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Scottish Covid-19 Inquiry

Day 6

November 2, 2023

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1 Thursday, 2 November 2023
2 (10.00 am)
3 THE CHAIR: Good morning, everybody, again.
4 Mr Gale.
5 MR GALE: Thank you, my Lord. Good morning.
6 My Lord, the witnesses this morning are
7 Dr Marsha Scott and Ms Catherine Murphy. They are
8 speaking jointly to a statement that Dr Scott has
9 prepared. The reference is SCI−WT0578−000001.
10 They are giving evidence on behalf of a group of
11 five organisations. As a group, they are called the
12 Scottish Women's Rights Organisations.
13 THE CHAIR: Yes. Very good, thank you.
14 DR MARSHA SCOTT (called)
15 MS CATHERINE MURPHY (called)
16 Questions from MR GALE
17 THE CHAIR: Yes, when you are ready, Mr Gale.
18 MR GALE: Thank you, my Lord.
19 I begin, Dr Scott, with you. Your full name,
20 please.
21 DR SCOTT: Marsha Scott.
22 MR GALE: Can you tell us how old you are. You don't have
23 to tell us your date of birth, but just your age.
24 DR SCOTT: Well, I am not sure what the difference would be,
25 but I am 70. Thank you.

1 MR GALE: Thank you.
2 The Inquiry is aware of an address at which to
3 contact you.
4 DR SCOTT: Mm−hmm.
5 MR GALE: Your position, as I understand it, is that you are
6 the chief executive officer of Scottish Women's Aid.
7 DR SCOTT: Yes.
8 MR GALE: That is one of five organisations you are
9 representing here today.
10 DR SCOTT: Yes.
11 MR GALE: Those other organisations are Close the Gap,
12 Engender, JustRight Scotland, Rape Crisis Scotland and
13 the organisation you are CEO of, Scottish Women's Aid.
14 DR SCOTT: Yes.
15 MR GALE: Ms Murphy, could you give us your full name as
16 well, please.
17 MS MURPHY: Catherine Murphy.
18 MR GALE: Yes. And your age again, please?
19 MS MURPHY: 44.
20 MR GALE: Again, the Inquiry has an address at which contact
21 can be made with you.
22 MS MURPHY: Yes.
23 MR GALE: Can you indicate your role within these
24 organisations.
25 MS MURPHY: Yes, I am the executive director of Engender.

1 MR GALE: Thank you.
2 We will come to discuss in some detail the roles of
3 the various organisations, but just to begin with,
4 I wonder if I can be permitted just to make a few
5 observations, really for your information and, indeed,
6 for my Lord's information.
7 We have already had certain information before
8 the Inquiry, particularly yesterday from a witness from
9 the Alliance, and I think Engender is a partner
10 organisation with Alliance. So there was some evidence
11 of the impact of the pandemic on women, but very
12 general, and we are looking for you to provide more
13 detailed evidence of that.
14 In your statement, which is under the name of
15 Dr Scott, you do refer to the black and ethnic minority
16 women's community, and I think it's right that I do
17 indicate to you that the Inquiry has been contacted
18 through Let's Be Heard by an organisation called Amina.
19 I think you are aware of that. It represents black and
20 ethnic minority women, and we will be obtaining further
21 information from that organisation, and probably
22 a statement from that organisation. So I would like you
23 to know that before we go any further.
24 In addition, as I think I have already told both of
25 you, the Inquiry is obtaining academic research in

1 relation to the impact of the pandemic on women and
2 girls, and that research is under preparation at the
3 moment. I can't give you a date as yet as to when it is
4 going to be produced, but obviously when it is produced,
5 we would like to have your comments on it.
6 Also, and I think probably finally, you have
7 provided us, accompanying your statement, with a number
8 of documents, and we are very grateful to you for those
9 documents because they assist the Inquiry considerably
10 in its work and its research, and the material that you
11 have provided us with will be taken into account fully
12 beyond anything that you may wish to say about it. But
13 it will be taken into account, analysed, and will be
14 input into our final work on the subject.
15 So, with those preliminary remarks, can we turn to
16 your statement.
17 Dr Scott, can I ask you, really, as the writer of
18 the statement and the person in whose name the statement
19 is given, could you go to paragraph 3, because I think
20 we have dealt with the introductory material in 1 and 2.
21 Paragraph 3, you indicate what this statement is
22 addressing, and I think in paragraph 4 you caveat that
23 by saying that this is necessarily a brief statement.
24 Has that presented any particular problems to you in
25 producing the statement?

1 DR SCOTT: I think the problem is the brevity, and we are
2 looking forward to having -- making individual
3 statements that will allow us -- so, for instance, under
4 my organisation, to give some much further detail and
5 nuance about the impact of the pandemic on the women and
6 children that we serve, as well the sister organisations
7 in it.
8 I think our biggest anxiety -- well, I know I speak
9 for Cat -- my biggest anxiety today was not doing
10 justice to the breadth of the issues. We will do our
11 very best to do that and, having said that -- could
12 somebody go and get my papers that you brought me?
13 I managed to leave them in the kerfuffle about my
14 laptop. Thank you. I suddenly realised this was way
15 too clean.
16 So we are going to do our very best to do justice
17 for everybody, but there will be, I know, opportunities
18 for us to do individual statements and we'll nuance
19 what --
20 MR GALE: I think the Inquiry recognises that this is
21 introductory so far as the Inquiry is concerned, and
22 that it is not possible to go into the depth of
23 information that you obviously can give us at this
24 initial stage.
25 But, as you have anticipated, it is, I think,

1 without committing, almost certain that you will be back
2 here at some point in time.
3 DR SCOTT: Can I just add a little something to that, which
4 is that we were delighted to see the input to the UK
5 COVID Inquiry from Claire Wenham about the impact on
6 women and girls and lots of discussion there about
7 structural inequality, and the same kinds of things that
8 we would be talking about across the piece. So I kind
9 of felt that there was another good reference available
10 or resource available for you.
11 MR GALE: That is very helpful because, of course, we are
12 liaising with the UKI --
13 DR SCOTT: Yes.
14 MR GALE: -- and we will be taking into account material
15 that is germane to both us in Scotland and UKI-wide, and
16 we will be looking at that.
17 THE CHAIR: Perhaps I could inject to say a little bit
18 further, and that is that, in a matter like this, it is
19 perfectly possible that your ideas or thoughts might
20 develop over time, and you should be under no fear that
21 anything you say today is cast in stone because, if your
22 ideas and thoughts develop over at least the course of
23 this Inquiry, as I am sure Mr Gale would agree with, you
24 should feel entirely free to come back and tell us and
25 indeed ask to give evidence again if you want to develop

