,12
careful (1) 48:3
carefully (2) 14:19 19:18
caregiver (14) 87:8 109:21 131:10,17 133:2,9,11,25 138:2 147:13,22 148:4,5 152:16
caregivers (6) 105:19 106:16 130:1 148:7 150:23 152:17
caregivervisitor (1) 128:13
carer (2) 128:7 132:9
carers (2) 106:12 138:3
caring (1) 102:7
carried (3) 2:16 100:7 155:17
carry (4) 65:16 68:18 69:9 95:25
carrying (1) 94:5
cars (1) 64:10
cases (2) 106:21 121:12
cast (2) 82:22 121:5
catastrophe (3) 136:13,18,21
cater (1) 75:20
catherine (1) 84:15
cathie (5) 85:4 92:17 94:25 129:16 130:5
caught (5) 37:13,16,17,18 70:9
cause (8) 25:5,6 56:11 68:22 74:18 77:23 109:6 110:4
caused (3) 25:8 101:18 118:17
causes (2) 13:14 133:11
caution (1) 112:3
caveats (1) 138:25
celebrate (1) 81:17
central (12) 2:15 33:22 36:4 42:24 67:19 72:24 78:9 103:12 122:8 138:14 143:3 150:25
certificate (1) 24:17
certificates (1) 24:22
chain (1) 52:25
chair (47) 1:3,6,8 20:5,9,13,17 33:3,5,10,16 58:10 66:16,21 83:24 84:3,11 121:22 122:1 132:15,21,24 133:8,19,23 134:7,21,24 135:9 139:16 140:5,13,21 141:4,6,17 147:9,15,25 148:10,20 149:17,23 150:4,11,22 158:17
challenge (2) 5:18 153:18
challengeable (1) 140:1
challenged (3) 139:20 153:20 154:3
challenging (1) 145:19
champions (1) 157:8
chance (4) 50:7 65:2 81:5 84:3
chancellors (1) 153:15
change (1) 155:17
changed (3) 29:18 131:15 154:25
changeorg (1) 127:6
changes (4) 123:16,18 138:25 145:10
changing (2) 89:22 90:3
chaos (1) 21:7
chapel (1) 63:3
charge (1) 116:9
charger (1) 79:3
charities (1) 82:2
chart (2) 52:3,5
chat (1) 102:14
check (3) 21:10 70:7 97:5
checked (2) 12:19 37:6
chief (1) 45:19
child (2) 77:10,13
childish (1) 32:8
children (5) 16:11 75:24 81:10 103:12 157:19
china (1) 47:21
chocolate (2) 8:7,8
choice (3) 40:15 62:10 158:6
choose (3) 28:13 63:4 81:16
chosen (1) 114:11
christmas (7) 103:16 104:4,7 129:3 145:24 156:7,8
chronic (1) 7:19
chrs (13) 85:23 86:2 96:2,16 109:25 110:9 111:23 112:3 127:5,8 128:4,12 151:18
chucked (1) 47:16
churches (1) 63:20
circa (1) 75:6
circles (1) 5:2
circumstance (1) 25:1
circumstances (13) 6:25 25:2 27:7,20 49:16 68:24 73:4 74:21 78:5 121:14 131:3 147:20 150:18
citing (1) 112:9
civil (1) 24:21
claimed (1) 153:4
clarifications (1) 112:19
clarify (2) 112:17 139:8
clarity (1) 101:18
clause (7) 129:7,15 130:18,24 131:16 132:20,23
clean (1) 26:19
cleaners (2) 39:6 106:11
cleanliness (1) 26:13
clear (7) 34:10 44:6 82:1 101:14,15 112:1 152:25
clearance (1) 82:3
cleared (1) 82:16
clearly (3) 12:16 102:3 144:13
climbed (1) 5:3
clinical (1) 57:23
close (7) 57:22 125:25 128:19 134:5 139:2,5 152:21
closed (6) 105:7 109:8,9 114:17 146:2 154:15
closer (2) 77:4 131:13
clot (1) 13:14
clothes (4) 26:17,20 64:2,4
clothing (1) 82:2
coach (1) 141:9
coalesce (1) 89:1
coast (1) 8:12
coffee (1) 33:7
coffin (3) 64:5,11,13
cognitive (2) 108:25 109:10
cohort (1) 126:16
coined (1) 127:21
collaborated (1) 117:17
colleague (1) 25:15
collection (1) 117:4
column (1) 75:10
come (32) 1:8 14:5,13 16:9,15 18:10 20:22 30:8 31:7 33:11 38:6 41:2 53:8 54:23 63:12 64:12,12 68:3,16 69:6,7 79:4 81:11 90:13 99:22 101:23 106:18 109:21 119:8 121:5,22 124:1
comes (8) 35:1 44:2,21 49:22 58:24 82:17,23 132:8
comfort (3) 38:16 64:6 72:2
comfortable (2) 26:22 40:14
comforting (1) 63:16
comic (1) 30:1
coming (17) 26:9 53:21 55:2 57:12,17,24 61:16 66:23 98:4 100:19 101:8,11,12,17 106:9 109:4 117:20
comment (4) 67:24 68:16 78:2 142:6
commentary (1) 142:4
commented (2) 25:20 67:21
commenting (2) 80:15 112:14
comments (5) 7:8 9:5 47:20 74:2 138:14
commission (3) 75:15 93:12,12
commitment (1) 138:22
commitments (1) 41:15
committed (1) 115:2
committee (2) 40:24 127:19
committees (1) 84:21
common (2) 88:1 150:10
communicate (2) 109:2,10
communicated (3) 44:13 53:15 98:12
communication (22) 18:19,23 19:1 21:8 25:17 30:14 31:21,25 32:4,5 40:19 43:7 44:16,20 51:6 76:14 79:10,13,16,21,23 87:13
communications (1) 93:25
communities (1) 76:10
community (9) 37:14 76:7,9 90:21 92:9 93:4 96:15 114:19 115:24
companion (3) 131:11 132:9 134:6
companions (1) 149:4
companionship (2) 91:24 106:8
company (1) 48:10
comparative (1) 55:17
compared (4) 18:25 30:7 73:13 75:7
compassion (4) 116:6 117:21 119:4,20
compassionate (7) 27:3,11 76:6,14 118:8 120:20 124:18
complaint (2) 60:7 138:6
complaints (2) 25:12 154:25
completely (10) 8:1 49:5,10 72:8 107:22 114:2,3 125:22 137:9 150:2
complex (2) 52:5 75:21
complexities (1) 61:5
complications (1) 133:18
comply (1) 65:22
compos (1) 25:22
comprehension (1) 53:20
compromised (1) 158:3
computer (1) 110:13
concentrate (1) 109:5
concentrating (1) 108:6
concept (19) 55:24 56:4 58:2 87:8 90:13 118:11 123:23,24 124:1 131:17 133:1,7,8,10,14,21 134:1,10,21
concern (7) 79:25 89:18 111:23 122:24 129:13,14 145:14
concerned (10) 14:20 89:15 101:24 109:25 112:6 118:6 125:18 128:22 131:24 138:1
concerns (6) 79:14 134:9 138:9,12,21 152:10
conclude (1) 66:6
concluded (1) 18:9
conclusion (2) 73:11 75:2
concrete (2) 95:6 101:13
condition (8) 4:25 7:20 12:21 13:3,23 21:10 29:12 72:14
conditions (5) 25:7 73:8 76:2 107:20 108:18
condolence (1) 9:6
conducted (1) 106:24
conference (2) 117:18,19
confidence (1) 130:11
confine (1) 148:23
confinement (1) 154:9
confirm (2) 24:23 32:24
confirmed (2) 29:20 54:5
conflict (1) 27:9
confronted (1) 52:25
confusing (1) 112:17
confusion (5) 101:7,18,24 112:22 113:8
connect (1) 78:6
connections (2) 89:3 143:9
conscious (1) 87:15
consequences (1) 73:6
consider (5) 74:13,17 79:8 110:2 139:16
considerable (1) 117:13
considerably (1) 90:24
consideration (5) 31:17 74:23 108:6,17 126:11
considerations (1) 69:1
considered (8) 34:3,4 42:9 56:4 67:21 86:5,21 157:20
consistency (1) 44:10
consistently (1) 76:17
consortium (1) 93:13
conspiracy (2) 65:24 83:4
constant (4) 29:11 69:12 126:9 129:6
constitutes (1) 83:16
constructive (1) 36:1
consultancy (1) 116:12
consultant (20) 13:3 17:20 18:1 22:7,8,9,9 23:24 24:14 25:20 28:24 29:5,20 30:2,3,9,15 44:19 115:20 145:25
consultants (4) 17:7 115:12 116:22 146:13
consultation (4) 128:8 137:20 142:8 143:23
contact (38) 14:6 18:3,7 24:19 26:17 60:6 63:9 76:17 81:22 87:7 89:16 90:1 91:16,16 93:8 95:20 97:14 98:7 109:12 110:14 116:4,7 119:5 120:12 124:3 125:6 132:14 133:7 134:15 137:25 138:3 139:3,4,9 141:13 144:3 154:18 155:11
contacted (4) 18:9 93:10 97:5 117:2
contacting (1) 93:5
contacts (1) 106:17
contained (1) 129:15
contains (2) 105:16 142:12
contempt (2) 54:3 83:11
context (12) 31:22 36:8 45:8 47:14 54:13 56:6 59:8 113:21 137:17,22 147:15,17
continue (10) 7:11 14:17 19:10 55:13 69:6 98:11 112:5 138:20 139:4 144:18
continued (2) 110:15 154:15
continues (2) 36:15 110:16
continuing (1) 125:5
continuous (1) 21:16
contribute (1) 83:14
contributed (1) 25:7
contribution (1) 72:18
control (38) 14:22 17:22 25:11 26:7 27:3,10 31:3,9 32:3 43:8 53:4 73:18 101:12 112:9 113:22 115:12,16,22 116:17 117:18 118:3,7 119:3,12 121:17 122:14 123:14,19,21 124:12,18,21 125:21 126:18 147:25 148:3,6 152:19
controls (1) 9:18
conversation (2) 29:6 95:23
conversations (1) 135:15
conveyed (1) 59:10
convince (1) 149:21
convinced (1) 149:23
cooker (2) 9:16 91:1
cooking (1) 9:19
cooperation (1) 125:7
cope (3) 40:12 70:24 107:25
coped (2) 49:18 51:14
coping (4) 68:25 70:21 74:23 80:15
coproduction (1) 131:7
core (4) 85:22 94:2 96:16 97:12
corner (1) 142:16
corporate (1) 93:24
correct (29) 3:5,8,14 4:3 12:10 33:1 34:14 35:18 36:11 40:20 42:12 44:15 46:18 47:9 66:8 67:9 68:15 78:17 85:14 88:6,11 90:15 115:14 124:23 129:8 131:22 134:23 148:2,8
correspondence (2) 124:10,11
corridors (1) 89:21
costs (1) 140:7
cough (3) 11:8 20:7 48:22
coughs (1) 49:9
couldnt (33) 10:11 11:20 13:19 14:22 15:19 20:4 22:6,12,22 23:11 25:24 29:2,3 54:17 62:21,22,23 63:1,3,12 70:6 72:1,3 77:19,20 80:3 90:1 91:23 123:3,4,7 133:20 134:4
council (1) 82:19
counsel (2) 83:20 140:14
counselling (11) 6:7,8,13,22,25 61:1,4,11,13,13,14
counsellor (2) 61:8,15
countless (1) 157:13
countries (2) 55:14,15
country (10) 42:16 55:2 58:3 104:4 105:9,14 113:3 129:23 136:13 146:10
couple (11) 12:2,20 15:19 17:12 21:18 24:24 26:16 100:9 105:13 117:17 137:7
course (9) 6:4,7,14 7:5 33:3 63:4,17 78:17 135:9
cover (1) 51:22
coverage (1) 127:20
covered (2) 40:17 96:12
covers (1) 51:21
covid (72) 1:23 3:25 11:5,9,12,17 13:8 14:15,24 15:20 17:23 19:3 20:2,4,6,14,23 21:1,1,2,11 22:14 23:18 25:5,21 26:4,19 28:4 29:4 31:7 34:7,13 36:14 37:7,12 38:9,22 39:9 40:22 47:14 50:5 55:3 57:4,15 58:3 60:17 69:3,15,21,23,23 70:9,16,22 77:15,18 78:8,11 82:13 83:2,5 107:4,6,9,15,16 108:7,20 117:3 152:4 154:7,23
covid19 (7) 25:6 67:16 73:2 76:10 110:1,9 118:1
cpap (3) 21:16 22:5 101:11
cpr (6) 29:7,10 30:11 32:9 44:11,22
create (4) 104:10,11,12 154:12
cremated (1) 28:1
cremation (1) 28:5
crematoriums (1) 63:19
crew (1) 78:21
criteria (1) 68:23
criticism (1) 43:4
cross (1) 11:11
cruel (2) 64:7 140:24
cruelly (1) 158:10
culture (1) 54:3
current (2) 122:22 125:18
currently (2) 144:7 145:5
custodian (1) 47:24
cut (4) 54:7 87:19 91:2,14

D

d (1) 68:13
daily (3) 103:18 107:7 114:24
damage (1) 13:15
damaging (1) 56:18
damocles (1) 119:16
dancing (1) 6:1
dangerous (2) 107:4 118:19
dangled (1) 119:16
dark (1) 8:2
dashing (1) 78:18
data (1) 67:7
date (4) 3:2 4:17 77:19 85:6
dated (4) 32:24 66:10 83:16 142:9
dates (1) 77:21
dating (1) 51:16
daughter (11) 26:23 27:1 71:1 89:7,11 90:12 106:14 132:11 134:19 150:7 152:16
daughters (2) 89:9 150:7
day (39) 14:12,13 19:19 25:17 28:23 30:15 37:13,13,15,16,16,17 56:16 69:22 71:9 77:17 83:3,3 91:10 97:4,6 98:8,20 104:5,7,7 106:4,6 107:12 114:2,3 115:3 119:18 120:23 123:1,24 146:3,24 156:19
days (12) 12:2 14:3,6 15:16 16:8 20:10 70:21,25 71:11 81:3 96:24 148:15
deal (13) 6:24 17:3 27:9 34:11 57:2 61:5 63:21 68:11 76:25 77:6 99:5 137:1 143:25
dealing (10) 25:16 47:17 54:14 57:15,22 60:25 65:15 82:18 87:18 125:10
dealt (1) 60:7
dearest (1) 55:5
death (32) 3:24 9:10 18:5 24:16 25:5,7,8 31:22 36:23 37:8 51:14 60:22 61:6 62:5 63:24 68:23,24 69:5 71:22 74:6,18,21 76:18 77:17,23 78:5 79:8,11,14,16 80:6 81:8
deaths (10) 36:22 37:2,3,5 53:1 62:6 75:25 78:7 82:20 107:16
deceased (2) 77:5 81:14
december (2) 129:2 145:24
decide (1) 78:17
decided (7) 22:10 23:1 27:25 28:3 29:9,9 99:12
deciding (1) 63:4
decision (9) 42:9 69:16 111:22 129:3,4,5 145:25 146:8,13
decisionmakers (3) 46:2 108:2 110:11
decisions (11) 45:23 62:14 65:6 108:3 112:11 113:19,21,24 145:19 153:19 156:21
decline (1) 78:14
decorations (1) 156:8
deemed (1) 37:13
deepest (1) 157:16
default (1) 139:8
defeating (1) 16:14
defeats (1) 31:8
defer (2) 59:15 133:5
definite (1) 101:18
definitely (5) 10:23 11:16 23:9 37:17 133:15
definition (2) 133:12,15
definitions (1) 37:9
deimplementation (1) 122:23
delay (1) 84:9
deliberately (1) 79:20
delighted (2) 98:10,22
delivered (1) 76:17
delivering (1) 142:13
demanding (1) 121:5
demented (1) 92:4
dementia (4) 54:17,18 111:9 143:13
demo (1) 96:12
democracy (1) 158:6
democrats (1) 127:25
demographics (1) 103:12
demonstration (11) 94:10,20 95:13,17,22 96:3,6,13 97:2,10,16
denied (2) 81:23 143:18
deniers (1) 83:5