1 or amend your thinking.
2 DR SCOTT: Thank you.
3 MR GALE: Thank you, my Lord, yes. I am in entire agreement
4 with that, and I would be saying to you at the end of
5 your statement and your evidence today that if there is
6 any matter that you suddenly realise you haven't
7 mentioned, you should have mentioned, would like to have
8 mentioned, whether that is tomorrow or two months hence,
9 please get in touch with the Inquiry and tell us about
10 it.
11 Can we go to paragraph 7, please, of your statement.
12 You tell us there about the five separate organisations.
13 They are all, as you say, charitable organisations, and
14 they work to protect the rights of women, children and
15 young people in marginalised groups in society, and
16 promote gender equality. Then you tell us about each
17 group.
18 So can I trouble you to read from paragraph 8
19 onwards so that we can have that available to us.
20 DR SCOTT: Sure.
21 Before I do that, can I just mention that part of
22 the reason that we hope the Inquiry will find what we
23 say powerful is that all of us are national strategic
24 intermediaries, which means that the Scottish Government
25 has recognised our role. So, for instance, we are an

1 umbrella organisation, which I will talk about, but we
2 cover the entire geographic area of Scotland, as does
3 Rape Crisis Scotland and Engender and JustRight Scotland
4 and Close the Gap. So while we are sitting here in the
5 central belt, it is critical that everybody understand
6 that the data that comes into us and our experiences is
7 very much coloured by that.
8 MR GALE: Thank you very much. That's very helpful. Yes.
9 DR SCOTT: Close the Gap is Scotland's expert policy
10 advocacy organisation, working on women's labour market
11 participation. For over 20 years, Close the Gap has
12 been working with policy-makers, unions, employers, and
13 employees, to influence and enable action to address the
14 causes of women's inequality at work and to tackle the
15 gender pay gap.
16 MR GALE: I think, Ms Murphy, you are Engender, so perhaps
17 you can just tell us about your organisation.
18 MS MURPHY: Yes. Let me firstly say that we are also
19 submitting evidence through the Let's Be Heard process,
20 and just in the question about the brevity of the
21 statement, one of the things that we wanted to stress is
22 that we will mention the intersectional dimensions of
23 people's experiences. So we are focused on gender
24 equality, but people have different experience based on
25 their race and ethnicity, their disability, etc, and we

1 try to do justice to that in this statement, but I am
2 really pleased to hear that you are inviting Amina too
3 because we would really encourage you to engage with
4 other groups of women to focus in on their specific and
5 particular experiences. So ——
6 MR GALE: Can I just pause there. Yesterday we had
7 an indication from Sara Redmond of the Alliance on the
8 proper understanding of "intersectional", and I think it
9 is very important that we have that, so thank you very
10 much for that.
11 MS MURPHY: We have that focus, but speaking to specific
12 groups gives you much greater depth of information.
13 MR GALE: Yes.
14 MS MURPHY: So Engender is Scotland's feminist policy and
15 advocacy organisation, working to realise a Scotland
16 where women have political, economic and social equality
17 with men and equal access to resources, rights, safety
18 and decision—making on the same basis. Engender engages
19 Scottish, UK and international policy—makers to ensure
20 that systemic inequality between women and men is
21 visible and understood in policy—making processes, and
22 addressed via equitable, gendered decision—making and
23 resource allocation.
24 MR GALE: Can I put this possibly to both of you, because
25 this is something that comes up later in your statement,

1 and it may be useful just to understand it at this
2 point.
3 Later in your statement, you refer to gender
4 competence. Can you explain what that is, please.
5 DR SCOTT: I am happy to do that. I have written a chapter
6 about it, as a matter of fact, which I am happy to send
7 the Inquiry.
8 Gender competence is essentially embedding the
9 understanding that men's and women's and girls' and
10 boys' lives are different, and that the policy that you
11 make and the services that you design and the resources
12 that you allocate are not gender competent if they don't
13 reflect that reality. It seems like it's very simple
14 but, in fact, you know, our societies are the result of
15 hundreds of years of gender incompetence, so to speak,
16 and the reality for us is that —— and this is a really
17 good opportunity for me to talk about the structural
18 inequality that drives the disproportionate harm that we
19 saw under COVID for women and children —— if in fact the
20 decision—making during COVID and prior to COVID had been
21 gender competent by officials —— and I think it is
22 really important that, at least from our perspective, we
23 are not just talking about the Scottish Government, but
24 we are talking about the court service, we are talking
25 about the police, we are talking about all of Scotland's

1 public institutions —— if they had been gender
2 competent, we would have seen a very different picture
3 during COVID.
4 So in Scotland, the Scottish Government is committed
5 to responding to the National Advisory Council on Women
6 and Girls' requests to embed gender mainstreaming and to
7 support the implementation of training such that gender
8 competence is a feature of the policy—making and the
9 Parliamentary work that we do in Scotland. We are far
10 from there, however.
11 MR GALE: Obviously you are going to give us examples and
12 explanations of where there has been a failure of gender
13 competence in the way in which the pandemic was dealt
14 with as regards the interests of women and girls. It
15 may seem a rather mundane question, but do you consider,
16 as a contrary position, that there was gender
17 incompetence?
18 DR SCOTT: Absolutely.
19 MR GALE: Okay. Thank you.
20 Can we go on to paragraph 10, please, JustRight
21 Scotland, whoever wants to deal with that.
22 MS MURPHY: Yes. JustRight Scotland was established by
23 an experienced group of human rights lawyers. It uses
24 the law to defend and extend people's rights, working
25 collaboratively with non—lawyers across Scotland towards