deny (1) 128:25
department (1) 18:2
departments (1) 126:3
depend (2) 57:5 153:8
depended (3) 113:12,12,14
dependent (2) 82:7 101:10
depending (4) 68:7 81:7 113:13 131:6
depression (1) 155:24
describe (1) 83:13
described (2) 33:19 79:6
description (2) 46:16 52:6
designated (3) 127:15 128:7 138:14
designed (2) 57:11 85:9
designer (1) 116:9
desperate (2) 88:25 152:22
desperately (2) 81:15 93:1
desperation (2) 88:13,14
despite (2) 103:8 153:2
destroying (2) 13:4,5
destroys (1) 13:13
detail (6) 3:21 49:23 58:16 74:16 89:5 147:10
detailed (4) 2:8 21:24 49:17 110:20
details (4) 24:25,25 73:9 115:7
determined (1) 149:1
detrimental (2) 88:2 108:3
devastating (1) 73:2
develop (2) 50:4 87:12
developed (3) 9:17 39:14 140:14
developing (1) 94:4
devi (1) 58:10
devolved (2) 50:17 51:4
diabetes (2) 13:17,20
dialysis (3) 24:2,3 29:3
didnt (59) 5:1 9:3,21 11:9 12:17 13:7,20,24,25 14:9 16:7,15 17:5 19:24 23:16 24:24 26:19 28:1,2,8 29:17 30:10 34:24 36:20 40:10 41:19 47:14 48:6 50:5 56:10,11,24 57:1,2 59:22 60:3 62:19 63:11 79:22 80:6 82:21 87:20 88:7 95:6 101:13 103:3 104:10 106:25 108:14,17,20 109:11 114:18 120:11 121:6 125:12 146:4,5,18
die (4) 54:1 62:11 69:16 80:5
died (28) 4:18 6:23,23 9:4 10:9 13:1 17:10 23:10,12 24:5 25:10 63:14 68:21 74:14 77:4,18,19 80:22 81:3,3,6 82:12 107:9,10,13,14,23 152:3
difference (7) 19:25 20:20 36:22 42:15 51:24 81:21 98:24
differences (2) 34:15 44:8
different (26) 5:17 10:7 11:6 17:15 30:7 35:10 42:6 43:24 44:1 47:13 49:5,10 51:12 55:7 62:14 68:6 82:7 86:13 89:10 93:5 98:25 101:8 107:19 113:6,11 147:15
differently (4) 43:25 113:9 136:9 157:25
difficult (16) 6:24 27:15 28:15 38:2 56:13 62:12,25 63:9,21 73:3 76:19 81:16 83:13 102:17 103:5 152:8
difficulties (1) 65:18
difficulty (7) 1:16 81:25 82:6 101:19 102:4,6 104:24
diluted (1) 139:14
diminished (1) 138:24
direct (5) 24:9,18 138:5 153:8 154:17
directed (3) 53:22 126:15 127:8
directing (1) 46:1
direction (5) 45:4 130:25 131:21 133:4 153:1
directions (16) 126:2 128:9 131:6,8,14,14 132:19 138:19,21,25 139:16,17,18,20,23 140:2
directly (1) 59:10
directors (3) 63:25 95:1 153:24
disability (1) 10:6
disappointed (1) 103:10
disaster (1) 48:9
disbanded (1) 41:14
discharge (1) 69:16
discharged (1) 69:20
discuss (3) 59:24 67:1 144:11
discussed (2) 2:15 80:2
discussing (3) 7:6 124:9 138:17
discussion (8) 28:24 45:24 59:5 75:1,2 76:19 133:1 142:4
discussions (3) 131:8 132:16,25
disease (3) 12:22 118:24 119:2
dishes (1) 9:20
disinfect (1) 12:4
disinfectant (1) 80:25
disorder (3) 59:14 67:6 73:7
disproportionate (1) 121:17
disregarded (2) 34:5 158:10
disrespect (1) 42:22
disruption (3) 68:24 74:23 80:15
distanced (1) 81:14
distancing (2) 16:19 96:4
distinction (1) 46:22
distinguished (1) 3:12
distraught (1) 107:23
distress (2) 109:6 157:13
distressed (1) 91:2
distressing (1) 83:6
distribution (1) 58:17
diverse (3) 35:13 38:23 107:18
dnacpr (1) 43:6
dnr (1) 30:12
dnrs (4) 28:17,23,25 80:2
doctor (6) 11:1,4,14 15:3 17:20 58:25
doctors (1) 32:12
document (16) 51:3,6,24 53:13 73:23,24 122:5,6,7 135:21 137:18 138:10 142:7,12,14,15
documentation (2) 24:16 101:17
documents (12) 49:20 51:12,19 86:18,19,20 112:15,18 116:13,16 135:1 142:2
does (13) 13:15 32:9 51:21 54:4 57:5 61:23 65:21 88:4 102:12 128:4,6 130:9,9
doesnt (8) 39:7 53:19 80:24 84:4 130:11,19,20 151:15
dog (1) 6:11
dogs (4) 5:21,22,24 10:16
doing (21) 7:14 13:2 14:1 16:25 18:12 21:22,22 39:18 51:10 53:24 55:6 61:12 70:7 71:10 82:22 84:19 101:9 105:12 108:19 121:4 140:6
domain (1) 116:15
done (27) 10:3 19:12,14 20:4 21:6 26:2 27:14,14,14 31:4 32:8,22 40:19 47:11 51:8,11 56:7 86:15 91:25 99:12 100:21 105:4,5 116:11 119:24 124:14 140:9
dont (46) 1:10 3:9 9:18 17:18 24:1 25:12 31:24 32:16 33:11 34:16,23 38:13,15 40:23 42:24 43:18 44:6 48:7 54:7 56:23 57:13 58:16 61:20 70:12 72:11 74:15 85:5 89:9 92:5,12,20 107:1 108:5,16 117:16 123:13 133:24 145:10,13,17,20 146:8,10 149:15 156:20,22
door (5) 11:19 16:24 109:17 120:5 141:24
doors (1) 91:21
doses (1) 13:18
dotted (1) 23:6
doublebagged (1) 62:19
doublevaccinated (1) 123:11
doubt (2) 102:8 146:7
doubts (1) 130:16
down (23) 7:16,18 11:19 21:16 27:18 29:11 30:10 46:7 50:9 52:24 53:8,11 54:12 79:15 80:23 93:7 99:6 125:24 145:23 146:10 149:10,11 153:3
dr (4) 67:11 72:20 80:14 102:23
draft (1) 135:22
drafters (1) 134:8
drafting (1) 132:16
drafts (1) 140:2
draftsmen (1) 133:23
drained (1) 14:25
drains (1) 19:23
dramatically (1) 65:13
draw (1) 122:7
drawn (1) 46:16
dreadful (4) 19:1 32:7 69:12 115:7
dreading (1) 29:14
dress (4) 62:23 64:2 81:14 156:25
dressed (1) 47:6
drink (3) 23:8,14 121:8
drinker (1) 12:18
drive (4) 14:12 23:23 99:17 149:17
driven (1) 53:21
driver (1) 89:24
drivetime (1) 96:11
driving (1) 134:7
drops (1) 150:2
drove (1) 141:9
due (1) 136:25
duke (2) 90:12 127:22
dumped (1) 48:15
dundee (2) 11:7,11
during (20) 2:2 3:20 18:22 24:11 35:9 46:11 54:2 67:2,13 69:4 72:13 79:16 82:1 125:20 127:23 128:21 129:25 136:14 146:17 148:12
dying (9) 22:21,23 70:23 72:7 78:2,3 82:13 156:18,19

E

ear (1) 104:15
earlier (6) 26:1 38:23 49:1 51:13 56:7 153:6
early (6) 40:11 49:14 87:4 105:2 148:15 157:4
earth (1) 147:19
eased (1) 82:9
easier (5) 5:20 28:12 45:22,22 65:22
easily (2) 59:11 146:10
east (1) 8:12
easy (1) 6:9
eat (2) 89:20 153:15
edinburgh (2) 5:6 58:11
editing (1) 133:4
edits (1) 112:14
educated (2) 49:15 65:17
education (1) 76:3
educational (1) 76:7
effect (4) 54:15 108:3 110:3 143:16
effectively (3) 40:23 75:20 125:11
effects (1) 74:1
eg (1) 78:2
eight (1) 37:16
either (7) 8:10 19:22 49:8 50:15 62:10 86:9 108:1
elderly (6) 26:23 49:4 69:17 80:1 89:12 118:20
election (5) 127:24 135:6,22 136:2,14
elections (1) 110:14
element (6) 13:12 50:18 74:22 77:12 138:6 141:7
eligible (1) 49:11
else (15) 1:21 4:2 11:20 17:2,19 27:25 35:7 38:10 48:12 65:21 72:12 92:15,20 114:24 140:15
email (5) 24:18 59:25 95:4 124:10,11
emails (1) 9:5
embedded (1) 100:9
emergencies (1) 51:21
emily (1) 67:11
emotional (2) 76:4 87:11
emotions (1) 87:17
emphasis (1) 120:17
emphasise (5) 47:4 52:16 60:13 92:22 139:7
emphasised (1) 12:8
emphasising (1) 99:18
empty (1) 81:9
enable (7) 70:25 76:18 116:6,14 119:12 124:15 131:2
enabled (1) 56:16
enabler (3) 117:21 118:8 122:15
enabling (3) 119:3 120:12 130:7
enacted (4) 128:2,23 129:10,11
encapsulate (2) 61:23 109:22
encapsulates (1) 151:14
encounter (2) 62:3,6
encourage (2) 61:7 87:10
encouraged (1) 114:24
end (34) 8:22 23:20 26:20 28:8 30:1 40:2 48:4,6 50:11 55:21 63:1 71:23 75:10 76:15 80:22 81:5 99:12 107:13,21 117:9 119:17,18 120:22 121:15 123:8 134:14,16 144:21 148:13,18 152:13 154:2,7 155:1
endeavour (1) 36:8
ending (1) 137:18
endoflife (3) 70:13,17 79:9
endothelium (1) 13:13
ends (1) 61:12
endure (1) 138:23
enduring (1) 73:3
enemy (1) 152:23
enforced (4) 58:2 103:17 110:3 138:23
enforcement (1) 138:20
engaged (1) 110:6
engaging (1) 155:3
engines (1) 48:1
england (5) 52:2 127:9 157:5,9,12
english (1) 112:4
enhance (1) 87:5
enhancing (1) 87:10
enough (8) 6:8 23:21 45:19 71:23 120:18 128:5 129:15 150:23
enquiry (1) 17:23
enshrined (3) 140:11 144:3 146:12
ensure (9) 75:19 76:14 94:21 119:19 127:10 128:13 138:22 144:2 153:10
ensured (2) 146:19 152:19
ensures (1) 132:2
entailed (2) 29:16 30:11
enter (1) 137:4
entire (3) 133:8,10 154:9
entirely (2) 119:18 141:18
entitled (6) 67:2,13 73:25 142:7 146:5,11
entry (2) 118:16 122:15
environments (1) 31:19
envisage (2) 147:12,20
epithelium (2) 13:4,5
equality (1) 138:13
err (1) 112:2
error (1) 50:13
especially (3) 22:11 25:18 76:16
essence (1) 126:4
essential (33) 87:7,8 105:19 106:16,17,17 109:20 124:3 128:13 131:10,10,17 133:2,7,8,11,25 134:13,15 138:2,6 139:4 147:12 148:5,6,7,13,16,17 150:22 152:16,17 156:16
essentially (2) 88:6 130:24
establish (2) 91:15 99:6
established (1) 89:17
ethos (1) 43:25
europe (1) 50:10
european (1) 57:16
eve (2) 129:3 145:24
even (37) 5:6 8:2 11:12 16:15 30:16 44:9 48:13 49:8 61:12 64:9 70:14 71:22,23,24 72:1,3,5,11,11 77:10,19 80:10 81:10 82:7,8,21,24 91:18 103:5 114:5 140:22,24 149:14 153:16,19 154:7 156:12
evening (2) 21:14 96:9
event (2) 65:6 73:3
events (5) 6:15 10:12 51:12 73:17 111:6
eventually (3) 7:25 35:13 44:5
ever (9) 43:19 53:5 106:15 108:10 113:23 121:6 123:12 136:13 155:2
everest (1) 5:4
every (20) 14:12,13 16:17 19:20 25:13 34:3 53:3 77:17 83:1 91:10 106:4,5 107:12 114:22 115:3 121:8 129:22 137:14 153:3 156:2
everybody (21) 1:3,21 12:3 13:8 14:9 22:20 27:24 28:10 34:18 35:4 36:25 43:22 58:2 65:21 84:25 92:18 104:6 108:6 144:22 150:19 151:12
everyday (1) 111:9
everyone (11) 4:1 32:21 84:5 91:22 105:8 114:23 125:15 126:22 144:19 156:16 158:12
everyones (1) 126:11
everything (20) 2:10 10:7 11:3,20,25 17:1 21:22 22:15 23:22 24:14,19 25:13 32:16 34:2 39:7 48:11 49:19 78:20 98:1 108:10
everywhere (1) 83:1
evidence (20) 1:22 2:4,21 3:17,18 30:4 48:9 52:18 55:17 66:10 83:16 84:18 103:14 125:9 132:15 147:16,16 155:5,6,13
exact (1) 49:6
exactly (4) 9:13 25:23 87:4 116:3
examination (1) 1:13
examined (1) 69:1
example (15) 17:16 21:23 24:1 27:13 53:3 58:1 69:10 73:15,17 77:9 78:7 94:4 98:23 129:1 150:5
examples (2) 43:20 105:13
excellent (2) 30:15 32:5
excess (1) 110:10
excluded (2) 98:25 112:8
exclusive (1) 124:19
exercise (1) 106:19
exhorted (1) 84:22
existing (3) 76:9 114:6 146:17
exists (1) 148:22
expand (2) 57:6 90:23
expands (1) 16:16
expected (2) 73:12 128:20
expectedness (3) 68:22 74:18 77:23
expecting (1) 20:21
expects (1) 22:20
experience (18) 7:6 15:17 18:22 19:5,6 31:22,23 41:19 42:25 44:21 47:8,15 52:10 71:11 92:14 93:23 117:15 120:16
experienced (2) 73:4 90:6
experiences (5) 36:10 45:15 73:6 76:20 137:24
experiencing (2) 75:17 98:16
expertise (1) 117:15
experts (1) 118:5
explain (16) 34:6 35:3 36:25 37:9,11 40:7 53:2 58:23 59:3 60:1 88:16 99:7 102:21 104:17 151:19,20
explained (6) 11:19 24:15 30:19 56:1,20 65:19
explaining (3) 30:10 32:9 153:6
explanation (2) 20:15,16
exposed (1) 48:14
express (1) 138:12
expressed (1) 129:14
expressing (1) 61:25
expression (4) 35:5,11 77:7 82:22
expressions (1) 9:6
extending (1) 140:21
extension (1) 9:16
extensive (2) 112:13 132:18
extent (8) 33:23 42:24 47:15 74:8 97:3 98:6 150:25 153:21
extra (1) 156:12
extreme (1) 150:18
extremely (3) 107:4,25 119:21
eye (15) 7:20,21,23 8:1,4,7,14,25 12:18,21,22 13:3,4,22 29:12
eyes (3) 8:3,6 10:21
eyesight (5) 4:24 5:10 6:3 7:15,18

F

face (3) 96:4 117:14 121:14
facebook (8) 9:5 36:16 39:25 88:7,18,22 90:16,17
faced (1) 25:2
facetime (1) 21:13
facilitate (2) 156:6,14
facility (1) 156:7
factor (2) 68:22 77:9
factors (6) 67:14 68:7,14 72:17 76:25 83:14
faculties (1) 141:21
failed (8) 22:4,5 152:14,25 153:1,10,23 154:5
failure (1) 22:11
fair (3) 131:7 133:23 150:23
fairly (2) 48:14 58:6
fall (1) 66:1
familiarly (1) 143:9
families (26) 12:23 16:20 26:9 34:13 40:4 52:20 56:14 70:1,4 81:23 99:23 100:22 104:11 118:18 125:6 126:15 129:5,25 137:1,2 145:19,21 146:3 149:10 151:16 152:21
family (30) 24:25 28:8 30:8 56:15 63:10 80:10 82:14 87:7 99:18 104:6 114:10 120:25 121:7 125:4 126:13 129:22 130:2 134:4 135:12,13 137:11,11,25 139:5 147:20 148:7 151:8,11 157:4,14
fantastic (1) 7:25
far (9) 42:19 80:14 98:17 101:4,23 128:5 129:15 133:9 140:22
farmer (1) 10:2
fast (1) 11:14
faster (1) 58:3
fatality (2) 60:17,20
father (4) 6:23 58:25 80:21 82:12
fathers (1) 139:5
fault (1) 71:19
faults (1) 17:10
favour (3) 108:9 126:8 136:18
favourite (1) 64:4
fear (4) 69:12 70:22 129:6 157:13
fearful (1) 69:15
fearing (1) 71:14
featured (2) 96:10,17
february (6) 18:15 47:23 50:12,13 142:9 151:23
februarymarch (1) 12:11
feed (1) 100:13
feedback (4) 61:2 100:1 101:1 116:21
feeding (2) 47:6 106:6
feel (16) 1:13 4:6 47:16 60:7 70:5 71:15 80:12 108:1 109:11 114:15 124:7 129:14 149:21 151:1 152:22 155:7
feeling (5) 35:8 79:17 90:5 92:19,24
fees (1) 153:7
fellow (1) 158:11
felt (29) 6:5 7:1,3 27:3 61:15 79:21 81:6 83:9,10,11 88:1 91:13 92:11 99:21 100:1 103:16 106:25 111:21 113:4 114:1,2 120:7 125:15 141:16,25 153:18,22 155:16 156:2
fever (2) 20:7 49:9
few (17) 1:21 11:8 12:2 15:9,16 33:2 39:19 41:14 45:7 81:3 82:4 86:3 88:22 95:3 105:11,12 151:15
ffp2 (1) 57:16
field (1) 118:5
fife (1) 129:2
fifth (1) 152:4
fight (1) 144:18
fighting (1) 149:11
figure (2) 17:2 49:6
figures (1) 37:6
fill (1) 130:11
filled (1) 8:13
filtered (1) 106:1
filtering (1) 57:9
final (13) 18:19 25:17 28:22 30:15 66:23 70:21,25 71:24 80:14 121:11 136:11 142:9 154:22
finalists (1) 111:3
find (20) 10:24 12:20 23:18 39:3 40:11 42:14 56:13 60:4 62:17 64:15,17 71:9 83:13 88:25 93:1,2 102:5 113:23 125:22 142:10
finding (5) 43:24 103:4 107:24 152:6,8
findings (1) 75:11

fine (2) 10:16 25:16
fire (1) 48:1
firing (1) 47:17
firms (2) 82:3,4
first (32) 1:4 3:17 8:19 15:11 21:7 34:9 35:14 40:25 41:5,8,10 49:21 50:4 67:3,16 76:25 77:3 97:10 103:7,11 104:1,8 105:24 121:11 130:14 135:4 138:12 144:1 148:12 149:23 151:24 152:1
firsthand (1) 52:10
fit (2) 41:15 57:13
five (7) 28:14 40:24 66:13 107:15 136:6 157:6,14
flavour (1) 58:18
flooding (1) 51:22
floor (1) 146:2
flu (4) 51:1,4 60:18 66:4
fluid (1) 14:25
fluids (1) 79:25
focal (1) 40:1
focus (1) 52:24
focusing (1) 137:24
follow (3) 96:4 102:17 156:22
followed (3) 16:13 100:18 153:2
following (16) 26:12 48:23 58:21 59:7 64:19 69:8 75:11,17,25 76:18 77:18 83:9 110:11 111:16 139:11 155:17
followup (1) 76:17
food (1) 121:8
foot (1) 141:24
footfall (2) 149:1,3
force (1) 124:7
forced (1) 40:13
forces (1) 157:4
forest (1) 48:15
forget (2) 78:21 150:5
forgotten (2) 89:23 96:14
form (2) 61:11 85:25
formal (1) 76:3
formally (2) 41:14 116:25
formed (1) 93:19
former (5) 34:9 35:14 40:25 103:7 104:8
forth (1) 133:17
fortunate (1) 71:23
forward (4) 89:1 96:9 98:4 128:3
found (12) 6:9,24 13:1 27:4 35:9 48:15 61:3 74:4 75:5 88:8 90:10 122:25
founded (2) 88:15,20
four (10) 51:2,7 52:1 67:15 68:20 84:13 85:22 97:7 98:5 155:18
frail (1) 141:21
framed (1) 113:24
frank (1) 45:24
fraught (1) 103:24
free (3) 58:3 116:9 155:20
freedom (2) 58:1 66:6
freeman (12) 96:22 97:6,8,19 98:7,11,18 100:13 101:15 104:16 110:12 115:6
french (2) 103:1,2
fresh (2) 26:17 153:14
friday (1) 1:1
fridge (1) 8:6
friends (4) 16:20 23:12 89:24 139:6
frightening (1) 60:21
froing (1) 8:21
front (6) 16:23 86:9,10 117:8 122:5 141:24
frontline (2) 53:12,16
frustration (3) 90:2 92:25 113:4
fuel (1) 8:13
fulfilling (2) 92:8,10
full (5) 2:25 15:16 45:24 71:5 154:18
fully (6) 22:15 25:19,22 69:1 106:15 145:21
fun (2) 4:23 8:9
fundamentally (1) 139:23
funded (1) 88:9
funding (2) 88:5,7
funeral (14) 27:23 28:1,14 62:11,15,22 63:5,10,25 64:17 77:20 81:12,16 147:19
funerals (7) 62:2 63:18,23 80:16 81:15 82:16 147:17
funnily (1) 6:7
further (5) 52:24 87:11 94:10 140:22 155:14
future (11) 15:7 17:3 29:14 45:22,23 65:7 73:16 75:13 122:24 140:4 144:22

G

gag (1) 11:13
gagging (1) 11:15
gain (2) 83:5 112:21
gained (1) 110:23
gale (122) 1:3,4,12,16,17,18 6:13 20:17,18 33:2,3,4,9,17,18 66:13,17,21,22 83:19,25 84:2,11,12,18,24,25 85:3,5,13,15,18,21 88:4,10,12 89:2,14 90:4,12,16,23 92:1 93:6,22 94:6,23 95:8,13,25 96:18 97:2,7,18 98:6,11,15 99:7,15 100:5 101:4,23 102:18,21 103:6 104:15 105:15 106:18 108:1 109:14 110:5,22 111:1,4 112:5,20 113:17 114:4 115:9 117:5,13,23 118:14,23 120:13 121:9 122:1,2,20 124:7,16,24 126:1,15,24 129:7,10,13 130:24 131:2,16,20,23 134:24,25 135:20,25 136:4 137:17 138:9 142:2 143:19 144:7 145:1 147:7 150:24 151:14 152:10 155:3 158:14 159:4,7
gasping (1) 72:7
gave (13) 8:23 24:9 74:22 93:4 99:11 100:8 103:14 115:6 116:9,23 119:22 143:3 147:16
gel (2) 16:16 53:7
general (8) 11:25 37:22 43:14 44:17 89:20 103:19 104:1 106:7
generally (3) 32:15 46:13 119:15
generate (1) 94:20
generation (1) 158:5
genetic (1) 4:25
gentleman (1) 115:2
genuinely (2) 7:4 38:17
geographical (1) 40:17
geriatric (3) 46:23,25 49:1
germany (2) 50:8,11
germs (1) 57:12
get (67) 8:24 11:1,24 12:7 13:14 14:20,22 15:4 18:1 19:8,9 22:6 23:5,23 24:19 25:15 27:15 32:3,12 39:18 40:1,10,15 41:12,12 43:21,22 45:5 47:6,6 53:17 61:21 65:23 69:15 71:22 82:21 88:1,14 92:5 95:3,4,7,22 103:5 113:23 115:17 116:25 120:4,11 123:7,10,18 128:18 130:17 131:3,9 136:24 137:1,17 144:13,15 145:9 148:16 149:14 151:2,9 153:14
gets (1) 46:19
getting (31) 4:25 6:3 7:16 9:9 16:19 17:1 21:24 36:1 38:9 39:20 44:8 48:4 54:24 57:4,14 70:17 79:20 94:13,19 99:23 102:13 105:10 107:5,6,12 108:7 113:6,9 131:13,13 150:4
give (28) 1:20 2:19 3:17 4:15 5:10 7:2 8:4 21:6 22:13 31:17 36:4 37:21 38:2 39:15 52:6 55:12 63:12 64:3 67:7 84:18 100:2 128:7 130:22 131:12 136:18 156:12,15,16
given (22) 2:9,21 6:24 17:24 18:1 20:14 25:5 46:23 60:5,22 61:3 62:10 66:24 84:20 86:19 98:21 101:3 102:25 111:13,20 126:11 152:16
gives (5) 98:5 128:8 130:9 155:6 158:6
giving (10) 3:18 39:18 43:9 45:2 101:1,14 111:5 112:7 138:19 140:3
glad (1) 157:17
glasgow (6) 98:24 99:1,3 105:8 123:9 154:17
glass (1) 8:23
glorias (1) 157:11
gloves (3) 14:11 71:24 72:1
god (1) 149:6
goddess (1) 48:1
goes (10) 37:12 63:5 73:22 124:24 129:15,22 134:17 135:15 148:21 150:19
going (70) 8:12 10:6,13 13:21 14:5,23 15:10 16:25 17:11 19:12,25 20:9 21:16 22:15,25 23:10 24:8,8 25:20 27:8 28:14,25 29:6,13 30:23 31:6 32:10,16 39:17,25 41:22 42:17 45:16 54:17 55:21 57:12 59:14 65:3,20,21,25 70:5 71:12 73:10 81:9 82:24 88:19 89:24 90:16 94:16 99:1,2,6 104:5,18 106:5 109:1,14 118:23 120:4,6 123:2,7,18 141:1,23 144:16 148:21 150:3 156:12
gone (9) 14:11 22:12 24:14,21 25:9 61:14 63:2 98:24 114:23
good (32) 1:3 9:13,21 10:25 18:5,24 20:24 21:9 26:15 27:9 31:25 33:16 36:10 39:21 43:20 48:2 61:10 63:25 84:11 96:15 102:9,9 105:14 116:5,24 120:8 124:22 133:19 141:8 149:18,19 158:8
goodbye (1) 72:2
goodness (4) 23:16 29:9 63:22 102:12
google (1) 99:17
government (28) 49:21,22 50:3,3,9 53:23 87:25 93:8,9,16 95:23 99:20 101:3,9 109:25 110:11 111:22 116:23 120:7 126:2 133:12 152:14,25 153:10 154:4,12,19 156:21
governments (3) 51:1 157:6 158:12
gps (1) 82:21
gradually (1) 4:24
grain (1) 7:23
grandchildren (1) 121:3
granted (1) 4:10
graphics (1) 116:10
grasp (1) 123:25
grasped (1) 123:24
grassroots (1) 104:18
grateful (5) 39:23 80:18 83:23 119:21 158:16
grave (3) 64:15 130:16 138:21
graveside (1) 64:11
great (4) 9:20 58:16 99:5 107:17
greater (4) 99:3 105:8 123:9 154:17
greatgrandchildren (1) 121:3
green (3) 10:4 48:1 127:25
greeting (1) 105:5
grew (3) 39:2,2 88:24
grief (21) 2:2,13 59:14 61:16 67:2,5,13,14 68:9,9,12 73:7,25 74:5,8,9,11,11 76:8 77:5 156:1
grieving (4) 68:25 74:23 75:24 80:15
grip (1) 65:23
ground (3) 64:13 83:5 104:22
group (102) 1:24 5:4 16:22 19:1,4 28:21 32:6 34:7,11,13,18,20 35:4,6,13,23 37:3,21,25 38:14 39:2,10 40:2,10 41:2,9,10,11,13,21,21 43:9,17 45:10 52:20 54:25 59:17,17,21 60:12,15 61:2,7,12 64:20 68:8 70:14 84:14 85:9,23 86:23,24 87:1,3,16 88:4,7,12,24 89:17 90:9,16,17,18,23 91:3,22 92:17 94:1,6,11,14 96:3,6,8,13,16 102:2 103:8,14 107:12 110:6 112:6,12,15,17 116:8 124:10 128:22 136:1 137:20,24 141:1 147:5 151:19,20,22 152:2,5,9 153:18 154:25
groups (13) 40:1 55:8 61:4,4 70:3 76:6 84:22 93:10 95:21 99:4 101:11,12 157:4
grow (1) 158:5
grown (1) 77:10
guarantee (3) 114:11 130:19,20
guarantees (1) 128:24
guardian (2) 23:15 153:25
guess (1) 100:3
guidance (57) 46:23 59:16 60:3 73:18 87:20 89:15 93:2 95:24 96:4 97:22 98:4,21,22 99:20 100:9,16,18,24,25 101:7,8,9,10,11,11,14,15,24 102:1,2,4 108:8 111:16,23,24 112:1,4,13,16,17,23 113:15 119:15 120:8 125:16,19 136:25 145:20 147:2 153:2,9 154:23,23,24 155:18 156:21,22
guidances (2) 59:20,23
guide (4) 5:21,22,24 6:11
guidelines (1) 87:9
guilt (4) 71:14 77:12 80:12 155:24
guys (1) 120:8

H

hadnt (8) 8:16 14:24 20:3,14 28:23 91:12 100:21 123:12
hair (1) 102:11
hairdressers (1) 156:10
hairdressing (1) 153:13
half (2) 11:3 23:17
hall (35) 84:15 85:11,12,14 92:22 93:19 94:25 95:9 101:6 102:8 105:23 110:9 115:15 117:12,16 118:13,22 119:7 123:20 124:10 125:18,25 126:9 133:3,14 134:10,23 135:24 141:20 143:16 146:24 147:8 149:20,24 150:10
halls (1) 114:17
halted (1) 111:19
hamilton (34) 84:16 85:18,20 90:8,12,15 95:17 96:1 99:17 100:20 104:2 108:5 113:1 122:18 126:11 127:1,5,5 129:9,12,16 131:25 133:15 135:7,10 136:20 138:8 140:16 144:6,9 147:14 149:8 150:13 151:3
hammered (1) 120:4
hand (6) 53:7 59:22 72:9 78:22 100:2 129:16
handed (3) 32:14 59:17,20
handled (1) 56:24
hands (5) 41:3 71:25 91:10 99:19 156:20
hang (2) 23:4 64:14
happen (7) 24:15 30:19 97:17 103:4 111:1 129:1 130:4
happened (15) 37:23 80:5 95:16 96:19 105:6 117:22 129:25 130:14,15,22 137:8 140:16 141:11 146:22,23
happening (9) 25:23 28:10 60:1,3 66:4 69:14 79:7 92:16 146:9
happens (3) 15:1 33:10 155:2
happy (4) 81:20 98:8 126:23 152:7
harbour (1) 5:3
hard (5) 107:25 116:13 120:2,18 157:1
harm (3) 61:10 110:2 118:15
harms (1) 92:16
harrop (2) 67:11 72:20
harrops (1) 80:14
hasnt (2) 34:5 60:7
hasten (1) 5:7
hate (1) 140:17
hats (1) 116:3
hattrick (1) 15:16
haunted (1) 80:4
havent (5) 31:24 67:21 132:19 156:10,14
having (22) 7:18 12:18 17:23 23:7 31:3 50:6 70:23 72:23 76:23 100:17 102:4 104:7 119:19 135:16 137:1 144:11,17,18,23 147:4 154:6,9
head (6) 18:2 23:16 49:7 79:4 119:17 156:24
headlines (1) 83:3
heads (1) 151:8
health (50) 4:20 43:24 44:1,4,9 46:7 48:23 53:3 58:10 72:14 76:2 78:14 93:14 95:1 96:22 101:10 110:1,3 112:7,16 113:11 116:10,12,22 119:9 120:15 123:22 124:5,12 125:19 126:3 128:9,16 129:2 130:13 133:5,6,11 134:11 142:24 145:25 146:7,13 149:1,6,21 154:4,22 156:22 158:7
healthcare (3) 31:19 57:21 76:15
hear (11) 3:19,21 21:19 25:18 27:8 66:3 81:19 95:5 97:23 145:13 156:5
heard (12) 39:11,14,23 42:7,8 61:18 71:7 98:3 100:23 101:2 112:3 147:15
hearing (6) 46:25 52:18 69:12 71:6 157:1 158:19
hearings (1) 129:19
heartbreak (1) 156:1
heartbreaking (1) 141:5
heartbroken (1) 156:1
heaters (1) 156:15
heaven (1) 119:6
heavily (3) 93:25 137:5 154:15
heck (1) 28:13
height (1) 145:17
heightened (1) 108:16
held (2) 91:10 110:18
help (13) 32:15 45:15 81:11 89:21 106:6,6,6,7 121:14 124:2 146:18 151:13 153:15
helped (2) 56:22 71:6
helpful (3) 58:25 61:3 134:25
helping (1) 47:6
helpless (1) 70:5
helplessness (3) 70:10 71:15 72:5
here (10) 8:16 16:17 55:1 71:17 84:2,3,5 102:12 124:1 136:17
heres (1) 100:1
herself (3) 7:1,3 8:23
hidebound (1) 52:17
high (4) 52:23 67:8 74:4 75:5
highdependency (4) 21:2,15 22:7 30:17
higher (2) 73:12 75:16
higherquality (1) 16:2
highlight (3) 95:22 122:10 149:10
highlighted (1) 146:25
highlights (1) 135:18
hindsight (1) 13:22
hinted (1) 26:8
historical (1) 50:24
hits (2) 32:20 78:24
hobby (1) 32:4
hold (2) 149:18 156:19
holding (2) 71:25 72:9
holds (1) 116:15
holiday (1) 89:25
home (106) 12:16 24:8 36:22 37:2 39:20 46:11,16,17 47:4,5,8 54:24 55:4,6,7,10,11 56:17 62:22 69:10 70:2,3,12,18,20 76:16 78:3 81:1 82:12,15 84:14,17 85:23 89:4,8,11 91:19 92:13 93:13 94:8 95:11 97:15 98:25 99:3 100:23 102:10 103:15,18,20,25 104:3,9,21 105:22 106:10,22 107:18 108:19 111:19,25 112:2,6 113:12 114:22,25 115:1,3 120:17,24 126:12,13,20 127:9 128:18,25 129:4,21,21,22,23 132:3,13 134:18 137:4,5 138:22 139:2,25 141:13,25 143:13 144:21 145:23 146:1,1 148:22 151:5,7,10,11 153:10,16 154:9,23 156:3 159:5
homes (77) 27:12,21 37:8 46:12 54:16 69:18,20 70:11 80:9 87:6,9,14 88:14 89:22 91:12 92:3,5,7 93:18 95:21 96:15 100:25 101:1,21 103:1,2,4 104:13,19,25 105:5,22 107:10 108:14,14,21,25 109:3,20 112:4,9 113:16,20 114:12 117:22 118:2,10,17 119:21 122:16 125:1 127:11,15 128:10,11,14,20 130:10 131:3 135:14 136:8 141:20 142:22 143:10 144:19 145:15,16 151:24 152:3 153:1,5,8,24 154:20,21 157:22,24
honest (1) 56:10
honestly (2) 20:21 140:25
hope (4) 34:22 35:23 45:18 65:2
hoped (1) 29:25
hopefully (2) 65:1 145:5
hopelessness (1) 155:25
hopes (2) 30:24 32:2
hoping (2) 46:6 71:13
horrendous (2) 69:13 136:25
horrible (2) 25:21 60:21
horse (1) 32:4
horses (1) 141:9
hospital (60) 3:25 4:19 7:24 10:13 11:5,11 12:11 13:2 14:21 15:9,11,12,13 16:8,21,24 17:6,10,13,24 18:14 19:8,15 20:10,24,25 23:11,17 26:9,10,11,13 27:12 31:5,11,13 37:12,14,17,18 44:5,9 53:9 60:6 70:12 71:9 72:13 78:4,7,11,12,17,19 81:2,7 82:13 91:9,11,14 132:9
hospitalacquired (1) 37:5
hospitals (9) 5:11 44:4,8 46:8 48:5 53:10 69:18 80:8 132:7
hotspot (1) 55:3
hour (5) 10:17 11:3 16:5 23:17 91:10
hours (9) 11:2,24 14:12 19:20 23:23 98:5 129:4 155:18 156:9
house (9) 9:16 10:5,6,17 81:9 82:1,2,16 105:13
however (8) 15:14 22:4 73:5 74:10 82:24 104:15 128:4,22
hubris (1) 54:4
hug (2) 63:12,14
huge (10) 87:16 90:25 91:2 92:6 119:7,20 130:3 144:17 154:5,14
hugs (1) 81:22
human (19) 81:22 93:11,12 114:19 118:9 119:4 136:12,17,21 137:10,15 138:12 139:3,24 140:19 142:1 143:11 144:2 158:11
humanity (1) 64:24
humour (1) 29:23
hundreds (3) 7:20 42:17 158:8
hurt (1) 66:7
hurtful (1) 66:2
husband (13) 16:10 26:24 81:2 91:9 106:14 108:12 132:10 134:18 138:2 143:17 149:25 150:6 152:15
husbands (4) 91:4,5 139:4 149:4

I

id (4) 40:24 58:9 72:9 102:22
idea (6) 40:2 125:11 131:10 132:6 133:1 134:21
ideas (2) 39:18 140:3
identified (1) 48:24
identify (1) 68:14
identifying (1) 75:22
ignored (4) 94:23 137:12,13 154:21
ill (3) 78:10 82:12 136:20
illegal (1) 130:21
illness (2) 18:22 57:15
im (3) 23:2 61:8 75:1
imagination (1) 80:8
imagine (3) 7:22 70:21 78:13
immediately (9) 16:13 19:23 38:9 46:15 79:11 80:20,22 90:20 99:3
impact (13) 80:20 82:25 104:13 129:25 130:3 143:12 144:17,18 154:5,8 155:15,16,22

impacting (2) 151:7 155:22
impacts (3) 3:20 98:15 129:19
impaired (1) 5:5
impairment (5) 6:10 7:19 9:23 109:1,10
implement (3) 99:11 112:1 145:7
implemented (4) 76:13 100:14,24 155:20
implementers (1) 46:2
implementing (4) 99:4 108:3 145:8 153:8
implication (1) 101:20
implications (1) 73:14
importance (3) 18:19 137:25 143:9
important (24) 9:10 22:17,19,19 25:1,4 43:13,14 46:22 57:15,21 58:22 62:15 63:15 66:25 73:14 92:22 95:10 105:17 121:8 127:12 134:2 142:23 150:2
imposed (2) 117:25 128:15
impossible (2) 84:4 118:15
impression (5) 104:23 112:22 118:21 125:9 154:13
imprison (1) 128:25
imprisoning (1) 154:1
improve (1) 76:8
improved (3) 65:12 79:13 111:16
improvement (3) 74:9 98:17 100:12
improving (1) 93:3
inalienable (1) 158:13
incapacity (2) 137:14 138:15
incarcerated (1) 114:13
incentive (1) 119:7
incidentally (1) 53:4
incidents (1) 26:8
include (5) 75:24 80:16 142:4 155:21,23
included (7) 93:8 100:17 103:18 119:16 127:24 143:5 155:20
includes (1) 154:10
including (9) 20:1 52:3 73:6 84:21 93:10 112:13 114:20 119:4 152:18
inconsistencies (2) 111:11 112:22
inconsistency (1) 113:2
inconsistent (1) 113:11
incorrect (1) 121:16
increased (2) 31:17 75:18
incredibly (5) 56:18 60:16,22 62:12 83:6
indemnified (2) 101:22 103:3
indemnity (1) 102:19
indeterminate (1) 37:15
index (1) 159:1
indicate (8) 1:14 35:12 40:18 52:12 86:10,20 93:7 110:5
indicated (8) 23:11 36:21 67:19 74:4 75:5 85:24 86:14 131:20
indicates (1) 8:16
indicating (1) 39:12
indication (3) 129:11 145:1,2
indications (2) 1:22 102:18
individual (11) 46:7,8 62:13 77:8 78:9 81:21 111:25 112:2 113:20 126:12 158:10
individually (4) 87:18 89:3 92:25 94:14
individuals (5) 40:5 54:15 55:10 118:6 142:25
indoor (2) 105:12 154:13
indoors (1) 91:11
ineffective (1) 57:10
inequalities (1) 76:11
inessential (1) 157:19
infection (44) 17:22 18:5 19:22 25:11 26:7 27:2,10 31:3,9 32:3 37:5 43:8 53:4 73:18 101:12 111:8 112:9 113:22 115:11,16,21 116:17 117:12,18 118:2,7 119:3,11 121:16 122:14 123:6,14,19,21 124:11,18,21 125:21 126:17 147:25 148:3,6 149:5 152:19
infectious (2) 28:8 119:2
influence (1) 158:12
inform (5) 55:18 75:12 102:1 125:5 135:2
informal (1) 76:4
information (23) 2:17 17:24 18:4 24:23 36:9 43:18 45:5 46:9,24 47:3 48:23 49:17 52:13 58:24 59:10,24 66:25 77:22 89:6 99:25 100:5 101:3 155:12
informed (4) 7:8 21:21 43:11 73:21
infringements (1) 137:3
inherent (2) 112:23,24
inhumane (1) 141:3
initial (3) 69:11 99:9 110:12
initially (1) 69:13
initiatives (2) 76:7,11
injections (1) 123:17
injury (1) 82:10
injustice (1) 137:8
inperson (1) 151:24
input (1) 39:16
inquiries (3) 40:16 50:19 65:8
inquiry (61) 1:5,10,24 2:14,19,22 3:2,6,16,17,20,24 4:15 30:25 32:2,25 34:4 35:17 36:4,13 39:22 40:11 41:12,16,25,25 42:5,18,22,22 43:5 45:3,4,5,13 46:6 50:18,20 51:25 52:9,12 55:16,16 65:1 66:10 83:17,21 85:8,15,25 86:6,17,22 110:22 120:13 121:20 127:4 135:3 155:4,6,11
inquirys (1) 39:11
insist (1) 153:1
inspection (2) 18:14 19:13
inspections (1) 128:21
inspectorate (6) 93:14 110:19 128:21 142:5 147:3 156:23
inspired (1) 9:8
instances (1) 46:8
instead (3) 122:14 125:5 153:12
instruct (1) 130:10
instructed (1) 102:25
instructions (1) 130:12
insufficient (1) 112:7
insulin (1) 13:18
insulindependent (1) 13:17
insult (2) 82:10 83:7
insurance (1) 103:5
intelligent (1) 58:8
intelligible (1) 59:11
intend (2) 1:25 3:9
intensive (5) 21:2 22:3,8 75:23 82:14
intention (2) 2:3,12
interact (1) 90:7
interaction (7) 37:20 39:10 118:9 119:4 144:10,23 151:16
interactions (1) 125:4
interest (3) 6:20,20 93:17
interested (6) 6:14 47:19 52:12,18 101:25 118:6
interesting (7) 9:19 42:14 50:21 97:13 122:20 147:11 150:24
interestingly (1) 117:1
interests (2) 53:25 153:23
intermittent (1) 13:23
internal (1) 13:5
interpret (1) 112:1
interpreted (1) 113:15
interpreting (1) 125:22
interruption (1) 2:11
interruptions (1) 2:18
intertwined (1) 50:19
intervals (1) 110:13
interview (1) 120:6
interviewed (1) 96:11
into (44) 1:11 5:25 6:22 8:13 10:13 12:11 15:11 16:21 17:9,23 20:23 22:3 24:4 26:11 32:14 37:12,14 49:24 54:6 57:14,17 58:4 68:8 69:18 80:23 83:22 88:1 91:13 95:22 98:25 103:23 104:5 108:5,17 127:15 128:10,14 129:20 131:3 132:9 134:17 135:15 146:20 148:21
introduce (1) 87:8
introduced (1) 128:17
introduction (2) 2:20 3:23
introductions (1) 85:2
introductory (1) 45:9
investigating (1) 50:18
investigation (3) 18:10 19:14 54:6
investment (1) 75:19
invidious (2) 147:20 150:8
invited (2) 96:6,23
involve (1) 32:9
involved (10) 19:3 22:1 40:10 41:17 92:9 93:25 105:20 131:5,7 133:3
involvement (4) 93:22 132:17,18,19
involving (1) 111:18
ipad (2) 108:24 109:5
ipads (1) 109:2
ipc (4) 116:5,6,22 117:20
ips (2) 117:10,11
ireland (4) 157:5,6,9,11
irrespective (2) 31:18 53:24
isnt (6) 125:17 132:6 134:13 145:9 146:12,13
isolated (4) 76:1 92:11,17,21
isolating (1) 154:1
isolation (7) 87:12 92:24 108:4,16,22 138:24 154:8
issues (9) 34:11 45:13,21 46:11 52:24 81:14 119:14 133:24 143:25
issuing (2) 95:24 130:25
italy (1) 69:14
items (2) 49:22 69:8
its (64) 9:1 10:19 13:12 17:2 22:25 27:15 28:22 31:8 33:20 35:6 37:6 38:11,14,23 39:7 43:2 45:10 48:4 49:8,16 52:5 53:21 57:3 63:15,15 66:3,4 67:2 72:11,22 73:24 77:9 78:16 79:6 80:10,10,12 83:25 89:4 91:14 92:3 105:16 110:7 116:24 119:19 121:8 125:16 130:19 133:6,14 134:1,21 140:5,16 142:9,10,11 144:15,17 147:11,19 150:3,7 158:7
itself (3) 70:8 73:25 79:8