1 the shared aims of increasing access to justice and
2 reducing inequality. JustRight Scotland provides direct
3 legal advice to people who would otherwise struggle to
4 access justice, and it operates the Scottish Women's
5 Rights Centre in collaboration with Rape Crisis Scotland
6 and the University of Strathclyde Law Clinic. It
7 provides free legal information, advice and
8 representation to women affected by abuse and violence
9 in Scotland. Informed by its direct work with
10 victim/survivors of gender—based violence, JustRight
11 Scotland seeks to influence national policy, research
12 and training to improve processes and systems, and
13 improve the outcomes for women who have experienced
14 gender—based violence.
15 MR GALE: Thank you.
16 Rape Crisis Scotland, I think probably
17 an organisation we have heard quite a lot about, so
18 perhaps you could just tell us about that.
19 DR SCOTT: Sure. Rape Crisis Scotland is the leading
20 organisation in Scotland working to end sexual violence
21 by influencing justice reform and gender inequality,
22 delivering prevention work to young people in schools
23 and higher education settings and running a helpline.
24 Rape Crisis Scotland works to raise awareness of the
25 prevalence and impact of rape, sexual assault and abuse;

1 advocates for better health, justice and community
2 responses; and works to make sure that survivors can
3 access specialist support. It has 17 member centres
4 that provide life-saving support and advocacy services
5 to survivors of sexual violence, and it co-ordinates the
6 National Advocacy Project, which delivers advocacy
7 services to survivors across Scotland.
8 MR GALE: Thank you.
9 Then, Dr Scott, your organisation, Scottish Women's
10 Aid.
11 DR SCOTT: Scottish Women's Aid is the leading third sector
12 organisation -- I can't believe I'm reading this -- in
13 Scotland working to end domestic abuse and promote
14 effective policy and practice responses for women,
15 children and young people who experience domestic abuse.
16 We are the national umbrella organisation for 34
17 autonomous grassroots services that deliver direct
18 support and advocacy to women, children and young people
19 across Scotland. Our members are local women's aid
20 groups that provide specialist services, including
21 refuge accommodation, information and support to women,
22 children and young people. We operate Scotland's
23 Domestic Abuse and Forced Marriage Helpline, which is
24 a 24-hour, 365-day service.
25 MR GALE: Dr Scott, something that occurred to me -- and

1 I think you are going to develop this as you go on in
2 your evidence, but perhaps useful just to touch on it
3 here -- how on earth did Scottish Women's Aid,
4 particularly through the use of refuges, operate during
5 the pandemic?
6 DR SCOTT: Well, we will definitely talk about that when we
7 get to housing and homelessness. But it was a very
8 significant challenge, and I would be really remiss if
9 I didn't sort of note here the above and beyond efforts
10 of the staff across Scotland.
11 I think it is worth noting also that two of our
12 services are BME specialist services, so some of what
13 I will say is very much informed by Hemat Gryffe in
14 Glasgow and Shakti in Edinburgh.
15 What happened in terms of housing and accommodation
16 was that it was a perfect storm, really. The response
17 to COVID and the safety precautions that had to be made
18 meant that all of our communal refuges, which is the
19 majority of refuges in Scotland, had to be reduced to
20 one family -- for the most part, I should say, not
21 all -- which absolutely very much constricted capacity,
22 and at the same time, local authority housing
23 allocations processes were for the most part frozen or
24 operating at a snail's pace.
25 Now, the way refuge generally works is that women

1 come to us from a variety of sources, usually in
2 an emergency situation or often in one, and they stay
3 for a certain period of time, but then they get rehoused
4 through the local authority or some other mechanism, but
5 mostly through local authority housing. When that
6 allocations process is frozen, there is no back door,
7 and so our refuges were full almost immediately. And
8 then -- so we spent enormous swathes of time during the
9 pandemic in which there was no emergency accommodation
10 for women experiencing domestic abuse.
11 MR GALE: Thank you.
12 Right, can we move on to the overview of impact of
13 the pandemic on women and children in Scotland.
14 Again -- Ms Murphy, you want to add --
15 MS MURPHY: Yes, could I just add something about our group
16 of organisations, in terms of how they operated
17 throughout the pandemic.
18 MR GALE: Yes.
19 MS MURPHY: So from our point of view, we engaged directly
20 with government as much as we possibly could. We tried
21 to undertake research to feed in in real time to
22 Scottish Government decision-making and through the
23 Parliamentary processes, etc, trying to get amendments
24 made to legislation, for example, emergency legislation
25 that was going through.

1 But also just to make one point that our partner
2 organisations were keen for us to make, was that even
3 though they were providing legal advice and direct
4 services to women who have experienced, for example,
5 rape and sexual violence, their workers often weren't
6 recognised as key workers and couldn't get access to
7 childcare facilities, etc.
8 So there was an element where a lot of the work that
9 was being done by the organisations we represent, and
10 particularly those providing direct services, were
11 providing vital, key services, but weren't recognised as
12 such, and it goes back to that point of view of gendered
13 decision-making. We weren't recognised because there
14 wasn't the gender competence to recognise that we would
15 be essential.
16 MR GALE: Please don't think I was excluding you from that
17 earlier question. It was just really as a matter of
18 pure practicality I was interested in women's aid, but
19 I am aware of what you go on to say in relation to
20 the input of your organisations into policy
21 decision-making, so I am aware of that. Thank you.
22 Right, can we go back to the overview of
23 the impacts, please, and whomever would like to read
24 that section, and we will pause at various points just
25 to obtain some clarity about various matters.

1 MS MURPHY: Sure.
2 Although each organisation is separate, there is
3 a shared recognition of the disproportionate impact that
4 the pandemic and lockdown measures had on women,
5 children and young people generally, but particularly in
6 relation to those experiencing domestic abuse. COVID-19
7 has exacerbated existing inequalities, and made the most
8 vulnerable and under-reached communities more vulnerable
9 and isolated.
10 In looking across all policy areas, including
11 justice, health, employment, education, children and
12 families and housing and homelessness, a key concern of
13 our organisations has been the cumulative impact of the
14 increased risk of harm to women and children.
15 MR GALE: Can you just explain what you mean by the
16 "cumulative impact"? I think we can probably guess at
17 it, but you have the knowledge, so can you tell us.
18 MS MURPHY: Yes. I think there is -- first of all, just
19 contextually, we were coming into the COVID crisis on
20 the back of a decade of austerity measures, where
21 services had been cut, there had been cuts to social
22 security. Women are more likely to access public
23 services, so the cuts that were made to public services
24 in that period had had a very disproportionate impact on
25 women. So women, and particularly marginalised women,

1 were already in a vulnerable position as we entered the
2 COVID crisis.
3 And throughout the COVID crisis, I would say the
4 cumulative impact speaks to lots of individual decisions
5 where there was not the appropriate gendered competence
6 and expertise fed into those decisions, and those
7 decisions, in the simplest term, chipped away more and
8 more at women's stability, their financial situation,
9 their safety, and it has had a considerable cumulative
10 effect across a very wide range of policy areas.
11 MR GALE: Thank you. That is very helpful.
12 Going on to the impacts on the physical and mental
13 health of women.
14 MS MURPHY: Yes.
15 So the full gendered nature of the health impacts of
16 the COVID-19 pandemic are still unknown. Although women
17 are more likely than men to seek out medical advice,
18 this is not reflected in their health outcomes. Women
19 are almost twice as likely as men to report that their
20 mental health worsened due to the pandemic.
21 Uncertainty, fear and long periods of isolation
22 compounded existing pressures linked to unequal gender
23 roles and norms, including the disproportionate burden
24 of caring responsibilities carried by women, leading to
25 increased experience of anxiety, stress and depression.

1 It is likely that women experiencing existing
2 marginalisation due to socio-economic exclusion or
3 intersecting discrimination have been particularly
4 impacted. Our organisations witnessed directly
5 a heightening of mental health problems and
6 psychological distress, particularly for
7 victim/survivors of domestic abuse or gender-based
8 violence.
9 MR GALE: I don't want to go into numbers, but are you able
10 to say the level of the increase in the reporting of
11 mental health problems? Was it appreciable? If you can
12 give a general indication rather than -- well, how you
13 would put it.
14 MS MURPHY: I think a general indication would be, in real
15 time, the organisations among us who are service
16 providers were reporting consistent acknowledgement and
17 people coming back to them in the delivery of services
18 reporting that their mental health was deteriorating,
19 that they were under extreme pressure for a variety of
20 reasons, some related to just the excessive pressure of
21 trying to deliver home schooling, childcare and possibly
22 doing work at the same time, not being given enough
23 support, not -- being made redundant, and then also if
24 you add in the additional dimensions for people who were
25 living with abusers, for example, you can imagine the

1 level of pressure people would be under. So our
2 services were witnessing that.
3 But I would also say as well that subsequently all
4 of the research that we were doing at the time, whether
5 that is on people's experiences of maternity services,
6 whether that was the experiences of carers, who were
7 a group that were under excessive amounts of pressure,
8 the issues around mental health and people's
9 desperation, people's anxiety and people just not seeing
10 how they could go through the next months, weeks, under
11 the level of pressure they were under, we were seeing
12 that coming out consistently. Regardless of the
13 research we were doing, that was a very strong message
14 that came through in everything we did in the pandemic.
15 And also, I should say, subsequently; it continues to
16 come through.
17 MR GALE: Right. You are perhaps wearing your Engender hat
18 in giving this piece of information. You are talking
19 about research. What research was going on, either
20 through your organisations particularly or for women's
21 organisations generally, about the impact?
22 MS MURPHY: So we were doing research on a wide range of
23 different areas. We were engaging with women through
24 our website, through our social media, asking people to
25 tell us about their experiences in real time. We were

1 doing research on, as you know, maternity services, the
2 experiences of carers.
3 We also conducted, with women's organisations across
4 the UK, a survey in May 2001, and that has quite
5 a strong focus on mental health. Two-thirds of women
6 that responded said that staying positive day to day had
7 become harder since the last lockdown. That was
8 significantly higher than men, which was 36%. Women
9 were almost twice as likely as men to report that their
10 mental health had got worse since the start of the
11 pandemic, and women in lower income households were more
12 affected.
13 So we were trying to capture data like this as we
14 went through the pandemic and on a wide range of issues.
15 I don't know from the service providers' side if you
16 were doing similar research.
17 DR SCOTT: I guess there are two things that pop to the top
18 of my mind, although there were multiple pieces of
19 research done, quite a bit of qualitative research
20 funded by the Scottish Government around the experiences
21 of children and women in the context of the pandemic,
22 and domestic abuse.
23 But I know that Amina, for instance, did a -- some
24 significant survey work with black and minority ethnic
25 women, and we certainly did surveys across our service

1 network, resulting in a report which I think we have
2 appended to this.
3 MR GALE: Yes.
4 DR SCOTT: I think the other thing to point out -- and this
5 is where gender really makes such a difference -- is
6 that the vast majority of people who work for our
7 organisations are women, and all of the women in -- all
8 of the staff in Rape Crisis and in Scottish Women's Aid
9 who are providing coalface services were women. So they
10 were not only experiencing the stresses of trying to
11 support people who they cared deeply about -- I remember
12 a discussion with a children's worker who was talking
13 about children who she saw regularly in school, and when
14 they shut the schools -- and in her district, children
15 experiencing domestic abuse were never recognised as
16 vulnerable, so they weren't even considered for being
17 allocated to hub schools -- that suddenly -- and also
18 children living with their abuser had absolutely no
19 access to the support that they had been getting on
20 a weekly or bi-weekly basis. The worry and the fear for
21 her was that that child was going to wind up dead. So
22 I think it is really important -- plus, on top of all of
23 that, she had children at home, she had -- you know, all
24 of the things that Cat described.
25 So it would be an absolute miracle if mental health

1 and stress and anxiety didn't suffer under those
2 circumstances, and they were, many of them, easily
3 avoidable if people had thought about the gendered
4 consequences of their decisions. So, for instance, what
5 Cat was talking about in terms of decisions about who
6 would be a key worker. If anybody had -- you know,
7 domestic abuse and sexual assault is not a niche
8 problem; it affects somewhere between 1 in 3 and 1 in 4
9 women in Scotland, and 1 in 5 children live with
10 domestic abuse. So there is no excuse for not
11 considering the impact on those populations when you
12 were closing the schools, when you were establishing who
13 were key workers, when you were thinking about housing
14 allocations, all of those things.
15 MR GALE: Ms Murphy, I think you want to come in there as
16 well.
17 MS MURPHY: Just very, very quickly. Just to say that there
18 was work done by One Parent Families Scotland. I mean,
19 92% of single parents in Scotland are women, and that
20 was a group of people who were under particular stress.
21 Carers Scotland as well, I draw the Inquiry's
22 attention to work that was done by Carers Scotland,
23 which found that 72% of carers reported that their
24 mental health had deteriorated since the start of
25 pandemic.