J

jacky (34) 3:24 4:2,12,16,17 5:18 10:12 11:13,21 12:11 14:13,21 16:5 17:5,8 19:18 22:15 23:1,21,25 25:16,19 26:21 27:25 29:5,8,12,20,23,24 30:18 44:22 56:11 63:14
jackys (10) 10:4 18:4,22 21:10 24:25 25:22 44:19 51:14 62:5 77:17
jammed (1) 24:3
jane (4) 1:5,7 3:1 159:2
january (5) 4:17 18:8 58:7,11 154:23
jaundice (2) 10:19,23
jeane (9) 96:22 97:6,8,19 100:13 101:15 104:16 110:12 115:6
job (1) 105:14
jobs (1) 39:4
john (1) 51:17
johns (1) 132:8
join (2) 36:20 90:20
joined (1) 157:4
joining (2) 35:6 127:5
joint (1) 50:8
joke (1) 15:10
judicial (1) 139:21
jules (6) 115:21 116:1,5,11 117:9,17
july (4) 2:23 27:5 90:11 127:6
jump (2) 11:14 136:21
jury (1) 42:12
justify (1) 126:5
juxtapose (1) 19:5

K

kaye (1) 96:7
keen (2) 133:6 147:5
keep (6) 8:6 21:21 42:24 106:9 128:10 131:9
keeping (1) 8:7
kelso (1) 105:13
kept (11) 56:12 88:8 91:19 92:14 101:14,17 105:24,25 130:1,2 152:20
kevin (3) 103:23 110:15 146:6
key (3) 103:13 123:19 152:15
kidneys (1) 22:4
kids (1) 16:10
kind (11) 1:8 16:14 24:13 91:16 92:22 93:19 106:1 109:12 119:16 123:1 147:3
kings (1) 11:11
kinross (1) 4:21
kins (1) 82:6
kiss (2) 72:1 78:23
knew (14) 22:21 25:23 29:13,16 30:9 41:4 59:25 80:11 94:18 98:23 115:25 123:15 146:4 148:15
knocking (1) 120:5
know (77) 1:15 9:24 11:16 12:17 14:5 18:13 22:23 24:1 26:19 28:21 29:2 30:11,21 32:22 39:5 40:12,23 41:25 45:11,21 47:12 49:19 53:3,12,14 54:14,23 56:12,24,25 60:2 62:2 63:15 71:11,22 72:1,6,9 77:17 79:3,7 80:6,8,24 81:17 85:1,5 92:5,12,13,20 94:15,16 102:14 104:21 105:4 107:1 117:16 119:22 121:1,12 123:3,6,13 124:13 125:15 132:12 133:10,24 134:4 145:18 146:5,5,11 147:17 155:11 157:10
knowing (3) 38:17 71:5 120:16
knowledge (3) 45:16 47:15 140:17
knowledgeable (1) 148:17
known (14) 3:2,6 4:17 5:2,2 12:23 54:18 67:6 73:5 85:15,24 107:21 108:10 148:14
knows (1) 32:21
koper (1) 120:5

L

labour (1) 127:25
lack (10) 10:4 31:18 44:10 48:24 54:22 60:22 63:9 89:15 101:18 107:1
lacking (3) 53:21 124:5,5
ladies (1) 106:11
lady (6) 26:23 88:21 89:7 97:13 147:16 148:1
ladys (1) 26:24
laid (1) 153:3
lanarkshire (6) 99:2 105:8 113:6,7 123:9 154:17
land (2) 10:2,4
language (3) 131:12 133:25 134:8
large (5) 8:23 23:14 54:7 107:20 108:24
largely (2) 2:7 135:3
larger (3) 70:2 148:18 157:15
last (9) 28:2 67:12 78:25 95:20 98:19 129:2 135:7 137:6 145:24
late (1) 56:5
later (12) 5:19 10:17 12:12 19:7 23:17 68:4 78:21 82:13 96:25 98:3 129:5 148:16
latest (1) 37:6
laugh (2) 9:1 11:12
laughs (1) 8:5
laughter (2) 4:23 8:9
laundry (1) 106:11
lawyer (1) 139:22
lay (1) 69:2
lead (6) 2:3 41:11,14,18,21 56:25
leading (2) 53:1 79:16
leaflet (1) 51:11
leaflets (2) 32:8,8
leaky (1) 48:10
leap (1) 41:24
learn (1) 65:2
learned (5) 30:24 31:2 60:10,24 155:2
learning (2) 65:3,18
least (14) 12:5 35:16 36:16 48:9 96:20 97:2 117:14 128:13 132:3 149:7,21,22 151:9 152:15
leave (7) 12:5,15 26:19 64:9 137:4 147:9 155:9
led (1) 10:12
left (6) 10:16 50:10 78:24 79:17 80:5 91:17
legal (8) 40:5,8,10 41:12 70:14 130:15,22 140:17
legalistic (1) 141:18
legalities (1) 140:18
legals (1) 52:3
legislation (4) 128:2,23 130:8 145:10
leitch (20) 84:15 85:16,17 89:19 92:2 95:10 99:9 100:7 103:10 108:23 110:25 111:13,16 112:6 136:3 137:9 145:12 152:14 155:15 158:14
lengthy (3) 43:3 73:21 75:3
less (4) 49:8,8 118:20 133:20
lesser (1) 74:8
lesson (2) 31:2,10
lessons (6) 30:24 60:10,24 65:2,3 155:1
let (18) 1:15 5:1 7:18 9:22,23,24 10:21 60:2 61:6,7 101:21 130:23 136:20 137:2 155:11 156:13,18,19
lets (7) 33:6 39:11,14,23 51:10 56:9 119:11
letter (24) 115:9,13,18 117:5,6,6,9,23 121:10 122:4 123:24 124:8,14,24,25 126:1,2 135:4,22 136:1,6 137:19 138:11 148:1
letters (6) 94:12,15,19,23 95:4 102:22
letting (2) 7:15 55:4
level (8) 30:14 31:13 44:19 46:7 52:23 69:11 77:6 104:18
levels (19) 14:19 17:15,16 21:15,24 22:6 67:8,14 68:6 69:25 71:12 73:13,25 74:4,7,8 75:5,19 76:2
levers (1) 153:4
liberal (1) 127:25
library (1) 117:1
life (21) 8:9 9:1 39:4 48:4 76:16 77:11 81:17,19 87:6 92:21 107:21 115:5 120:23 134:14 137:11,11 143:8 148:13,18 154:7 157:18
lifelong (1) 149:4
light (2) 8:2 116:2
lights (1) 10:20
like (67) 4:7,13 7:22 8:24 10:13,18 11:2 12:19 14:2 18:10 26:16 27:23 30:13,25 32:7 34:10 38:15 42:18 43:15 45:20 47:9 50:22,23 52:13 54:10 56:19 57:15 60:13,19 64:5,17 66:23 67:1 70:3 77:22 79:6 87:2 90:25 91:18 92:12,19 97:20 99:19 100:1 104:21 105:13 109:11 111:12 113:9 116:2 117:3 120:8 121:14 122:9 125:14 133:18 134:15 135:1 136:22 139:17 142:7 144:10 150:3,16 152:22 155:14 157:8
liked (4) 5:24 9:4 63:2 155:10
likely (2) 75:23 122:23
likes (1) 114:21
limited (2) 9:11 76:1
line (3) 47:17 134:16 149:11
lines (1) 87:12
links (2) 63:20 77:25
list (4) 95:1 111:4,7 146:21
listen (2) 43:17 108:20
listened (4) 17:21 32:5 157:21 158:2
listening (3) 1:21 39:11 65:7
literacy (1) 76:8
literally (2) 13:2 79:5
literature (1) 142:5
little (12) 8:21 30:7 33:25 50:23 54:10,12 56:5 69:11 73:5 79:20 109:21 140:21
live (9) 3:7 28:8 56:17 63:11 92:12,13 127:10 129:5 145:15
lived (5) 14:24 56:14 136:23 137:4 145:16
liver (7) 12:17 13:1 15:1 22:4,9,11 29:2
lives (8) 81:22 82:11 91:3 92:2,8,10 137:6,7
living (5) 72:15 92:20 136:8 142:22 157:23
load (2) 45:13 66:3
loads (2) 7:22 152:4
local (6) 4:20 5:23 51:15,20 96:12 126:3
locally (1) 76:20
location (1) 78:2
lock (2) 54:20 130:23
lockdown (9) 55:24 56:5,11 72:10 95:19 104:5 128:24 130:1 153:11
lockdowns (3) 54:13 56:8 104:8
locked (6) 129:6 130:11 140:19 145:14 146:3 151:8
locum (3) 5:12 145:24 146:13
logic (3) 42:20 78:9 149:17
logo (1) 93:19
london (1) 5:5
long (13) 8:17 33:3 56:8 71:12 87:19 123:2 133:21 144:13,15,25 145:7 148:5 154:8
longer (8) 10:20 12:1,3 33:20 91:6 92:19 122:22 144:16
longitudinal (1) 67:15
longterm (1) 73:5
look (30) 7:7,8 10:21 19:16 20:13 23:18 24:21 33:18 41:24 51:20 55:13,19 56:16 59:15 67:10 68:3 69:6 71:16 90:13 91:7 97:22 106:12 114:5 115:15 116:16 117:5 135:1,4,20 151:17
looked (11) 10:18 48:1 67:4,17 68:7,20 74:2 76:23 77:24 79:18 106:10
looking (21) 8:19 10:20 16:5 36:18 45:6 46:3 51:14 55:17 71:4 78:15 86:8 98:1 117:23 120:8 122:4 132:23 134:16 137:22 138:9 144:7 147:1
looks (1) 132:10
lordship (2) 1:20 138:18
loss (2) 20:8 107:25
lost (9) 37:7 38:8,13 39:9 77:10,14 80:21 151:18 152:5
lot (48) 4:22,23 5:11,19 7:1 9:13 27:17 28:22 29:11 33:22 38:12 45:16 47:21 48:10 49:17,23 51:8 52:22 54:8 57:4 61:3 62:5 63:19 65:12 66:25 86:17,19 91:4 92:14 94:3,3 97:10 107:3 113:8 116:11 117:15 119:23 121:12 127:20 131:6,11 132:7 133:18 135:16 141:12 151:23,25 152:2
lothian (1) 111:7
lots (8) 8:8,9 14:2 94:12,13 105:9 146:18 147:21
lottery (1) 113:3
loudest (1) 53:23
love (10) 5:15,15 71:5 91:24 119:21 121:7 157:17,22 158:8,9
loved (66) 9:18 52:25 54:22 55:8 56:14 62:6,10,19,23 64:2 69:5,10,15 70:6,9 71:6,10 72:14 78:14,22 79:2,15,18 80:3,5,11 81:5 87:6,14,22 88:3,14 89:16 90:7 91:17,24 92:12 98:15 104:20 105:21 106:19 107:5,13,23 109:19 110:4 113:25 114:1,4 116:5,18 119:5,13,22 126:19 127:16 129:1 139:13 143:7 144:19 146:22 151:19 152:1,20,22 154:18
lovely (3) 9:21 24:7,20
loves (2) 71:1 106:21
low (3) 49:7 69:11 76:2
lower (1) 17:16
luck (1) 149:16
lucky (7) 18:25 21:4 60:16,22 71:4,9 109:5
lunch (1) 89:25
lungs (1) 57:18

M

macaskill (1) 102:23
machine (2) 21:20 24:3
machines (4) 17:8 21:25 23:3 30:18
macron (2) 102:24,25
mail (1) 127:21
main (10) 14:4 31:2 32:13 40:1 57:16 116:1 143:5,20,24 145:10

mainly (1) 28:22
maintain (1) 132:14
maintained (1) 109:13
major (3) 104:13 111:23 148:25
majority (2) 105:6 107:20
makes (1) 115:9
making (6) 20:20 88:23 95:1 135:3 145:25 146:13
male (1) 24:7
man (3) 9:17 51:17 115:4
manage (1) 50:10
managed (6) 8:24 23:18 35:23 56:7 95:13 130:17
manager (3) 102:10 119:18 156:24
managers (5) 111:25 112:2,6 119:17,20
manchester (1) 117:19
manifesto (3) 127:23 135:11,17
manifestos (1) 128:1
manna (1) 119:6
manner (1) 59:11
mantra (1) 116:5
manufacturing (1) 50:8
many (39) 3:18 9:14 19:1 31:24 32:6 36:7 42:11 53:12 54:2 58:9 62:18 71:3 74:10 75:13 79:14 80:8,11 81:23 82:20 96:12 101:8 103:8 105:14,19 106:5,20 107:17 109:18 115:23 118:1 121:9,10 123:8 133:16 137:6 140:24 145:16 153:22 154:16
marathon (1) 5:6
march (10) 12:9 34:9 35:15 46:24 91:15 94:15 107:11 114:18 128:17 151:23
marie (1) 110:17
marketing (1) 94:1
marking (1) 95:19
marriage (1) 24:22
mask (13) 16:1,2 17:17,18 57:3,5,8,8,11,19,25 58:2 109:9
masked (1) 78:23
masks (16) 14:10 16:2,7,18 17:14 18:6 56:23 57:2,2,15 58:1,1,7 63:17 71:24 96:5
mass (1) 63:24
massage (1) 6:4
massbereavement (2) 73:3,17
massive (2) 31:15 82:25
massmanufactured (1) 50:7
matches (1) 37:4
material (2) 33:22 57:9
maternity (3) 15:14 17:15 26:22
matter (6) 39:7 53:19 84:4 86:16 133:25 147:22
mattered (1) 118:20
matters (9) 36:4,7,12 43:5 54:9 73:20 94:7 117:15 122:8
maximum (2) 16:5 22:5
maybe (4) 10:19 27:2 113:7 149:12
mean (12) 21:5 42:19 53:2 56:6 63:13 77:20 102:12 105:2 106:16 136:19 147:2 148:4
meaningful (9) 76:18 89:22 90:1 91:16 95:20 109:12 116:6 144:3 145:22
means (1) 85:6
meant (4) 9:7,13 30:11 47:13
meantime (1) 128:16
measures (8) 73:18 88:2 112:10 115:16 116:17 119:12 125:21 148:6
media (8) 36:19 65:23 96:5,16,17 127:7,20 154:13
medical (7) 14:23 30:8 31:5 39:5 45:19 60:4 79:22
meet (6) 23:24 97:24 98:2,11 103:8 128:20
meeting (17) 16:20 22:7 26:9 34:8 35:14 41:5 96:23 97:7,18,21 98:9 103:23,24 104:17 105:5,24 110:12
meetings (7) 38:5 97:21 99:22 100:3 110:10,18 133:16
member (7) 58:8 63:11 70:14 80:10,21 82:11,14
members (39) 37:7,20,24 38:6 40:9,9 52:25 62:6,9 68:11 69:3 79:14 81:4 84:13 85:22 88:10 92:11 94:2 96:8,16 99:19,25 102:2 106:5 112:19 113:1,8 115:23 135:12,13 136:3 137:24 139:5 143:11 155:16,19 157:14 158:7,10
membership (3) 34:20 35:12 39:2
memory (1) 121:2
mental (6) 93:12 110:3,15,17 118:16 143:6
mentality (1) 17:2
mentally (1) 141:21
mention (11) 19:7 30:2 39:10 67:4 89:7,9 103:6 131:16,19 151:18 157:8
mentioned (25) 3:15 16:17 17:11 18:15,17 21:8 26:1 35:15 38:23 45:10 48:20 51:13 70:1 81:13 102:18,24 103:20,25 104:4 111:14 120:13,19 125:8 136:16,17
mentions (4) 155:23,24,25 156:1
mentis (1) 25:22
mers (1) 60:20
message (3) 39:20 103:12,15
messaged (1) 88:24
messages (4) 9:5,9 71:5 103:11
met (7) 11:19 41:15 88:22 96:24 97:9 98:3 103:13
methods (2) 73:9 75:21
metres (3) 87:23 91:20 157:1
metresthree (1) 87:23
microlight (1) 5:7
midway (1) 93:7
might (21) 5:14 15:20 19:21 21:6 25:7 27:10,19 30:7 47:11 55:5 65:18 94:21 98:21 99:22 123:16,17,17 134:5,14 140:3,14
million (1) 50:14
millions (1) 50:16
mind (7) 29:18,25 34:10,23 44:3 82:23 124:3
minds (1) 151:9
minimum (2) 151:13,14
minister (12) 34:9 35:14 40:25 41:5,8 103:7,11 104:8 110:15,17 130:10 138:4
ministerial (1) 138:21
ministers (6) 41:10 128:8 130:12,22 131:21 138:20
minuscule (1) 13:18
minute (2) 139:18 148:21
minutes (10) 12:5 24:5 33:2,4,5,11,12 66:14 156:19 157:2
mirrors (1) 129:24
misconception (1) 92:2
miserable (1) 9:2
mitigations (1) 152:18
mmhmm (3) 61:22 64:22 67:25
mobility (1) 106:6
mocking (1) 38:7
modifications (1) 10:10
modifying (1) 148:10
modular (1) 41:16
module (1) 51:25
moment (8) 101:23 116:2 134:10 138:18 140:3 144:8,9 145:9
moments (1) 82:9
momentum (1) 93:4
monday (1) 141:14
money (1) 140:7
monitor (1) 21:23
monitoring (2) 14:19 19:18
month (3) 50:15 67:12 106:4
monthly (1) 38:5
months (8) 12:12 63:13 75:6 95:19 107:14 115:4 153:15 157:16
moonwalk (1) 5:6
more (54) 2:18 18:4 21:5 23:2 26:2 27:19,20 28:22 38:2 39:2 43:9 45:1 46:8 51:8,23 52:7,23 53:25 56:19 57:14 58:4,9 60:18 61:10 64:24 65:12 70:2 71:3 75:21,22,23 77:5,22 83:5,6,21 91:6 94:17,18,22 107:14 122:22 126:22 127:17 130:5 134:1 137:17 147:21 148:13,17,24 149:19 153:13 156:18
morning (8) 1:3 19:24 20:19 33:16 59:9 96:7 103:14 147:16
morrison (22) 1:5,7,19,23 2:16,21,25 3:1 4:11 27:23 30:20 32:23 33:16,18 64:19 66:9,22 76:22 83:15,19,24 159:2
morrisons (1) 1:22
most (7) 8:3 24:22 63:8 75:22 78:8 97:20 114:7
mother (15) 58:25 70:15,16,18,20,22 77:18 81:2,3 82:13 90:14 91:19 114:8 127:13 152:16
mothers (2) 70:25 139:5
motorhome (1) 8:11
mouth (1) 57:12
move (2) 62:2 66:23
moved (5) 15:9,15 20:23 21:14 129:20
moving (5) 10:8 17:13 31:10,12 55:6
mps (1) 53:23
mri (1) 12:1
ms (165) 1:5,7,19,22,23 2:16,21,25 4:11 27:23 30:20 32:23 33:16,18 64:19 66:9,22 76:22 83:15,19,24 85:4,12,14,16,17,18,20 87:4 88:6,11,18 89:13,19 90:8,12,15,18,25 92:2,22 93:19,24 94:12,25 95:9,10,17 96:1 97:1,4,9,20 98:7,8,11,14,18,20 99:9,17 100:7,20 101:6,20 102:8,20,22 103:10 104:2 105:1,23 106:25 108:5,23 109:25 110:9,25 111:3,13,16 112:6 113:1 114:1,5 115:15 117:12,16 118:13,22 119:7,14 120:22 122:18 123:1,20 124:10,23 125:12,18,24,25 126:9,11,22 127:1,5 129:9,12,16 130:6 131:1,4,19,22,25 132:6,18,22 133:3,14,15,22 134:3,10,23 135:7,10,24 136:3,20 137:9 138:8 139:15 140:2,10,16,24 141:5,7,20 143:16 144:6,9 145:4,12 146:15,24 147:8,14,24 148:9,12,25 149:8,20,24 150:10,13 151:3,22 152:14 155:15 158:14 159:2
msps (1) 93:10
much (39) 1:6,9 2:3,11 9:3,7,21 12:3 28:12 33:12 38:25 40:18 43:18 47:1 49:16 52:6 58:4 62:1,16 65:22 72:15 77:25 79:15 83:12,24 94:13 99:18 105:11 120:17,22 121:7 123:1 126:8 136:24 144:16 153:6 155:3 158:14,15
mugs (1) 83:12
mum (12) 89:25 90:1,2 92:15 94:17 97:15 108:11 114:21 127:22 129:20 132:1 137:15
mums (4) 102:10 137:10 145:23 146:1
must (10) 28:12 31:11,11,13,15 32:18 38:10 139:4,12 155:1
mutation (2) 12:22,22
mutually (1) 124:19
myself (8) 23:14 30:14 31:23 36:18 85:12 88:23 102:9 136:22