1 So all of -- lots and lots of kind of charitable
2 organisations were trying to engage with our
3 constituencies to find out what was happening, and we
4 were getting that feedback very strongly: that people's
5 mental health, particularly those that were under a lot
6 of pressure, was really under kind of strain.
7 MR GALE: Can I ask you this: was this -- particularly the
8 stress, the anxiety, the mental health impact --
9 something that became apparent very early in the course
10 of the pandemic so far as the impact on women was
11 concerned?
12 MS MURPHY: I would say yes. I would say -- and I think as
13 well that -- the point as well is I think that, going
14 back to again our earlier point about gender competence,
15 it was -- it could have been entirely anticipated, and
16 I think that the -- and this is not Scotland-specific,
17 it's globally, but there was an in-built assumption in
18 the decisions that were made that the responsibilities
19 of the state could by and large just be offloaded to
20 women with regards to childcare, etc, and we could have
21 anticipated very easily that that was going to create
22 enormous stress for the vast majority of women.
23 MR GALE: I don't want to become legal about this, but in
24 law we are very familiar with the concept of what we
25 call "reasonable foreseeability". Now, without defining

1 that for you, because I am not entirely sure I can, just
2 applying what I think would be just a general
3 understanding of that, at the start of the pandemic, do
4 you think the potentially adverse impacts on women that
5 you have been describing could have been reasonably
6 foreseen by decision-makers?
7 DR SCOTT: I think it is what we were saying about gender
8 competence. Reasonably foreseen, absolutely, if there
9 had been gender competence in the decision-making and in
10 the institutions that were making decisions. It
11 actually -- as I said, it doesn't take much to step back
12 and say: well, how will this impact different
13 populations in Scotland? And this is what we were
14 talking about in terms of when you look about what you
15 were calling gender incompetence: it operates with
16 a male default. So it assumes that the programmes and
17 the services and the policies that are being designed,
18 which are designed with the male model in mind -- good,
19 bad and indifferent -- is appropriate for the rest of
20 the population -- can I say: for the majority of the
21 population. But a failure to understand that male
22 default gaze is built into decision making means that
23 you make decisions that are deeply incompetent and
24 harmful.
25 MR GALE: I think one of the points you make later in your

1 statement is the message of: stay safe at home.
2 DR SCOTT: I'm sorry?
3 MR GALE: You make the point later in your statement that
4 the message coming from government was: stay safe at
5 home.
6 DR SCOTT: Urgh. Yes.
7 MR GALE: As we would say in legal circles: for the benefit
8 of the notes, you shrugged at that.
9 DR SCOTT: Oh, I know. I mean, to be fair to certain
10 officials in the Scottish Government, when we raised it,
11 they were quick to understand the mistake, and
12 Police Scotland also, but the damage had really pretty
13 much been done in the sense that the messages were
14 really clear and loud out there that restrictions on
15 movement were going to be -- trump pretty much
16 everything else in people's daily lives. And obviously
17 for those living with domestic abuse, especially now
18 because their abuser was home all day too, that just was
19 an extraordinarily insensitive message.
20 I have to say when we went to Police Scotland with
21 it, they were like, "Absolutely, domestic abuse is one
22 of our highest priorities, we won't change our response
23 to domestic abuse". But that message essentially was
24 that the status quo was in place, and instead of saying
25 very directly: "If you are experiencing domestic abuse,

1 don't stay -- you are not safe -- and you are not safe
2 at home, these are the things you could do".
3 MR GALE: Ms Murphy, you want to chip in there.
4 MS MURPHY: Just very briefly, I think the other context
5 which I reference just quickly is that there was a huge
6 amount of learning that had been gathered in recent
7 history. So following on from the 2008 financial
8 crisis, we had saw the impact that that had had on
9 women's quality of life, their financial situation. We
10 had evidence and learning from that crisis. We also had
11 been through a decade of austerity. There was research,
12 there was a lot of kind of data that had been gathered.
13 So just to give you one example, Women's Budget Group
14 had found that the vast majority of cuts that were made
15 to public services and to social security came directly
16 out of women's incomes. So we knew the vulnerability
17 that existed with women going into the crisis.
18 I would say as well that within Scottish Government,
19 the people who were there to be gender or equality
20 experts did an absolutely sterling, fantastic job. The
21 issue is that there are not enough of them, and the
22 generalised knowledge is not where it needs to be. The
23 generalised competence is not where it needs to be.
24 Just finally, I would say the Scottish Government
25 were very quick to react and did reasonably well,

1 I think you would say, with regards to violence against
2 women. But the broader issues of women's financial
3 situation, women's health, etc, that wasn't responded to
4 in the same way or to the same extent.
5 MR GALE: Thank you.
6 At paragraph 16 of your statement, you give two
7 quotations. I know where they are from because I have
8 seen them in the documents you provided for us. These
9 are two statements; one is October 2020 -- well,
10 in fact, they are both October 2020, and one
11 is January 2021.
12 I think it is interesting if somebody would just
13 read those statements.
14 MS MURPHY: "Attempting to home-school children, whilst
15 working from home, alone most of the time as my partner
16 was working in a hospital, was one of the most stressful
17 situations I have encountered. I felt like a failure as
18 a parent and an employee. Constantly on edge, anxious,
19 losing my tempter with the children. No contact or
20 support from school, family shielding, I felt completely
21 alone, isolated and close to breaking point a lot of the
22 time."
23 Mum of two, January 2021:
24 "... I feel like I'm failing in every area of my
25 life right now. I'm failing as a mother, as

1 a professional woman, as a team mate, as a daughter.
2 I wake everything morning with a fear for what the day
3 may hold. My sleep is broken and I have nightmares most
4 nights. The weekends bring no joy. It is relentless
5 and I am exhausted."
6 MR GALE: And the final one.
7 MS MURPHY: The final one. Anonymous, October 2020:
8 "I had covid way back in March and I am still not
9 fully recovered, my lung capacity is greatly decreased,
10 I now have chronic fatigue and I am unable to
11 concentrate on anything. I was made redundant from both
12 of my jobs ... I have attempted suicide twice since
13 lockdown began and have not been given any meaningful
14 help from my local mental health team. I am struggling
15 to hold on."
16 MR GALE: Do these represent a broad range of the
17 information that you were getting, or your organisations
18 were getting, at the time?
19 DR SCOTT: I think they are the tip of the iceberg, and
20 I think when we are talking about intersectionality, it
21 is a good reminder for us about the fact that, you know,
22 women are 52% of the population and the levels of their
23 resilience are very much affected by race, ethnicity,
24 whether they are exposed to violence, etc.
25 I was just thinking about the question about whether

1 we noticed these impacts early in the pandemic. I think
2 we saw them early, in the middle and we are still seeing
3 them now, and it's really -- I remember the helpline
4 responses. So we had a 70% increase in calls to the
5 helpline for the same period shortly after the beginning
6 of the pandemic, but what we didn't have was an increase
7 in the first couple of weeks after lockdown. And when
8 people ask me about that, because there have been
9 reports from down south that were not our experience,
10 nor the other helplines in the UK, that domestic abuse
11 was going through the roof, and our helpline did not
12 have a significant increase, and our response to that
13 was: that's because women are out trying to find loo
14 paper and, you know -- toilet paper and figure out how
15 to home school their children and, you know, the sort of
16 Maslow's hierarchy of meeting the needs of their
17 families.
18 And then as time went on, they began to explore what
19 their options were and how -- what choices they had in
20 the face of domestic abuse. Their choices are so
21 constrained. If you think about their space for action
22 for people who experience all of their human rights most
23 of the time, women just start here, because there are no
24 women in that. But women experiencing domestic abuse
25 are here and children are here.

1 So they began to explore. And the majority of the
2 increase in calls that came after that period were
3 asking for information about: could they leave? There
4 was a women who wanted to take her children and go see
5 her mother in England, but she was worried that the
6 British Transport Police would arrest her and send her
7 back home. I mean, you know, all of these things about
8 just trying to find space for action.
9 And it carried through from the beginning, through
10 the middle and, you know, the sequelae at the moment in
11 terms of staff in our organisations is they're just
12 really suffering, and I don't know how long recovery is
13 going to take.
14 MR GALE: Thank you.
15 Can we go to paragraph 17, please, where you talk
16 about gendered issues regarding healthcare. Perhaps,
17 again, somebody could just tell us about those.
18 MS MURPHY: Would you like me to read them?
19 MR GALE: Yes, please.
20 MS MURPHY: Yes. So gendered issues regarding healthcare
21 included negative impacts on access to perinatal,
22 maternity, fertility and sexual health services, the
23 suspension of breast and cervical screening programmes
24 and inconsistent advice and support for pregnant women
25 around the risks of COVID-19 for mother and child.

1 Pregnant women were unable to have someone with them at
2 healthcare appointments, and lockdown restrictions
3 impacted access to maternity wards for partners, which
4 in some instances meant enduring traumatic experiences
5 alone, for example miscarriage.
6 MR GALE: Just pausing there. Inconsistent advice and
7 support for pregnant women; how significant was that in
8 the experience that you have gleaned from your members,
9 those who you advise?
10 MS MURPHY: I think -- and this refers to the research that
11 we submitted that you are aware of.
12 MR GALE: Yes.
13 MS MURPHY: I think in terms of the inconsistency in
14 information, that was across quite a wide range of
15 things and evolved as the pandemic went on. That
16 related to the initial stages, where women weren't sure
17 about their levels of risk, shielding, etc, and were
18 possibly being given at times inconsistent, shifting
19 information and struggled to find the information
20 sometimes.
21 Then it also related as well to vaccination. So we
22 had -- in that research, we got a lot of feedback from
23 women telling us that they got very conflicting accounts
24 of vaccination. So we had examples of women who had
25 a good experience and got the information they needed

1 and had great experience with healthcare workers. We
2 had other women who had educated themselves through the
3 internet. One woman told us that she had used social
4 media to find an academic and read all of their
5 research, but then when she went to access services, the
6 healthcare worker that was delivering her vaccination
7 was kind of congratulating her for being brave, but
8 saying she wouldn't necessarily have made that decision.
9 So women were reporting very inconsistent information on
10 vaccination from the healthcare workers they directly
11 engaged with. But I do want to stress, many had good
12 experiences, but there were a critical mass that didn't.
13 So the lack of information went across a range of
14 areas, and then also in terms of whether partners could
15 access services with them, come to appointments, etc,
16 that varied, the information chopped and changed, and at
17 times it felt very arbitrary at different stages in the
18 pandemic whether women would have that support or not,
19 and it seemed to be down to individual decision-making
20 at some stages within the pandemic.
21 MR GALE: Individual decision-making by whom?
22 MS MURPHY: It would be hard to tell, but I would assume
23 either the decision-makers in those services or within
24 the health board areas, for example. I think probably
25 the earlier stages in the pandemic, it was more national