N

n95 (1) 57:19
name (14) 2:25 4:16 18:1 30:3 44:5 86:24 89:9,10 116:15 118:2 127:21 133:22 135:16 158:3
named (3) 90:14 127:22 132:1
narrative (1) 118:19
natasha (7) 84:16 88:20 93:25 99:5 127:5,13 137:9
nation (1) 45:17
national (10) 37:4 117:1,19 128:3,6 129:7 130:7 131:4 137:19 145:4
nationally (1) 76:20
nations (7) 51:2,4,7 52:1 157:7,14 158:11
natural (2) 77:11 80:12
naturally (2) 57:13 69:25
nature (2) 29:9 89:18
naysayers (1) 66:3
ncs (2) 145:6,6
near (1) 115:3
nearer (2) 98:2 131:9
nearest (1) 55:5
nearly (3) 49:23 142:21 143:22
necessarily (3) 22:20 139:19 140:5
necessary (2) 89:4 139:11
necessitates (1) 139:2
need (22) 1:13 24:23,23 34:16 44:12 53:14 54:19 56:21 59:9 61:10 74:15 75:22 83:19 85:6,21 88:7 101:15 141:7 143:10 144:2 150:18 152:14
needed (7) 13:18 14:25 24:10 34:10 68:5 107:3 128:12
needing (1) 15:4
needs (10) 12:8 27:7 32:11,22 53:11 67:4 68:2 75:21 146:11 154:21
negative (4) 11:16 54:15 143:12,16
negatively (1) 74:6
negligent (1) 106:23
neither (1) 8:20
net (1) 150:3
networks (1) 76:9
never (20) 11:14 40:13 68:8 88:5 103:18,20 105:6 106:15 107:10 108:9 109:2 116:24 119:9,10 137:3 138:23 141:10 150:2 154:19 155:2
nevertheless (1) 147:10
news (1) 83:2
newspapers (1) 141:22
next (19) 10:8 26:6 30:19 31:10 32:20 34:23 45:7 59:13 64:25 66:14 73:10 77:25 82:6 84:13 95:14 103:25 109:16 111:10 158:5
nhs (2) 10:24 111:7
nicely (1) 32:8
nicola (2) 107:8 135:10
night (2) 23:8 24:11
nightshift (1) 24:12
ninewells (8) 3:25 4:19 7:24 11:18 14:3,6 19:15 20:24
nitpick (1) 26:15
nobody (8) 38:7 71:5 92:15 95:11 123:24,25 148:15 150:3
nominated (5) 110:25 139:10 150:11,15,22
none (1) 5:24
nonpandemic (1) 75:7
nonverbal (1) 157:2
normal (4) 35:11 74:9 125:4 141:23
normally (5) 12:1 81:17 87:21 91:13 115:2
north (1) 113:7
northern (1) 157:5
nosocomial (6) 36:23 37:4,7,9 69:23 78:10
noted (1) 89:6
notes (1) 60:4
nothing (6) 22:10 23:2 89:22 90:3 95:5 130:8
notice (2) 43:5 98:21
noticed (2) 19:20 88:18
notified (1) 96:2
november (2) 100:8 127:19
nowhere (1) 147:1
number (22) 24:9 31:16 55:13 61:20 97:6 99:3 105:4 107:8,9 115:11 117:10,13 124:25 126:2,15 136:16 138:12 142:2,14,16 150:22 154:10
numbered (1) 138:10
numbers (2) 61:12 148:19
numerous (3) 96:17 138:25 139:1
nurse (11) 10:25 11:18 12:15 16:22 47:5 59:1 70:18 72:8 80:24 123:21 124:12
nursed (1) 70:20
nurses (3) 24:7 32:12 106:12
nursing (19) 39:6 46:16 47:4 115:10,19,20,22 117:6 118:1,9,16 120:24 121:18 122:4 125:1 136:8 148:2,2 157:24
nutrition (1) 80:1
nutshell (1) 125:12

O

oath (1) 1:10
object (1) 31:8
objectives (2) 86:24 87:3
obligations (1) 137:12
obs (1) 19:20
observation (5) 49:13 64:20 65:5 105:18 113:17
observations (4) 17:12 58:17 88:23 142:15
obstacle (1) 156:3
obtain (1) 122:11
obtaining (1) 55:17
obvious (4) 74:14 77:4 83:21 140:7
obviously (29) 5:17 6:15 12:8,15 22:13 24:12 25:24 28:7 35:19 36:8 37:2 38:14,25 42:7 45:16 49:14 52:10 58:19 62:5 69:1 74:19 78:5,10 80:16 89:6 96:18 101:24 122:6 134:3
occasion (1) 125:13
occasions (6) 61:20 84:20 96:17 98:12 136:16 139:1
occupational (3) 5:9 6:2 29:15
occurred (1) 69:22
occurs (1) 155:9
oclock (1) 121:21
october (13) 1:1 3:25 4:19 10:15 12:12 25:9 98:18 100:8,8 111:17 115:11 155:18 158:20
odd (1) 106:22
offered (3) 50:7 81:5 108:23
office (2) 153:25 156:24
officers (1) 45:19
official (4) 59:23 69:17 93:20 101:2
officials (2) 93:9 124:9
often (11) 15:12 44:4 61:20 112:2,9,12,17 113:21 119:19 121:17 156:5
oh (8) 17:18 23:9 26:17 38:10 59:22 95:5 102:11 116:24
ohh (1) 37:23
okay (6) 14:17 16:3 19:10 38:19 102:16 119:11
old (3) 38:11 158:5,7
older (3) 12:25 56:14 154:6
ombudsman (1) 60:8
once (12) 14:14 21:17 22:12 23:23 29:1 39:16 71:9 91:3 92:23 106:3 145:6 157:2
ones (43) 50:4 52:25 54:19,22 56:14 62:6,23 69:15 70:9 71:6 80:5 87:6,14,22 88:3,14 89:16 90:7 91:17 98:15 105:21 106:19 107:5,23 109:19 110:4 113:25 114:1,4 116:5 119:5,13,22 126:19 127:16 129:1 139:13 143:7 144:19 146:23 151:19 152:22 154:18
onetoone (1) 61:13
ongoing (1) 147:4
online (2) 39:19 96:24
onus (1) 120:10
onwards (6) 37:17 43:2 62:8 80:19 152:11,12
open (11) 48:15 91:18,20 103:1 109:7,17 112:15,18 115:9 117:6 151:22
opened (2) 62:20 91:3
opening (4) 34:25 42:7 89:19 120:13
operate (1) 10:7
operated (2) 112:24,25
operation (1) 120:5
operations (2) 7:24 15:12
opinion (2) 34:15 146:19
opinions (1) 143:20
opportunities (1) 76:4
opportunity (3) 2:10 50:6 81:24
opticians (1) 153:13
optimistic (3) 144:8,10,23
option (3) 108:15 138:13 150:20
ordeals (1) 136:25
order (4) 2:5 30:5 70:12 112:16
ordered (1) 58:7
ordinary (3) 21:11,11 54:3
organ (2) 13:15 22:11
organisation (6) 45:1,3 55:11 111:8 116:10,12
organisational (7) 2:1,6 18:18 30:22 33:20 66:11 86:1
organisations (6) 53:8,12 90:21 110:20 118:6 143:1
organise (2) 81:11 95:13
organised (1) 82:16
organising (1) 10:1
organs (1) 13:6
originally (4) 9:17 34:12 35:7 48:20
originator (1) 90:17
others (7) 19:4 34:10 90:6 98:16 117:13 118:18 153:22
otherwise (4) 9:1 26:4 27:10 54:1
ourselves (3) 93:20 158:5,11
outbreak (1) 17:23
outbreaks (1) 148:25
outcome (4) 97:3,18,20,20
outdoor (3) 91:18 105:11 154:16
outlined (1) 79:17
outofdate (1) 48:6
outpouring (1) 87:16
outset (1) 32:21
outside (10) 16:13,14 17:12 31:6 65:11,13 82:11 95:18 97:25 156:14
over (27) 5:21 7:21 8:16 14:12,20 15:12 20:25 23:22 33:25 40:4 49:20 64:12,14 67:8 74:11 78:22 79:5 81:11 84:22 86:3 88:10 106:1 119:16 129:16 141:24 150:8 157:16
overall (5) 51:7 74:5,7 142:19,21
overly (1) 120:11
own (31) 15:25 16:1 22:23,25 24:9 28:5 33:24 34:24 43:10,11 50:11 53:10,10 56:15,17,17 57:8 60:11 71:11,19 72:11 77:11 79:5 80:6 81:9,10 92:14 97:24 105:2 115:5 156:6
owned (1) 54:25
oxygen (5) 21:12,15,24 22:5,6

P

pack (1) 70:13
pages (2) 2:24 49:23
paid (3) 82:16 138:3 153:22
pain (5) 7:19 9:23,25 29:11 72:7
painful (1) 8:3
palliative (1) 32:11
pancreas (1) 13:23
pandemic (46) 2:3 11:25 12:9 16:23 25:6 27:17 32:20 35:9 47:22 49:3,14,16 51:1,4 54:2,4,14 60:18 61:6,17 64:25 65:7,23 67:3,14,16 69:4 73:2 75:17 82:2 97:13 105:20 110:7,9 113:23 125:20 134:12,20,20 145:17 146:17 148:13,15 149:24 152:21 157:16
pandemicbereaved (1) 73:8
pandemics (3) 73:17 75:13 148:25
pandering (1) 53:22
paper (9) 48:25 49:14 67:20 68:4 72:20,21,24 83:2 142:4
papers (2) 49:2 142:6
paragraph (68) 4:12 7:11 19:11,13 26:12 30:3 34:6,8,17 35:2,22 36:9 37:21 38:3 39:10,25 40:3 41:23 42:2,4 43:2,13,16 44:25 46:14 47:19 48:16 49:25 50:17 52:8,22 54:11 55:22 59:20 64:19 67:3 68:1,19 75:9 76:24 80:19