1 decision-making, but as things started to open up a bit
2 more, there was more likely to be inconsistencies
3 geographically in terms of whether women, in
4 a particular week or month, for example, could bring
5 their partner along to an appointment.
6 MR GALE: Thank you.
7 You mention in paragraph 18 a number of advances in
8 abortion care, and you also mention reproductive health
9 needs. Again, you say in relation to abortion rights
10 campaigners, they have for many years advocated a safe
11 telemedical service. Can you just tell us what that
12 was, please.
13 MS MURPHY: Yes. So very early on in the pandemic, the
14 Scottish Government introduced telemedical support for
15 abortion and medical abortion, which is medication pills
16 that can be taken at home to induce abortion. That was
17 something -- I believe, if I remember correctly, that
18 there was a bit of a U-turn by UK Government, because
19 obviously Scottish Government is to a certain degree
20 bound by UK decision-making around the Abortion Act, and
21 there was a U-turn by UK Government and there was the
22 provision of these services in Scotland, and these have
23 been services that have been available for some time,
24 they have been services that we have advocated for
25 a very long time, and it's quite sad that it took

1 a pandemic for us to get them, but we were very grateful
2 that they were introduced because they made
3 a potentially catastrophic situation with regards to
4 unplanned or unwanted pregnancies more tolerable for
5 women in Scotland.
6 DR SCOTT: Can I just add something?
7 MR GALE: Yes, certainly, Dr Scott.
8 DR SCOTT: I think this is one of the areas where geography
9 really needs to be paid attention to, geography and
10 decisions that were inconsistent across health boards.
11 So we know that some health boards, for instance, were
12 quite quick to provide access to telemedicine, and
13 others were still for quite a long time requiring women
14 to travel to their doctors or to a hospital to pick up
15 their medication. Now, when you live in a very rural
16 area in the north of Scotland, what we heard were
17 stories about women who were -- had picked up their
18 medication and -- no, they had to go to the local
19 hospital or practice to get -- to take the medication in
20 front of a doctor, and then because of the long distance
21 involved in travelling back to home, the medicine had
22 already started to work, so they started to go through
23 a medically-induced abortion in the car. And they knew
24 that, and they had no -- this is what I am talking
25 about: constrained choices. They had no other options.

1 And the officials making those decisions really would
2 have known that that was the case also.
3 MR GALE: Just in paragraph 19, you mention there was a 19%
4 increase in the abortion rate in Scotland in 2022. Is
5 that in any way relevant to what we are talking about
6 today?
7 MS MURPHY: Yes, I think absolutely, I think it is very
8 relevant. And just to add to that as well, there was
9 a particularly sharp rise of 25% among young women aged
10 16 to 19 accessing abortion in that period, and that was
11 following a 14-year fall in that age group accessing
12 abortion, so something has happened of significance. We
13 would -- one of the things that we would like is more
14 research and learning to be done in that area to see
15 exactly what were the drivers.
16 We would suggest and anticipate that the drivers
17 partly were economic -- socio-economic within the
18 pandemic and the subsequent cost of living crisis, that
19 many women lost their jobs or were furloughed and
20 earning reduced wages, were under an enormous amount
21 of pressure; that some women who -- for example,
22 disabled women might have been under particular pressure
23 because of the fear and anxiety and the unknown that
24 existed around COVID-19; and then also, for young women,
25 there was a lack of and inconsistencies in sexual and

1 relationships education that is delivered through school
2 because the education system was so disrupted. So we
3 would hazard -- our best guess, based on years of
4 working on this issue, we would imagine that they were
5 key drivers into that increase, but there certainly
6 needs to be more learning about that and more research,
7 I think.
8 MR GALE: I suppose at this stage you can make an informed
9 and intelligent guess --
10 MS MURPHY: Yes.
11 MR GALE: -- as to if there was a causal connection between
12 various aspects of the COVID pandemic and the
13 restrictions and the limitations imposed and that
14 increase in abortion rate.
15 MS MURPHY: Yes. One thing that is also relevant to that is
16 inconsistencies in being able to access contraception.
17 Yes.
18 DR SCOTT: I would just like to add to that that we know
19 that domestic abusers are likely to use women's sexual
20 health as a very powerful tool, so both restricting
21 access to contraception or insisting on abortion when it
22 was against the woman's choice. So the fact is that
23 women can often have a bit more control over the
24 questions of their fertility , and often -- although
25 often have to engage in coerced sex because of the abuse

1 they are experiencing -- really high rates of that --
2 the reality is that in the pandemic, because women were
3 getting such mixed messages about whether they were
4 allowed to leave, how they were going to access, both in
5 terms of finance but in terms of restricted access to
6 health services, getting contraception will have been
7 much more difficult.
8 MR GALE: You provide a quotation, again from an anonymous
9 source, from September 2020, and this is from somebody
10 who was pregnant. Could you just read that out, please.
11 MS MURPHY: Sure:
12 "Being pregnant and re-entering lockdown situations
13 is awful. I relapsed into my eating disorder ... I have
14 some cpn [community psychiatric nurse] support from the
15 west of Scotland perinatal mental health service but
16 they can't offer me as much because of face to face
17 restrictions . [My] husband has been able to attend
18 scans but not emergency appointments or routine ones.
19 What will happen at birth is a mystery and women are
20 being stripped of choice - little to no option for home
21 or water births, births that are highly medical and full
22 of interventions, rushed to when giving birth then
23 rushed out the door. I have very little trust my birth
24 will be a positive experience ... All in, I'm an anxious
25 mess. My [eating disorder] is back, my [borderline

1 personality disorder] symptoms are heightened despite
2 two years of no symptoms at all, and I feel a distinct
3 pressure to comply as a good girl and not push for the
4 birth experience I want to protect my own body and
5 mind."
6 MR GALE: Right, now we turn to health and social care
7 workers. Obviously this is an area in which women are
8 disproportionately involved.
9 So could you read on in paragraph 20, please.
10 MS MURPHY: Yes. Women represent a significant proportion
11 of front-line workers in the health and social care
12 sector. During the pandemic, about 80% of health and
13 social care workers were women. They put their lives
14 and their health at risk to look after patients during
15 the pandemic, while being undervalued, underpaid and
16 under-protected. There was a lack of appropriately
17 sized and fitted personal protective equipment -- PPE --
18 for women, meaning they were at increased risk of
19 contracting the virus during the course of their work.
20 They were also exposed to unprecedented levels of death
21 and grief, impacting their mental well-being. Staff
22 shortages, the inability to attract new staff,
23 unprecedented levels of stress and pressure, fears of
24 passing the virus to patients, colleagues or family
25 members and a lack of recognition for social care staff