86:9,23 88:4,12 89:2,14 90:10,16 93:6,7 94:6 95:15,17 103:6 104:16 105:15 109:24 111:14 113:17 115:9 121:11 127:1,3 136:7,11 151:18 152:10
paragraphs (8) 30:2 45:8 51:5 53:17 58:21 69:8 109:16 110:5
paramount (1) 143:8
pardon (1) 135:25
parent (1) 77:9
parents (4) 82:12,15,20 157:19
park (1) 64:10
parks (1) 16:18
parliament (5) 95:18 96:1 110:14 127:18 129:8
parliamentary (2) 84:21 133:23
part (26) 1:23 15:13 34:7 35:16 36:16 55:20,21 80:14 89:8 91:3 106:13 108:2 111:17 113:4 117:3 128:3 131:4 132:7 134:19 139:13 142:12 143:22 148:12 150:13 151:16 152:23
participants (2) 142:21,24
particles (2) 57:17,24
particular (16) 30:14 42:2,9 44:3,4,21 46:3 47:2 60:12 67:22 79:25 94:24 96:21 98:13 102:3 131:2
particularly (25) 2:11 18:22 25:2,4 27:21 36:3,18 39:22 41:7 46:1 50:20 52:13 54:16,16 56:14 57:21 79:11,22 80:2 91:4 123:9 127:20 131:23 134:22 140:6
partly (1) 53:21
partner (3) 77:14 106:21 157:11
partners (4) 75:25 106:17 157:8,18
partnership (1) 24:22
parts (4) 31:1 86:13 105:9 148:9
party (2) 93:11 127:25
partygate (2) 54:6 83:8
pass (3) 34:24 62:17 158:4
passages (2) 72:24 76:24
passed (2) 102:5 145:7
past (3) 33:12 86:3 117:10
patient (3) 15:20 17:13 22:14
patients (9) 16:7,18 17:11 31:6,10 53:5,6 54:18 80:1
patio (1) 91:21
pattern (1) 74:9
patterns (1) 74:10
pause (2) 18:16 99:15
paused (1) 145:5
pay (1) 94:22
payment (1) 153:7
pe1841 (1) 127:6
peaceful (2) 25:9 80:7
peersupport (1) 76:6
people (186) 1:10 5:5 6:9 7:4 8:18 9:7,11,14,24 12:2 13:15 16:25 25:18 26:8 27:6,11,19 28:2 30:8 32:6,15,22 35:7 36:7,18,20 38:10,12,15,17,21 39:3,3,5,6,18,19 40:13 41:17 42:17 47:7 49:4 51:19 52:13 53:15,25,25 54:3,21 55:1,2,5 56:13,19 57:4,11,21 58:5,12 59:23 60:2 61:2,6,7,7,14,20 62:13,14,15,16,17 63:5,17,23 64:7,17 65:2,3,14,18,18 66:1,7 67:15,23 69:12 73:4 75:16,22,23 76:1,9 79:20 80:11,20 81:9,18,22 82:21 83:8 87:23 88:18,22,24,25 90:19,21 91:1,2,12,13 92:3,4,14 93:7 94:3 97:11 101:25 104:13,20 105:5 106:11 107:8,10,12,17,19,19,20,22 108:13,14,25 109:7,19 114:12,21 115:8 116:23 118:20 119:2 120:10 121:5,12 124:9 127:10,12 128:10,10,18,19 131:3,12 132:13 136:8 137:6 140:12 141:2 142:22 145:13,15,16,17 146:10 148:14,16 149:14 150:7,15,20,22 151:25 152:2,2,3,5,7 153:23 154:1,1,6,16 155:21 157:23 158:9
peoples (1) 42:11
per (1) 139:12
perceive (1) 121:16
perceived (1) 79:10
percentage (1) 108:25
perception (1) 133:4
perfect (1) 97:16
perfectly (1) 124:4
perhaps (22) 27:13,14 33:25 36:25 38:3 45:7 46:9 50:1 53:18 56:8 58:22,22 62:7 90:4 95:15 109:23 110:7 111:14 119:8 135:2 138:17 151:2
period (3) 9:9 100:16 137:20
periods (2) 127:14 154:8
permission (1) 10:3
permitted (1) 113:22
person (49) 25:14,16 31:25 57:13,18 58:6 60:6 62:17 68:21 69:2 74:13,15 77:3 80:9 81:18 89:11 97:12 101:13 106:21 109:4 111:14 116:10 120:25 124:3,4 125:23 132:4,8,10 133:7 134:13,15,17 138:1 147:13,21 148:23 149:3,7,12,15,19 150:2,14,16,19,25 151:4,10
personal (20) 1:25 2:6 4:11,13 18:17 30:21 32:4 33:24 41:19 43:10,11 47:6 57:22 59:8 60:11 63:23 77:16 113:25 139:3 153:7
personally (4) 56:10 58:6 113:24 129:19
personcentred (1) 87:10
persons (1) 81:19
perspective (9) 31:2 33:24 43:9,10,11 59:3,25 119:1 137:10
perspectives (1) 19:4
perth (1) 4:20
perthshire (1) 3:7
pessimistic (4) 144:8,9,12,24
pet (2) 6:11 7:17
petition (7) 88:21 90:10 127:6,10,14,19 129:20
petitions (2) 88:19,20
pgd (9) 68:6 72:18 73:7,13 74:4,7 75:5,17 79:9
phone (11) 21:10,18 23:13 24:10 25:15 28:9 71:8 78:16 79:2 97:5 108:12
phoned (5) 10:24 21:9 24:21 25:13 97:6
phones (1) 72:13
photo (1) 105:4
photographs (3) 121:2 141:1 151:25
photos (1) 152:6
phrase (1) 61:18
physical (3) 63:9 119:4 143:6
physically (3) 90:18 99:24 141:20
pick (2) 147:19 150:8
picked (1) 83:2
picture (1) 157:15
pictures (1) 87:22
pilot (1) 5:8
pinny (1) 14:10
placards (2) 94:20 96:14
place (25) 5:13 6:16 11:7 30:13 32:19 38:16,17 45:12 48:2 53:4,19 64:24 65:4 68:22 70:15 74:18 77:23 108:9 110:13 111:19 114:6 120:2 130:2 145:13 147:1
placed (2) 115:19 127:18
places (5) 43:21 64:7 70:3 101:8 105:11
plainly (1) 134:8
plan (3) 51:13 53:9 56:9
planned (3) 95:17 96:2,5
planning (2) 10:3 22:2
plans (9) 32:19 45:12 51:15,15,21 53:4,8,10,19
platform (1) 39:21
platforms (1) 40:21
play (1) 58:14
played (3) 112:13 113:4 130:3
plea (2) 115:18 149:2
please (43) 2:25 4:11,14 7:12 10:14 12:14 14:17 26:12 28:19 31:1 35:3 38:4 43:15,17,23 44:25 46:14 47:20 48:19 49:25 50:22,25 53:18 54:12 55:22 56:3 57:7 62:8 65:10,16 68:19 69:6 77:2 95:25 102:21 112:5 117:5 122:3 142:16 149:2,6 155:11,15
pleased (2) 79:23 152:8
plenty (1) 49:2
plethora (1) 101:16
plight (1) 94:8
plough (1) 101:16
plunger (1) 8:24
pm (13) 66:16,18,20 83:25 84:1,5,6,8,10 121:22,23,25 158:18
podiatry (1) 153:13
pointing (1) 8:14
points (9) 18:6 24:24 26:7 27:8 67:20 124:16 135:2 136:6 151:15
police (3) 87:24 96:1 147:4
policies (2) 76:13 154:6
policy (2) 73:14 75:13
policymakers (1) 87:13
political (5) 45:17 53:17,20 93:11 135:5
politicians (3) 45:18 94:21 96:21
politics (2) 45:20 96:9
poor (6) 6:6 79:9,10,15,21 114:14
poorly (1) 100:14
pop (2) 8:12 56:15
popping (1) 106:3
population (4) 58:9 92:6 107:18 154:10
populations (2) 73:8 75:8
portugal (1) 58:1
position (9) 8:25 25:22 31:15 96:10 104:25 121:19 127:17 139:9 141:17
positions (1) 109:18
positive (14) 14:15 20:21,22 21:17 31:22,23 35:20,24 39:13 43:1 58:4 116:21 119:10 124:1
positively (2) 87:25 143:1
possible (6) 27:9 31:17 83:25 86:15 119:2 138:25
possibly (12) 6:9 13:5,22 14:15 26:18 46:2,7,21 95:4 113:15 139:22 151:6
post (1) 103:24
postbereavement (1) 75:6
postcode (1) 113:3
posters (1) 96:13
posting (1) 151:25
posts (1) 39:19
potential (4) 124:25 126:1 136:1 147:22
potentially (2) 31:7 144:20
poured (2) 8:23 23:14
power (5) 93:4 128:9 130:23 131:20 137:12
powers (1) 138:20
ppe (26) 15:22 17:5,15,16,17 26:10,13 27:18,19 31:11,12 47:19,21,21,24 48:7,10,15 54:22,23 55:9 58:18 82:5 139:11 152:18 156:25
pr (3) 93:23 94:10 105:2
practical (2) 139:19 140:6
practice (5) 43:20,21 73:15 82:21 139:23
practices (1) 36:10
praise (1) 44:19
praying (1) 71:13
precautions (1) 139:11
precise (2) 85:6 120:15
preexisting (2) 72:14 108:18
preference (1) 114:9
preferred (1) 5:12
prepandemic (1) 73:13
preparation (3) 47:17 51:8,9
prepare (3) 51:10,12,20
prepared (3) 39:18 67:10 86:11
preparedness (1) 73:16
preparing (1) 60:23
present (6) 3:3,9 34:15 49:9 75:13 85:8
presentations (2) 84:20 111:6
presented (1) 93:20
presents (1) 156:8
president (1) 102:25
presidents (1) 117:10
press (5) 69:13 94:21 96:17 105:4 154:13
pressure (2) 21:17 91:1
presume (1) 9:9
pretty (4) 11:9 14:11 26:14 57:10
prevails (1) 122:22
prevalence (1) 73:7
prevention (20) 111:8 115:11,16,22 116:17 117:12,18 118:3,7 119:3,11 121:17 122:14 123:19,21 124:12,18,21 125:21 126:18
prevents (1) 57:17
previously (3) 21:6 79:17 80:2
principles (1) 136:5
prior (8) 6:15 46:15 60:14 105:20 109:3,19 111:19 127:5
prioritized (1) 76:11
prisoners (1) 154:24
privatisation (1) 48:7
privatised (1) 48:10
probably (22) 3:11 6:10 21:5 23:8 27:22 33:7 35:1 37:11,16,22 43:13 58:9 74:20 75:3 78:25 85:7,21 87:1 98:2 109:2 111:11 121:10
problem (11) 8:20 11:25 12:16 44:3 56:11 69:19 107:2 126:9 130:6,18 131:13
problems (8) 13:1 27:18 48:11 126:21 131:11 133:5,12 134:6
procedures (2) 32:19 64:24
proceed (1) 10:11
proceedings (2) 4:7 84:9
process (4) 10:1 51:10 62:18 68:25
processes (2) 74:24 80:16
produced (9) 18:13 51:3,6 72:21 83:12 112:16,18 116:16 154:22
produces (1) 63:7
producing (3) 50:11,14,16
professional (3) 93:20 116:3 120:16
professionals (1) 76:15
professions (1) 39:5
profile (1) 94:11
programs (1) 76:7
progress (3) 94:7 98:10 156:2
progressed (2) 19:24 20:19
progression (1) 145:1
project (2) 39:11 127:1
prolonged (6) 59:14 67:5,13 73:7 127:14 128:24
promenade (1) 115:3
prominent (1) 115:23
promises (2) 71:15,18
proper (2) 32:19 148:3
properly (11) 15:2 44:13,13 53:15 60:8 65:20 71:1 72:3 79:18 148:3 158:2
property (1) 82:20
proportion (1) 75:16
proposal (1) 142:18
propose (1) 1:10
proposed (3) 99:10 150:13,16
proposing (2) 148:20 149:17
prosecution (1) 103:3
prosthetic (2) 8:4 10:22
protect (6) 77:13 119:2 137:14 144:2 150:18 153:22
protected (1) 31:12
protecting (2) 108:20 144:22
protection (1) 31:14
protocols (1) 152:19
prove (2) 99:20 100:3
provide (9) 2:17 10:14 36:8,15 85:24 86:11 91:24 112:18 152:25
provided (14) 1:24 2:14 3:15 15:23 16:4 86:17,21 110:21,22 135:3 142:3 143:23 148:5 155:13
provider (3) 111:20,21 113:13
providers (3) 76:18 93:13 99:10
provides (3) 22:25 36:15 147:12
providing (2) 100:6 155:4
provision (4) 36:19 73:14 75:20 76:5
psyche (1) 77:21
public (40) 35:16 38:8,13 51:19 58:10 89:20 93:14 95:1 101:10 103:20 104:1,24 110:1 112:7,16 113:11 116:22 119:9 123:22 124:5,12 125:19 126:3 128:9 129:2 130:13 133:5,6,11 134:11 145:25 146:7 149:1,5,21 153:22,25 154:4,22 156:22
publicised (1) 127:7
publics (1) 94:8
published (7) 67:12 86:5 87:20 111:24 115:10,20 117:2
punished (1) 83:9
punishment (1) 140:25
purely (2) 100:24 130:2
purpose (4) 3:18 16:14 45:2 151:19
purposes (7) 3:3,9 32:25 34:16 67:23 68:8 85:9
purse (1) 153:22
push (2) 149:15 156:13
pushing (1) 131:9
putting (9) 34:22 41:6 46:3 63:20 78:18 83:22 93:16 120:9 144:14

Q

q (127) 3:2,6,9,15 4:4,10 6:19 7:6,11 8:15 9:9 10:12 12:7,11,14 13:11 14:5,17 15:17,23,25 16:3 17:4 18:16,21 19:2,10,16 21:20 22:17,19 23:7 25:1,4 26:6 27:8,22 28:17 30:2,20 32:2,23 33:22 34:2,15,22 35:12,19,22 36:3,7,12,25 37:11,19 38:2,19 39:10,22,25 40:7,17,21 41:2,23 42:4 43:2,13,23 44:11,16,19,25 46:1,14,19,21 47:19 48:16 49:13,25 50:17,25 52:4,8,12,16,22 53:17 54:7 55:13,24 56:1 57:7,23 58:16 59:3,7,13,20 60:10,24 61:18,23,25 62:2,5 64:19,23 65:10,16 66:6,9 67:10,19 68:1,13,16,18 69:6 72:19 75:1 77:23 78:5 80:14,18 83:15
qualification (2) 34:20 35:6
qualified (1) 47:5
quality (2) 87:6 143:8
quantify (2) 99:13 155:19
quarantine (1) 28:7
quarantined (1) 156:9
question (9) 4:6 46:10 59:22 93:2 102:19 142:19 143:20,23 147:10
questioning (1) 1:11
questions (9) 1:17 18:3 30:16 32:13 45:2 72:6 84:24 159:4,7
quick (1) 78:23
quickly (6) 31:16 63:20 88:24,25 93:19 101:6
quietly (2) 62:22 63:2
quite (32) 2:8,14 5:11,17 6:24 7:16,22 8:20 11:13 12:2 13:19 16:11 20:23 27:17 39:13 42:6 46:21 50:3 57:1 63:2 70:5 79:19 90:23 92:11 97:17 100:14 103:24 120:12 122:20 146:10 147:11 150:4
quote (3) 34:23,25 37:22

R

radar (1) 103:17
radio (3) 96:7,11,12
raft (1) 20:1
rage (1) 114:13
raise (5) 17:6 18:5 45:13 47:2 103:22
raised (4) 103:22 141:18 143:25 146:6
ramped (1) 70:10
ramps (1) 69:25
ran (2) 5:5 7:17
rang (1) 23:17
range (2) 65:17 111:6
rapid (2) 73:18 156:10
rapidly (1) 78:14
rate (5) 37:8 60:17,21,22 63:24
rather (14) 5:12 43:10 46:12 53:24 61:13 89:12 97:24 106:22 114:9 119:25 139:22 140:10,15 141:18
rationale (1) 59:4
reaching (1) 75:22
reaction (4) 80:13 99:9 100:5 103:9
read (30) 5:18 30:25 34:5 35:2 38:4 45:7 50:1,22 51:19 53:18 54:11 56:2 58:19 65:10 68:3,18 72:24 73:22 77:1 80:18 87:2 95:15 109:23 111:15 120:14 122:6,9 127:2 131:16 151:17
reading (5) 4:14 5:15 61:18 69:9 141:22
readings (2) 47:11,13
reads (2) 110:8 152:12
readthrough (1) 75:4
readthroughs (1) 2:8
ready (5) 23:2 24:4 33:17 64:10 66:21
reaffirm (1) 81:21
real (1) 30:10
realisation (1) 22:24
realise (1) 62:19
realised (3) 70:22 91:4 123:1
realities (1) 121:18
really (36) 7:16 21:18 39:20 41:4 43:18 44:12 57:20 65:20 68:11 87:24 88:8,24,25 89:24 90:2 91:1 95:6 98:8,22 99:5 100:2 106:25 109:15,22 116:13,20 122:10 124:17 126:10 127:1 141:2,3,15 145:13 152:7,7
realms (1) 68:9
reason (14) 1:14 26:3 101:20 111:20 126:12 129:18,19 136:9 140:8 144:11,21 146:15 148:4 157:24
reasonable (1) 91:16
reasonably (1) 58:8
reasons (9) 101:4 108:18,21 112:8,10 113:22 143:3,5,14
reassert (1) 157:15
received (6) 18:23 82:19 88:5 116:20 127:20 155:22
receiving (1) 52:13
recent (4) 72:22 75:14 114:7 125:16
recently (2) 2:14 48:14
recipients (3) 44:14 124:25 126:1
recognise (4) 36:17 121:6 152:14 154:5
recognised (8) 49:4 79:23 106:15 107:4 111:2 116:25 134:17 139:12
recognition (1) 116:25
recommendation (1) 79:12
recommendations (3) 75:12 126:18 139:17
recommended (2) 126:18 139:11
recorded (1) 47:12
recording (1) 142:17
reduce (2) 149:1,2
reduced (1) 82:3
reestablished (2) 91:11,12
refer (4) 1:19 34:19 46:22 109:20
reference (21) 2:4,22 19:15,16 47:3 49:13 53:5,6,7 72:20 86:6,6 94:9 104:17 115:9 117:7 122:11 135:23,24 137:18 142:10
referencing (1) 49:2
referred (1) 48:25
referring (3) 4:2 59:18 86:18
refers (3) 13:8 19:14 127:7
reflect (1) 77:16
reflection (1) 76:19
reflects (1) 121:19
reflex (1) 11:13
reflexology (1) 6:4
refusing (1) 112:10
regard (1) 113:25
regarding (2) 2:2 137:19
regards (1) 45:3

region (1) 60:19
registered (2) 4:23 128:19
registrar (3) 24:18,18,20
regrettably (1) 36:5
regular (3) 98:12 110:13 139:2
regularly (1) 21:9
reinforcing (1) 128:17
reiterate (2) 4:5 59:7
related (2) 74:20 134:5
relation (8) 4:12 77:17 79:8 117:25 133:24 138:15 139:18 142:19
relationship (5) 8:8 68:20 74:15 77:3 102:10
relationships (3) 134:4 141:8,8
relative (9) 106:20 113:5 115:1 134:5 143:17 147:1,21 152:15 157:2
relativefriend (1) 139:10
relatively (4) 66:24 74:4,11 75:5
relatives (33) 12:21,25 84:14,17 85:23 87:14,19 95:21 97:24 102:7 105:10 107:3,5,11 108:4 112:8,10 113:4,18 114:17 115:17 125:13,20 141:10 147:18,18 152:6,21 154:20 156:17,18,20 159:5
relevant (3) 81:8 117:16 134:22
relief (1) 92:18
reliving (1) 42:24
reluctant (1) 101:21
relying (1) 145:18
remain (1) 137:25
remained (1) 74:11
remark (1) 45:9
remember (11) 11:21 26:25 49:6 50:14 64:8 79:1,2 94:25 95:10 114:13 120:15
remembered (1) 28:3
remind (1) 38:19
remit (1) 50:19
remotely (1) 40:19
remove (3) 8:4 70:20 126:5
removed (1) 8:1
renal (1) 22:8
repeat (1) 64:20
repeating (1) 136:22
replies (2) 94:13 95:3
report (16) 18:13 19:12,14 67:7,10 68:6,14,23 69:7 74:3,22 75:14 78:7 79:12,23 142:9
reported (4) 81:15 100:11,15,17
reporting (1) 96:10
reports (2) 77:24 112:3
reposition (1) 12:18
represent (3) 40:4 52:19 87:13
representation (1) 41:13
representative (1) 46:25
represented (2) 38:21 40:16
represents (1) 52:20
republic (1) 157:6
request (2) 60:5 139:8
requests (1) 103:8
require (4) 75:18,24 139:16,17
required (1) 82:5
research (4) 2:15 7:7 49:24 94:5
resemble (1) 87:21
resided (2) 126:13 130:3
resident (6) 94:8 129:23 139:2,25 143:17 151:11
residential (6) 118:1,9,17 125:1 136:8 157:23
residents (30) 70:12 89:23 90:3 95:12 100:23 103:17,18,20,25 104:3 108:9 118:18 127:8,9 128:7,25 138:23 139:9 143:6,10,13 151:5,7,10,13 153:11,16 156:3 157:9,21
resides (1) 132:3
resonate (1) 75:14
resonates (1) 92:1
resources (1) 121:13
respect (4) 10:3 126:17 136:24 158:6
respective (1) 122:17
respiratory (2) 13:9,10
responded (2) 94:24 142:25
respondents (4) 100:11,15 143:3,22
responding (1) 143:1
response (8) 35:20 38:9 47:1 100:10 142:13 143:4,19,23
responses (4) 73:19 142:8,11,17
responsibility (2) 77:8 111:25
responsible (1) 51:17
rest (5) 38:17 51:9 63:3 136:10 157:25
restarted (1) 154:14
restrict (1) 125:19
restricted (2) 137:5 154:15
restricting (2) 150:25 151:4
restrictions (11) 63:19 81:8 82:8,8 95:20 108:8 117:25 125:5 128:15 143:12 155:21
result (1) 11:23
results (4) 11:24 73:10,12 99:7
resuming (1) 87:7
resuscitate (3) 44:22 58:21 59:5
reticent (1) 120:12
retired (2) 3:13 39:6
reunited (1) 107:24
reversed (1) 129:4
review (2) 139:21 142:5
reviewed (1) 112:16
revoke (1) 131:21
revolutionary (1) 132:6
rewriting (1) 133:3
ride (1) 83:11
ridiculous (1) 65:24
righthand (1) 75:10
rightly (1) 16:11
rights (24) 93:11,12 113:25 114:1,3,19 127:8 128:18 136:12,17,21 137:10,10,11,16 138:13 139:24 140:19 142:1 143:11 144:2,22 153:20 157:9
riot (2) 72:6 80:8
risk (3) 72:16 75:17 114:9
riskaverse (2) 58:6,9
risky (1) 111:21
ritual (1) 62:15
road (1) 10:2
robust (1) 75:21
roche (1) 50:8
rock (1) 120:2
role (3) 112:13 147:6,7
roles (1) 40:22
roof (1) 71:12
room (13) 11:22 17:9 23:18 24:4 54:20 77:21 80:23 85:1 97:24 116:20 144:20 155:9 156:17
rooms (1) 154:2
rose (1) 133:22
rotate (1) 48:3
rotated (1) 150:21
round (2) 16:19 130:14
route (1) 153:11
routinized (1) 122:23
rubbish (1) 66:4
rubric (1) 73:11
rules (7) 31:4,7 52:17 83:10 146:4,5 153:3
run (2) 88:7 153:17
runs (2) 72:6 80:8
runup (1) 140:17
rushed (2) 78:12 81:7
russell (60) 84:15 85:3,4,4 87:2,4 88:6,11,18 89:13 90:18,25 93:24 94:12 97:1,4,9,20 98:8,14,20 101:20 102:20,22 105:1 106:25 109:25 111:3 114:1,5 119:14 120:22 123:1 124:23 125:12,24 126:22 130:6 131:1,4,19,22 132:6,18,22 133:22 134:3 139:15 140:2,10,24 141:5,7 145:4 146:15 147:24 148:9,12,25 151:22

S

sad (1) 81:20
sadly (3) 10:9 44:1 80:20
sadness (1) 155:25
safe (9) 56:12 58:14 92:15 116:14 119:4,19 122:15 124:15 125:6
safely (4) 97:17 116:18,19,20
safety (2) 126:19 150:3
sake (1) 102:12
sakes (1) 158:13
same (28) 12:21 14:10 19:6 27:24 29:5,22 30:22 31:13 48:25 53:9 54:24 65:21 71:13 81:2 85:7 88:23 92:24 115:16 122:18,19 129:24 135:14,17 138:3 141:11 143:11 150:9 152:18
sand (1) 7:23
santa (1) 103:13
sars (1) 60:19
sat (4) 10:20 24:5 63:2 91:9
saw (9) 9:14,14 19:24 20:19 90:6 105:18 110:1 112:23 148:1
saying (32) 6:1 8:7 18:21 27:13 29:22 32:10 43:17 54:24 58:19 66:3,6 69:9 97:23 99:4,11 100:3 101:14 105:24 107:15 115:15 116:3,4 117:19,20,24 119:11 120:8 141:15 149:8,9 150:14,17
scan (1) 12:1
scandal (1) 54:6
scanner (1) 12:4
scared (1) 149:13
scary (1) 60:21
scenario (2) 78:13 149:25
schools (1) 5:23
scichrs000039 (1) 135:21
scichrs000124 (1) 142:11
scichrs00014 (1) 117:7
science (1) 53:24
scientific (1) 119:1
scientists (2) 39:6 45:18
sciwt0730000002 (1) 72:21
sciwt0731000001 (1) 86:7
scotland (22) 1:23 28:9 40:18 51:8,10,23 82:11 84:14,17 85:23 93:13,15 95:2 96:9,10,11 112:7 116:23 117:1 154:14,22 159:6
scottish (37) 34:7,11,12 35:16 36:14 38:22 40:22 46:6 49:22 50:20 52:6 69:3 87:9,25 93:8,9,11,13 95:18,23 96:1 101:9 102:23 109:25 110:11,14,19 111:7 112:3 116:23 127:18 152:25 153:9 154:4,12,19 156:21
screen (3) 86:10 117:8 157:1
sealed (1) 62:20
searching (1) 142:10
second (6) 14:13 21:5,7 122:13 129:16 136:4
secondhand (2) 52:9,14
secondly (1) 76:4
secretary (1) 96:22
section (26) 26:6 27:22 36:21 37:19 38:21 43:3 48:18 54:12 56:3 58:20 59:13,13 73:21,23,24,25 75:2,2,3 95:14 111:10,15 112:20 128:6 152:12 155:21
sections (3) 33:25 54:7 68:4
sector (1) 153:3
sedated (1) 25:24
see (36) 9:13 26:15 30:23 62:22 64:23 65:21 70:4,6 74:3 82:22 87:22 89:24 91:7 105:17 106:19 114:10 115:17 117:8,24 119:12 120:25 122:7 123:3 125:2 127:11,13 128:18 138:1 140:25 141:4 142:17,19,23 152:8,22 156:18
seeing (5) 44:6 94:17 108:11 126:13 141:23
seek (1) 76:8
seem (4) 104:15 114:18 121:6 131:11
seemed (4) 41:17 83:5 103:11 123:25
seemingly (2) 13:19 14:20
seems (5) 51:8,23 77:4 92:3 133:18
seen (13) 11:14 27:10 52:4 58:10 61:19 78:13,25 107:10 126:5 136:13 147:3 149:3,4
selfevident (1) 124:17
selfies (1) 152:1
selfish (1) 28:13
send (3) 59:25 95:3 136:3
sending (2) 94:12,15
senior (2) 123:21 124:11
sense (6) 29:23 88:1 92:18 93:4 105:1 150:10
sensible (1) 33:10
sent (10) 47:21 48:4 70:3 98:12 102:22 103:11 116:22 135:22 136:1 137:21
sentence (1) 105:16
sentiments (1) 158:17
separate (2) 77:24 152:9
separation (2) 110:3 138:23
separations (1) 157:14
september (10) 72:22 86:25 95:18 96:8,19,24 97:19 99:13 114:14 135:10
series (2) 51:11,16
serious (2) 14:23 15:3
seriously (1) 8:9
seriousness (1) 118:24
service (9) 36:14 61:11 128:4,6 129:7 130:7 131:4 137:20 145:4
services (6) 36:14 46:10 70:19 75:18 76:21 153:12
session (1) 155:15
set (21) 3:10 7:14 34:6 43:4 68:13 86:23 87:4,16 88:6 89:3 90:9,10,18 129:20 136:4,6 143:4 145:11 151:20,22 154:22
sets (1) 73:4
setting (1) 57:23
settings (1) 76:16
settle (1) 146:16
setup (1) 20:24
seven (3) 37:15 63:13 153:15
several (4) 5:21 11:24 56:15 91:20
severely (1) 92:4
shall (3) 8:22 44:7 66:16
share (4) 36:12 38:7 81:20 158:17
shared (2) 90:20 102:6
sharing (1) 45:15
shed (3) 11:4,8 102:16
sheer (1) 88:13
sheila (3) 84:15 96:10 107:2
shelf (1) 53:14
shelves (2) 48:6,13
shift (2) 55:6,7
shifts (1) 70:2
shock (1) 77:11
shocked (1) 100:14
shop (2) 7:17 57:9
shops (2) 8:13 108:13
shore (1) 6:1
short (6) 33:14 66:19 84:7 91:14 121:24 145:15
shortage (2) 15:15 54:25
shorter (1) 66:15
should (34) 2:21 34:2 45:4 50:13 52:12 58:12,13 76:5,11,13,17 77:13 106:9 116:6 117:20 118:7 122:14,19 124:21 133:17,19 139:9 141:10 142:22 144:12 146:19 148:3 150:15 152:23 153:21 154:2 155:5,10 157:15
shouldnt (3) 27:14 140:20 148:10
shout (1) 71:4
shouting (1) 91:20
show (4) 96:7 97:16 99:24 121:2
showed (1) 51:24
showing (2) 9:7 51:25
shown (2) 72:19 135:21
shows (2) 146:4 149:10
shut (7) 108:10,11 125:24 145:23 151:12 157:22,23
siblings (1) 75:25
sickness (1) 158:7
side (11) 11:22 17:9 23:18 24:4 40:5,8,11,11 53:23 80:23 112:3
sign (2) 40:14,15
signatures (1) 127:17
signed (9) 32:23 40:5,7 66:9 83:15 88:22 115:11,23 117:9
significance (1) 74:20
significant (6) 31:16 68:21 71:21 72:18 76:25 118:18
significantly (2) 60:23 82:3
signposting (1) 76:20
silly (1) 41:17
similar (1) 75:7
simple (3) 101:15 124:4 144:12
simplified (2) 51:23 52:7
since (8) 74:6 91:15 100:16 107:11 110:7,9 114:18 146:24
singing (1) 63:6
single (3) 105:15 107:12 129:23
sister (1) 16:10
sit (5) 24:4 81:5 99:21 102:14 156:25
sitting (8) 23:13,24 48:12 71:8 87:23 94:25 105:7 141:22
situation (14) 19:8 28:20 32:17 62:13 63:21 77:16 89:10 92:24 94:16 99:13 106:24 122:22 130:21 136:12
six (6) 13:20 63:5 95:19 115:4 147:18,19
sixseven (1) 12:12
size (2) 40:2 63:24
skills (1) 94:3
skim (1) 33:25
skip (1) 54:10
skipping (1) 75:9
slightly (4) 38:2 43:25 57:6 89:10
smacked (1) 23:15
small (2) 3:22 154:2
smaller (1) 42:16
smart (1) 10:6
smell (2) 20:8 48:24
snp (2) 127:23 135:17
socalled (2) 54:6 83:8
social (17) 16:18 36:19 46:10 65:23 70:19 73:15 76:2,5,9 87:12 96:4 110:16,17 127:7 128:16 153:25 156:23
socially (1) 81:14
society (15) 46:23 47:1 49:1 64:15 89:20 111:8 117:12 136:10 141:23 143:11 153:4 157:15,25 158:4,8
socioeconomic (1) 67:22
socket (1) 8:15
soft (1) 120:19
solicitors (1) 85:10
somebody (11) 87:1 89:4,12 92:20 93:22 95:15 109:10,23 110:8 120:16 134:11
someone (28) 5:14 14:15 25:21 27:6 31:12 35:7 37:7,12 38:8,13 39:1,9 44:1 64:8 80:9,11 93:1 97:5 104:9,12 113:7 131:12 134:17 136:21,23 139:22 144:14 148:21
someones (6) 31:21 57:12 60:4 69:10 82:1 139:24
something (56) 4:6 6:15,16,19,20 7:2,3 11:2 13:21 14:23 28:18 29:7 32:7,14 37:24 38:10 42:5 44:22 48:3 49:7 55:18 56:6 58:12 60:10,19 61:9 62:3 64:4 67:4 74:1,19 80:24 85:21 90:5 92:1 98:6 100:2 101:6 111:11 115:13 118:11 120:20 122:25 126:7 129:17 131:23 134:8 138:17 140:6,8,11 144:4,12 145:8 148:20 155:10
sometimes (8) 9:20 13:24,24 44:7 46:19 109:7,8 113:15
somewhere (5) 24:1 48:14 89:1 109:4 144:14
son (3) 106:14 134:19 150:6
sons (1) 150:6
soon (4) 64:13 69:19 117:2 134:17
sort (22) 8:8 14:6 18:2 21:13 22:23 24:19 32:10 34:19 41:8 45:23 47:7 53:10 57:25 60:6,8 63:7 65:19 81:25 82:17 108:5 134:7 144:21
sorted (3) 15:21 23:25 39:17
sorts (3) 39:4 62:25 107:19
sought (1) 127:10
sound (2) 5:14 136:21
source (1) 124:22
south (1) 113:6
space (1) 15:10
spaghetti (2) 52:2,5
spain (1) 69:14
spare (1) 8:6
speak (12) 18:11 41:7 42:22 69:2 86:12,12 96:6 108:11 130:5 136:20 153:23 158:1
speaker (1) 41:10
speaking (10) 17:20 29:5 42:18 45:5 95:11 102:9 117:21 139:22 140:18 151:6
special (1) 27:7
specialist (3) 73:16 75:19 115:21
specialists (2) 32:12 115:12
specific (5) 41:19 59:15 69:8 122:7 143:12
specifically (1) 6:8
speech (1) 66:6
spend (1) 127:11
spent (2) 87:21 91:21
spike (1) 19:20
spirit (1) 125:7
spiritual (1) 120:19
spoke (7) 7:4 28:9 39:2 40:25 135:11,17 141:14
spoken (2) 29:8 33:24
sport (1) 110:18
sports (1) 38:12
spot (1) 139:15
spouses (1) 157:18
sprayed (1) 80:23
spreadsheet (1) 110:20
sridar (1) 58:10
staff (20) 14:23 31:5 47:8 53:12 54:25 70:3 79:22 104:10 115:16 119:20 122:18 126:20 135:14,18 136:24 137:2 139:12 141:10,13 152:18
stage (10) 1:12 5:22 11:17 15:4,16 22:2,21 23:11 48:21 68:4
stance (1) 50:10
stand (2) 131:25 157:7
standard (1) 57:16
standards (10) 114:6,7 128:17,20 145:12,18 146:16,17 147:4 153:6
standing (2) 78:24 91:17
standpoint (1) 106:20
stands (2) 144:7 145:8
start (7) 21:4 47:22 83:25 95:19 110:7,9 151:24
started (12) 5:16 11:15 16:23 34:12 41:9 90:23 91:18 93:5 94:6,15 127:6 146:24
starting (5) 19:22 62:18 87:22 92:17 151:12
starts (1) 69:4
stated (3) 136:23 138:4 139:1
statement (78) 2:1,1,2,6,7,13,13 4:11,13,15 13:8 18:17,18,19 26:6 30:21,22 31:1 32:23,24 33:19,20,20 34:3,25 37:20 41:23 42:7 43:3 48:8,17 54:8 55:13,20,22 56:25 58:20,23 59:9,14,16 60:11,25 61:19 66:9,14,24 67:20 76:23 83:15 85:25 86:1,4,7,8,11,13,14 89:2 93:6 95:15 103:6 104:19 105:15 109:14,16 111:10 112:21 120:13,14 122:3 126:24,25 128:12 151:16,18 152:13 155:4
statements (9) 1:20,25 2:4,11 3:10,16 83:22 126:5 155:23
states (1) 125:19
static (1) 74:11
stations (1) 96:12
statistics (1) 37:4
status (4) 67:22 87:8 109:21 152:17
stay (1) 82:15
stayed (2) 16:5 82:6
staying (1) 82:20
step (1) 61:11
steps (3) 82:5 95:14 125:6
stewart (3) 103:23 110:15 146:6
sticky (3) 13:14 24:2 29:4
still (22) 15:7 19:25 22:2 28:6,7 29:23 63:23 82:9 92:8,10 103:13 105:6 106:15 108:11,12,13 110:16 116:14 129:8

149:11,25 157:7
stimulate (1) 121:1
stock (2) 48:3,6
stockpiled (1) 57:2
stockpiles (2) 47:24,25
stood (4) 91:20 104:8 109:9 135:10
stop (19) 5:1 6:13 9:23,23 13:25 16:25 54:4 56:21 57:3,11 63:13 65:24,25 72:19 76:22 94:17 96:18 112:20 129:3
stopped (4) 6:2 8:12 56:18 115:4
stopping (3) 107:5,6 125:4
stops (2) 57:19,24
stories (9) 32:6 38:7 52:23 66:2 69:13 81:19,20 83:8 141:1
storm (1) 53:21
storr (2) 115:21 117:9
story (1) 39:21
straight (2) 1:11 20:23
strange (1) 5:14
strategy (2) 51:6 123:3
strengthened (1) 76:5
strengthening (1) 73:15
stress (2) 71:12 155:23
stressed (2) 32:17 68:5
stressing (1) 68:2
strict (1) 27:9
strong (1) 11:13
stronger (1) 128:12
strongly (2) 100:21 141:25
structural (1) 76:10
structure (2) 45:17 51:22
structures (1) 52:1
struggling (2) 68:11 87:18
student (1) 114:16
students (3) 103:15 114:14,15
studies (2) 74:6 75:7
study (1) 48:23
stuff (3) 9:22 120:18,19
stupid (2) 8:10 38:12
stupidity (1) 38:15
sturgeon (1) 135:10
subject (2) 30:5 63:17
subscribe (1) 125:10
subsequent (1) 72:18
subsequently (2) 18:17 27:4
substantial (1) 154:10
substantive (2) 95:8,9
successful (1) 97:3
suddenly (3) 47:8 78:24 109:3
suffered (1) 3:20
suffices (1) 3:11
sufficient (2) 3:3,7
suggest (2) 32:11 73:12
suggesting (5) 112:14 139:19 140:5 150:5,9
suggestion (1) 125:2
suicide (1) 115:2
summarise (1) 118:7
summarised (1) 97:25
summarises (1) 137:23
summary (2) 112:18 138:16
summed (1) 79:9
sunday (3) 10:24 106:3 127:21
superb (1) 25:17
supply (2) 27:19 58:17
support (25) 21:12 29:19 68:25 73:16,18 74:24 75:12,18,23,24 76:2,5,8,21 79:5,11 80:16 81:11 107:3 125:6 126:19 127:16 128:18 136:14 142:23
supported (2) 141:15 152:20
supporter (1) 122:15
supporting (1) 87:11
supportive (1) 76:14
supports (1) 118:19
suppose (10) 19:2 25:1 34:20 40:21 42:10 44:20 50:17 121:9 124:24 141:6
suppress (1) 25:25
sure (14) 1:9 4:10 8:20 11:9 14:11 29:22 36:7 65:12 111:16 130:17 132:5 135:13 150:4 153:19
surely (2) 19:9 116:4
surface (1) 7:21
surgical (1) 16:2
surgicaltype (1) 57:11
surprised (1) 120:11
survey (6) 67:15 99:12 100:7,7,10 155:17
surveyed (2) 67:23 155:19
surveys (4) 94:4 98:13 99:16 100:22
suspect (3) 27:19 84:3 140:13
suspend (1) 138:13
swab (1) 11:15
swim (1) 5:24
swimmer (1) 5:3
swimming (1) 5:2
swine (1) 51:1
swinney (1) 51:17
switched (1) 83:2
sword (1) 119:16
sydney (1) 5:3
symptoms (13) 11:10 13:16 20:7 26:3 31:18,18 48:22,25 49:5,6,10,12 74:7
system (2) 51:11 70:24
systems (2) 48:2 64:24

T

table (1) 143:4
tailor (1) 53:10
tainted (1) 71:25
taken (18) 10:16 20:25 28:4 41:17,25 42:6 47:10 55:14 68:10 80:23 83:11 86:22 88:2 99:25 119:10 121:20 128:3 146:20
takes (1) 140:7
taking (13) 8:9 11:20,23 12:1 19:19 41:24 42:5 65:6 73:20 92:15 121:20 144:15,25
talk (28) 6:9 10:12 21:18 24:10,12 26:6 28:21 30:17 31:21 36:13 37:19 38:16 40:13,22 44:11,16 46:12 47:19 50:17 60:25 61:7 72:12,23 84:22 86:1,23 99:22 135:16
talked (6) 6:16 43:6,7,7,8 44:23
talking (23) 5:17,22 6:12 15:6 17:7 23:12,24 28:20 30:9,12 38:5 39:19 46:14 50:2 55:24 57:13 69:3 89:16 105:25 108:7 129:18 135:18 151:6
talks (1) 147:5
tape (1) 87:24
task (1) 42:19
taste (2) 20:8 48:24
tayside (1) 4:20
teachers (1) 39:6
team (19) 39:15 40:16 41:14,18 83:20,21 86:22 89:8 94:2 95:23 97:12 106:10,12,13 134:19 139:13 141:11 152:24 155:12
teams (3) 67:11 72:20 110:13
tearing (1) 102:11
tears (1) 81:23
telephone (1) 72:12
television (2) 61:19 141:22
telling (4) 52:9,15 92:14 103:15
temperature (6) 19:21,25 20:3,3 47:10 48:22
temperatures (1) 47:11
ten (5) 16:8 33:4,5 66:14 147:18
tenfold (1) 70:10
tenterhooks (1) 72:15
term (6) 2:7 33:8 46:3 52:14 133:13 136:17
termed (1) 130:25
terming (1) 86:1
terms (5) 43:14 44:17 101:25 117:23 156:2
territory (1) 27:16
test (11) 11:6,12,16 20:2,4,6,15 26:4 50:5 156:25 158:5
testing (6) 26:1 31:17 48:18 50:2 123:11 156:10
tests (13) 11:24 13:2 14:2 16:9 20:1,13,20 31:16 48:20 49:11 50:14,16 156:6
text (1) 155:21
textures (1) 10:7
thank (43) 1:4,6,8,16,18 4:9 7:11 14:17 19:16,17 20:18 23:16 29:9 32:23 33:12,18 37:19 39:24 43:2 44:11 49:25 52:8 54:7 63:22 64:19 66:17,22,22 83:20,23,24 84:5,12 110:5 121:22 122:2 126:24 134:25 150:24 155:3 158:14,15,16
thats (17) 37:23 45:17 50:12 57:25 74:19 85:12 90:8 92:6 100:1 106:14,16 119:9 121:4 125:12 133:19 140:21 144:14
themselves (1) 140:2
theories (1) 65:25
theorists (1) 83:4
theory (1) 14:11
therapies (1) 6:5
therapist (3) 5:9 6:2 29:15
thereafter (1) 96:20
therefore (2) 36:19 121:15
theres (10) 47:23 77:21 92:6 94:9 107:20 133:16,16,18 135:16 146:2
theyd (1) 108:10
theyre (3) 55:1 109:5 157:10
theyve (2) 61:2 65:24
thick (1) 134:20
thin (1) 134:20
thing (35) 16:6,16 21:13 26:21 27:4,15 28:2 29:22 30:22 32:9,11,18 33:10 35:10 42:21 45:23 47:7 50:4,8 58:4 60:7,9,14 63:7,16 65:19,22 70:10 113:10 120:3 123:14,19 134:7 135:7 149:20
thinking (10) 15:6 22:24 44:3 49:15 65:13 79:1 108:19 119:9 147:11 151:9
third (1) 122:20
thirdly (1) 87:12
thompsons (1) 85:10
thoroughly (2) 12:4 144:5
though (4) 32:18 140:22 153:19 156:12
thought (16) 2:19 10:19 13:3 19:21 23:9,13 24:13 26:14 27:2 28:25 58:14 68:5 86:15 87:24 94:10 109:11
thoughts (3) 26:12 28:19 39:16
thousands (4) 42:17 118:17 121:5 158:9
threatened (1) 70:19
threats (2) 17:1 70:24
three (16) 1:24 3:15 12:23 20:7 26:3 37:8,15 48:25 49:12 97:11 100:18 111:18 149:11,14 150:15,20
threeway (1) 29:6
throat (1) 11:15
through (45) 2:4 3:10 7:2 11:3,23 18:11 24:14,21,24 25:19 26:11 30:25 34:16 43:19,19 48:18 51:16 53:8 58:16 62:7 65:21 71:4,12,19 74:16 76:5 84:25 89:5 91:7,20 98:6 99:17 101:16 106:1 109:12 110:15 111:13 119:3 132:5 134:20 136:25 144:13 145:17 146:7 154:20
throughout (6) 16:6 25:23 94:1 97:13 113:23 152:21
tick (1) 13:20
tide (1) 111:8
tied (1) 145:4
tier (1) 98:25
ties (1) 157:16
time (87) 5:13,21 7:19 8:11,19 11:23 14:10,21 15:11 16:7,9,17 18:12 20:4,11 21:6,10 24:11 25:8,13 26:2 27:2 28:7,10 29:6,10 32:7 41:3 46:11 48:5 54:24 55:3 63:18 70:16 71:1,13 72:13,15,23 73:5 74:1,5,6,12 75:13 77:17 78:25 79:16 80:4,10 81:17 82:8,15 83:1,4 87:21 91:8,14,21 95:11,16 97:9,10 98:22 102:3 103:22,22 104:1 114:22 116:9 123:10 124:12 127:11 129:24 130:14 133:16 140:7 145:15 150:9,12,19 151:5,24 152:1 155:8 156:2 157:3
timeframe (1) 12:7
timeline (1) 49:21
timepoint (1) 67:15
times (16) 15:9,19 37:8 54:2 56:15 71:17,18 73:13 104:3 115:10,20 117:6 122:4 139:10 148:2,2
timing (1) 81:8
tin (1) 130:9
tired (1) 16:5
title (1) 59:22
today (7) 26:18 86:18 121:20 145:16 155:5 157:7,10
todd (1) 110:17
together (21) 4:22 32:12 37:25 39:1 41:6 51:2 63:11 78:19 81:18 83:22 84:18 88:13,17 91:5,21 92:18,23 93:3 111:9 116:13 118:5
toing (1) 8:21
told (19) 11:13 20:9 21:22,24 22:22 23:21 24:15 28:9 62:9 64:12,13 70:11 81:1 104:6,11 119:25 129:21,24 132:22
tonnes (1) 48:15
too (12) 5:10 6:4 8:9 29:4 40:11 56:5,5 98:9 111:21 118:1 120:17 141:16
took (16) 6:16 8:25 12:3,15 16:1 23:22 24:4 34:23 108:5,17 110:12 111:18 114:22 115:4 123:20 129:2
topic (4) 41:19,20,22 77:25
total (2) 72:5 142:24
totally (4) 29:13 31:8 42:20 149:9
touch (16) 5:16 23:16 40:17 59:13 90:19 91:25 97:25 98:5 100:18 105:3 106:7 111:18 116:1 152:20 155:19 156:6
touched (4) 33:23 54:9 60:11 111:12
tough (1) 71:17
toughest (1) 71:18
towards (4) 40:2 48:4 55:21 75:9
trade (1) 141:14
tragedy (1) 3:24
trained (1) 61:9
training (3) 76:13 79:13 156:11
trajectories (1) 74:9
transcript (3) 2:23,24 127:3
translate (1) 32:14
translated (1) 53:11
transplant (4) 14:25 15:5 22:13,14
trashed (4) 114:2,3 137:15,16
trauma (9) 22:25 69:4 70:21 71:3,7,21 77:12 82:24 110:2
traumatic (8) 40:12 56:13 62:18 67:6 70:9 72:17 78:8 80:7
travel (1) 89:21
treat (2) 115:8 129:22
treated (8) 56:19 83:10,12 136:9 141:2 157:18,19,24
treatment (3) 25:11 60:5 78:12
treatments (2) 6:6 123:5
trek (1) 5:4
tremendous (2) 54:15 55:9
trends (1) 44:6
trial (1) 111:17
tried (3) 24:2 26:17 97:2
trouble (1) 134:1
troubling (1) 76:19
true (4) 77:14 92:6 100:4 148:25
truly (1) 9:3
trust (5) 107:1 125:7,13 156:5,20
trusted (3) 125:11,16 158:1
truth (1) 57:4
try (15) 7:14 8:22,22 21:18 23:4 40:12 80:9 87:25 96:14 99:13,19 121:1 131:9 150:18 151:13
trying (16) 16:25 59:24 71:4,20 72:2 78:19 81:25 87:5 93:1 97:5,16 101:16 106:19 109:9 121:13 148:23
tuc (1) 111:7
tuesday (2) 120:14 158:19
turned (5) 14:14 16:10 50:9 58:4 115:25
turning (1) 14:9
turnout (1) 96:16
tv (1) 5:23
tweet (1) 58:10
type (4) 36:13 80:25 105:10 113:14
types (2) 13:20 111:21

U

uk (18) 2:22 12:23 41:16,25 42:19 47:21,24 49:21 50:3,9 51:9,25 52:2 53:23 56:25 75:14 103:4 118:2
uki (2) 2:23 42:7
ultimate (1) 83:7
ultimately (1) 53:1
unable (4) 81:1,10 127:13 153:14
unannounced (1) 18:14
unconcerned (1) 106:23
underestimate (2) 65:14 118:15
underestimating (1) 107:16
underpinned (1) 131:5
understand (28) 7:4 13:19 32:15 35:19,19 38:14,18 42:20 47:13 54:17 56:1 59:4 63:18 64:16,21 65:20 74:17 126:7,17 132:15,24,24 133:9 134:24 140:13 141:17,17 149:9
understanding (2) 104:24 150:17
understood (6) 35:8 44:14 46:21 59:11 61:16 124:8
undertakers (1) 64:10
unexpected (1) 75:25
unfair (2) 90:11 125:22
unfairness (1) 90:5
unfortunately (2) 5:24 119:8
unhappy (1) 146:15
unified (1) 51:3
unimaginable (1) 71:15
unimportant (1) 157:18
union (1) 141:14
uniquely (1) 73:3
unit (7) 15:14 17:16 21:2,15 22:8 26:22 30:17
universities (1) 67:12
university (1) 58:11
unless (8) 12:17 78:10 92:13 101:2 104:9 132:2 145:9 156:8
unlocked (1) 62:21
unseal (1) 64:1
untested (1) 69:18
until (9) 5:9 9:4 11:22 15:21 59:15 64:10 65:1 158:19,19
unused (1) 156:13
unusual (1) 140:25
update (1) 103:25
updates (3) 60:1 71:8 103:19
upon (4) 33:23 54:9 68:7 82:7
upper (1) 100:2
upset (2) 1:13 107:7
urgent (1) 121:15
used (17) 8:6 47:24 48:5 56:15 79:19 84:19 96:13 102:11,14,14 107:7 109:2,6 116:6 117:20 122:15 128:21
useful (7) 2:19 8:1 17:21,25 37:11 110:8 152:11
using (3) 99:19 116:5 152:17
usually (2) 16:4 132:10
utilise (1) 93:23

V

vaccine (1) 123:5
vaccines (1) 123:17
vaguely (1) 87:21
varied (1) 3:12
variety (1) 93:16
various (7) 43:4 68:4,13 69:7 76:24 84:20 142:6
vary (1) 131:21
vascular (2) 13:10,12
vast (1) 105:6
vectors (1) 149:5
verbal (1) 17:1
version (1) 57:19
versions (1) 112:14
vessels (1) 13:13
via (1) 110:13
vicariously (1) 6:20
video (2) 63:20 156:7
viewed (1) 104:13
viewings (1) 62:21
views (10) 29:7 39:16 60:14 61:25 87:13 112:12 122:12,17 137:23 146:20
violated (1) 142:1
virtually (2) 105:8 106:4
virus (5) 13:9,10 56:21 114:10 123:16
visceral (1) 106:14
vision (4) 4:24 6:6 8:2 10:4
visit (14) 15:18 16:17 18:14,14 19:13 26:18 27:20 54:21 100:17 108:24 116:18 150:1 156:12,16
visiting (25) 14:8 70:8 87:9,20 89:15 91:11,18,19 99:1 100:12,15 104:9,12 105:11,12 125:20,25 126:6 128:15 130:25 131:21 134:13 148:17 151:25 154:14
visitor (5) 16:12,19 92:5 127:15 128:8
visitors (11) 14:16 15:20 17:15 26:14 53:6 104:14 105:25,25 106:2 138:14 156:11
visits (11) 105:3 111:18,18,21 112:10 129:3 154:16,16 156:6,12,14
visual (3) 6:10 7:19 9:23
visually (1) 5:5
vital (1) 139:12
vocal (1) 83:6
voice (5) 10:7 95:12 101:2,14 109:3
voices (2) 100:23 157:21
volunteer (1) 61:4
volunteers (1) 39:15
vulnerability (2) 74:5,8
vulnerable (3) 118:20 132:8 153:23

W

waistline (1) 9:21
waiting (9) 16:8 17:7 30:18 71:8 79:6 123:4,5,5,6
wales (1) 157:5
walk (3) 31:6 114:24 153:17
walked (2) 61:15 115:3
walking (1) 16:20
walks (1) 39:4
wander (1) 54:19
wanderers (1) 54:19
wanting (3) 27:24 121:4 137:1
wants (1) 29:18
ward (9) 11:21 16:10 20:23 21:1,11,12 23:19 24:7,9
wards (3) 17:14 31:14 44:9
warehouse (2) 48:11,12
wary (1) 8:17
wasnt (21) 11:9 12:19,19 18:12 20:19 23:9 45:12 54:22 60:23 63:24 80:13 91:21 93:2 99:1,2,21 101:4,12 107:9 114:4,21
watched (1) 16:15
watching (4) 1:21 85:1 141:22 157:10
water (1) 5:25
wave (3) 21:5,7,7
way (43) 8:14,16 14:12 22:20 28:3 42:11,23 47:9 64:16,18 84:19 86:2 89:12 90:4 92:7 93:20 95:8 97:15 106:18,23 107:16,24 112:23,24 115:7 119:9,14,24 120:7 122:18,19 124:1 132:1 138:3,17 139:14 140:6 141:2 145:21 147:12 151:1 153:18,21
ways (7) 30:6 49:18 51:14 62:14 94:24 120:10 121:9
wear (11) 14:10 15:22 16:7 17:5,6,18 31:11 57:3,25 64:4 96:4
wearing (7) 17:14 31:12 57:18 58:2 63:17 71:24,25
weather (1) 51:22
web (1) 116:9
website (1) 116:14
wed (1) 104:7
wednesday (1) 21:14
wee (6) 7:21 8:24 11:12 23:6 41:9,21
week (8) 50:15 82:13 83:3,3 114:17 117:17 132:22 157:2
weeks (6) 11:8 41:14 98:3 100:9,18 154:2
weird (1) 13:21
welcome (2) 79:12 138:19
welcomed (1) 152:23

welfare (1) 93:12
wellbeing (6) 87:11 110:16,17 142:24 143:6 158:3
went (33) 5:6,19 6:22,25 7:15 8:13 11:3,6,11,18 12:1,11,16 14:21 16:17 17:17 26:16 29:2 37:14 43:19 45:11 48:24 64:21,23 77:20 83:1,4 97:7,11 99:25 114:22 120:3 146:7
werent (14) 20:21 36:20 49:11 50:16 94:13,19 101:22 106:3 120:10 121:4 126:13 137:2 141:23 149:3
weve (15) 23:18 39:5,7 50:10 53:13 54:25 56:20 64:17 65:11,17,22 99:25 119:20 120:1 145:10
whatever (10) 13:25 29:19 63:3 117:4 133:1 134:10 135:6 136:9 148:6 157:24
whatsoever (2) 1:16 47:9
wheelchair (2) 114:23 156:13
whereas (6) 57:25 92:6 94:19 120:1 134:15,16
wherever (2) 105:21 124:6
whilst (2) 138:19 145:12
whim (1) 146:14
whirling (1) 79:3
white (1) 10:22
whole (9) 16:14 20:1 51:11 54:13 62:18 70:10 104:4 146:21 148:7
whom (4) 116:11 124:9 125:10 152:4
whose (3) 56:14 89:11 107:23
wide (3) 38:23 93:16 111:6
widely (1) 83:21
wider (6) 34:13 47:1 55:15 60:12 104:24 152:21
wife (13) 3:24 4:2,16 16:13 91:9 106:14 132:11 134:18 138:2 143:17 150:1,6 152:15
wightman (1) 41:5
wild (1) 5:2
willingness (1) 85:24
window (6) 71:4 91:8 108:24 109:7,8,9
windows (2) 105:7 154:16
wine (1) 8:23
winging (1) 56:10
winter (1) 156:15
wish (6) 4:15 54:7 73:22 86:12,16 158:4
wishes (1) 157:20
withdraw (1) 10:9
withdrawal (1) 79:25
witness (4) 1:4 3:17 33:19 56:25
witnesses (4) 3:19 84:2,13 86:20
wives (4) 91:4,5 139:5 149:4
woman (1) 16:22
womans (1) 16:9
won (2) 110:25 130:18
wonder (6) 33:2 66:13 68:2 86:25 135:20 137:17
wondered (2) 8:18 127:2
wonderful (1) 23:20
wondering (1) 148:22
wont (2) 65:1 78:20
work (26) 5:10,12 6:2 41:22 55:4 67:23 80:14 87:25 99:5,7,8 109:1 110:6,24 116:11,12 119:12 123:4,7,15,16,17,18 124:14 135:12 153:25
worked (8) 5:11 13:24 16:24 28:6 39:15 93:24 116:8,13
worker (1) 103:13
workers (4) 54:24 57:21 70:1 156:23
working (5) 15:2 87:7 99:21 100:25 101:4
works (1) 42:15
world (4) 53:20 60:15 116:10,12
worn (1) 149:10
worried (2) 58:13 78:15
worry (6) 9:18 17:18 24:17 61:9 144:16 155:24
worrying (1) 72:16
worse (6) 4:25 60:23 68:9 72:5,11 78:3
worsened (1) 100:16
worsening (2) 74:10 108:22
worst (7) 70:22 71:14 76:10 149:24,24,24,25
worthy (1) 75:3
wouldnt (15) 9:22,23,24 22:13 25:8 26:4,25 38:16 49:9 56:8 64:16 99:11 134:1 145:7 146:23
wouldve (1) 130:18
write (2) 53:13 93:1
writers (7) 74:3,13 117:24 118:14,23 121:9 122:7
writing (2) 59:10 95:2
written (5) 86:14,25 119:15 123:20,23
wrong (13) 8:14 33:7 38:10 41:3 45:11 61:10 63:13 64:21,23 111:22 120:3 129:5 135:23
wrote (2) 146:6 148:1

X

x (1) 68:10

Y

y (1) 68:10
year (18) 2:23 15:6 49:21 67:16 77:18 94:17,18 103:16 123:10 129:2 130:12 135:6 145:24 153:13 154:1,18,23 157:13
years (9) 4:22 13:16 15:7,13 86:3 91:6 106:1 137:7 149:11
yellow (1) 10:22
yet (10) 15:5 48:25 55:4 77:18 110:25 114:23 121:6 128:2,23 129:10
youd (1) 135:8
young (7) 6:23 24:7 107:18 114:20 154:10,21 158:7
youre (5) 15:6 55:4 70:23 72:10,11
yours (2) 114:4 139:24
yourself (3) 6:21 49:15 126:19
yourselves (4) 52:14 102:1 105:18 106:24
youve (13) 10:23 17:18 43:7 44:25 55:2 57:16,20 64:14 109:3 122:25 147:18,18 149:23

Z

z (1) 68:10
zoe (1) 48:23
zoom (2) 38:5 40:19

0

000119 (1) 137:19

1

1 (6) 51:25 60:17 75:16 142:19 159:2,4
10 (9) 33:11,12 35:22 36:9 49:8 60:20 90:16 93:6 100:11
100 (3) 49:23 114:11 155:24
1000 (3) 1:2 49:20 158:19
1050 (1) 33:13
11 (1) 94:6
111 (1) 54:11
1110 (1) 33:15
12 (6) 14:3,6 88:16 95:15,17 107:14
1207 (1) 66:18
1220 (2) 66:16,20
1245 (1) 83:25
1249 (1) 84:6
13 (1) 75:6
130 (3) 55:22 56:2 110:10
14 (5) 37:16,21 69:8 76:24 95:2
143 (1) 58:21
145 (3) 84:1,5,8
15 (4) 20:10 37:17 38:3 156:19
15000 (1) 107:14
151 (1) 58:23
152 (1) 59:7
15200 (1) 152:3
15th (1) 19:19
16 (4) 58:11 95:18 96:8,19
160 (1) 59:20
165 (1) 155:23
168 (1) 60:24
16th (1) 97:4
172 (1) 62:7
18 (4) 2:23 92:7 96:24 97:19
182 (1) 64:19
183 (2) 65:10,10
19 (1) 146:3
1955 (1) 85:5
1971 (1) 4:18
1977 (1) 85:18
1986 (1) 85:19
1995 (1) 85:13

2

2 (6) 4:24 126:2 142:12 143:20,22 157:1
20 (7) 4:22 7:24 12:5 15:13 49:8 73:24 146:2
200 (4) 40:4 52:20 64:16 84:10
2000 (1) 88:10
2009 (1) 51:1
2011 (1) 51:4
2012 (1) 51:5
2016 (1) 51:16
2018 (1) 51:17
2020 (23) 3:25 4:19 12:11 27:5 46:24 47:23 50:13 58:7 86:25 88:16 89:17 90:11 95:18 96:8 98:18 104:4 111:17 114:14 115:11 127:6,19 135:6 155:18
2021 (9) 18:8,15 34:9 35:15 50:12 110:14 127:24 151:23 157:4
2022 (2) 128:17 142:9
2023 (2) 1:1 158:20
21 (3) 80:19 103:6 135:10
22 (1) 104:16
23 (2) 105:15 142:16
230 (1) 14:21
24 (3) 4:19 10:24 109:16
24th (1) 25:10
25 (5) 2:24 37:6 39:10 75:6 143:19
26 (4) 4:17 39:25 109:22,24
27 (3) 1:1 100:8 110:5
278 (1) 143:22
280 (1) 142:24

3

3 (9) 4:12 19:19 34:6 60:19 78:1 79:12 86:9 100:8 121:21
30 (4) 14:20 60:20 111:14 157:2
301 (1) 121:23
31 (1) 158:20
315 (2) 121:22,25
32 (1) 101:17
322 (1) 155:22
33 (1) 100:15
34 (2) 2:24 113:17
347 (1) 100:11
36 (1) 115:9
37 (4) 127:1,3 135:24,25

4

4 (6) 10:15 25:9 34:8 50:14 68:1 138:11
40 (7) 91:5 128:6 129:7,15 130:6,24 131:16
408 (1) 158:18
40bed (1) 146:1
41 (1) 73:24
42 (1) 19:11
43 (1) 74:17
44 (1) 74:20
45 (1) 41:23
48 (1) 129:4
49 (3) 4:18 42:2 156:1

5

5 (5) 60:19 68:19 75:3 86:23 126:15
50 (3) 24:5 42:4 91:6
500 (1) 82:19
51 (3) 43:2,13,16
52 (1) 43:23
53 (1) 19:13
57 (1) 151:18
58 (1) 26:12
59 (3) 152:10,12 155:25

6

6 (3) 34:17 35:2 88:4
60 (3) 6:23 22:6 67:8
600 (1) 9:6
63 (1) 44:25
65 (1) 3:4
650 (1) 14:22
68 (1) 85:8
69 (1) 30:2

7

7 (1) 100:17
70 (2) 30:2,3
72 (2) 46:14 156:9
73 (2) 47:19,20
74 (1) 47:20
76 (1) 48:16
79 (1) 49:25

8

8 (2) 75:6 88:12
80 (1) 50:17
80s (1) 29:25
81 (1) 50:19
82 (1) 50:21
84 (2) 159:5,7
88 (1) 52:8
89 (1) 52:19

9

9 (5) 7:11 37:3 89:2,14 90:10
90 (1) 120:24
90yearold (1) 92:4
92 (1) 52:22
93 (1) 53:17
94 (2) 53:17 57:17
95 (1) 57:20
97 (1) 142:25
97000 (1) 127:17
99 (1) 142:25
998 (1) 57:24