1 compared to the NHS workforce have negatively impacted
2 mental health and morale within both the health and
3 social care sectors.
4 MR GALE: Carry on, if you would. If you would carry on
5 reading all of paragraph 21, including the quote.
6 MS MURPHY: Of course.
7 Workers in the care sector have faced an increased
8 burden of risk. Information from National Records
9 Scotland indicate that the death rate from COVID-19 for
10 social care staff was higher than average for all
11 occupations in Scotland: 14.4 per 100,000 for social
12 care workers, compared to 10.3 per 100,000 for all
13 occupations.
14 Mother of two, March 2021:
15 "I was a keyworker when the pandemic hit and with 2
16 school age girls at home. I was filled with fear and
17 dread about how I could manage my work and my family.
18 My husband's job is also so busy that I knew he couldn't
19 take the brunt of things at home. I lost 4 of my
20 clients within 2 months at the start and there were so
21 many others I was worried about. I was part of a busy
22 assessment team and the decisions we were being asked to
23 make scared me. My job role also entailed speaking
24 about a lot of difficult situations in relation to
25 domestic abuse, mental health, severe sickness and

1 illness , and the things I spoke about in my day job just
2 couldn't be spoken about at home with 2 young
3 impressionable girls in the house at the same time.
4 I had absolutely nothing left to give them, and my
5 boss's response was that he wanted me in the office more
6 and out doing visits more, even though we had no PPE and
7 there was nowhere for my girls to go."
8 MR GALE: One point you raise —— and it may seem slightly
9 insignificant , although it probably isn't —— you mention
10 in paragraph 20 about inappropriately sized and fitted
11 PPE. This is something the Inquiry has heard a little
12 about in the investigative work that we have been
13 carrying out. Can you explain how that came —— well,
14 not how it came about, but how it manifested itself.
15 MS MURPHY: I think just at the outset, I would say, going
16 back to one of the earlier points Marsha made, is that
17 all of our structures unfortunately in society for the
18 large part, the default is a man of a certain age who is
19 more often white, does not have a disability , etc, and
20 what that means is that so much of our society is
21 designed with that person in mind. So PPE was designed
22 in large part and the PPE that was accessed in large
23 part was designed to fit men and therefore was oversized
24 for most women, and therefore compromised their safety.
25 The Royal College of Nursing raised concerns about

1 this , and much of the information that we have gathered
2 has been via these sources that were working in those
3 sectors , and particularly for social care workers, they
4 had less access and struggled more to access even
5 ill -fitting PPE. So that was kind of —— then there is
6 also —— the TUC has done some work as well saying for
7 black and minority ethnic social care workers, they
8 struggled to get access to PPE even more so.
9 So there is —— there was a real serious issue. But
10 at the beginning of that, the point is that much of what
11 was bought wasn't designed for women and it wasn't
12 properly recognised. There might have been more access
13 within the NHS, potentially, to better quality , but
14 social care really struggled.
15 MR GALE: Thank you very much.
16 My Lord, that is 11 o'clock, or just beyond. Thank
17 you.
18 THE CHAIR: Yes. We will take quarter of an hour for the
19 stenographer's sake. Thank you.
20 (11.02 am)
21 (A short break)
22 (11.17 am)
23 THE CHAIR: Right, now, when you are ready, Mr Gale.
24 MR GALE: Thank you, my Lord.
25 We were dealing or had reached the point in your

1 statement where you are going on to talk about domestic
2 abuse and sexual violence, paragraph 22.
3 Again, I think it would be helpful if you just read
4 through some of that.
5 DR SCOTT: Sure.
6 So domestic abuse and sexual violence, and this will
7 be just the tip of the iceberg, but women and children
8 experienced an intensification of domestic abuse and
9 gender-based violence during the pandemic. Scottish
10 Government reporting on how the COVID pandemic affected
11 the justice system found in October 2020 that recorded
12 crime was 7% lower over April to September compared to
13 2019; however, domestic abuse incidents were 8% higher
14 in April to September 2020 compared to 2019, with 34,106
15 domestic incidents recorded. And it's really important
16 to understand that a small minority of domestic abuse
17 victims report to the police, and that is where this
18 data will have come from.
19 MR GALE: I think you provided us with the data.
20 DR SCOTT: Mm-hmm.
21 MR GALE: Yes. Carry on, please.
22 DR SCOTT: Domestic abuse is a pattern of behaviour that
23 instills fear and is used by abusers to maintain
24 control . The pandemic did not cause domestic abuse to
25 spike —— many media reports —— but measures taken to

1 address the pandemic, such as lockdown, closure of
2 schools, working from home, early release of prisoners
3 and reductions in the work of the courts provided
4 additional tools for abusers to exercise control, and
5 removed opportunities for women to access services,
6 access justice , or seek help in other ways.
7 MR GALE: Please continue.
8 DR SCOTT: Due to lockdown restrictions, women and children
9 were subject to heightened monitoring and control by
10 their abusers, with limited ability to move around
11 freely or, for example, to take their children and flee.
12 There was less access to safe spaces or support from
13 family, friends or community services.
14 The full and longer-term impact on victims and
15 survivors has yet to be understood, particularly the
16 impact on children and young people living with coercive
17 control during lockdown. Not only were children not
18 safe at home, living with an abuser, but all the places
19 where they were usually safest —— school, nursery or
20 after-school clubs —— had suddenly been taken away from
21 them.
22 MR GALE: I would like to just pause and reflect on that
23 point.
24 You have provided the Inquiry with a number of
25 documents. One of those documents is SCI-SWRO-00003.

1 I'm sorry, these reference numbers are rather
2 complicated.
3 DR SCOTT: I know exactly which one that is. I have no
4 idea.
5 MR GALE: Well, I'm very glad you do. It is SCCJR --
6 DR SCOTT: Oh, yes, the Scottish Centre for Crime and
7 Justice research.
8 MR GALE: This, I think, is a paper prepared by Ms Burman
9 and Ms Brooks-Hay from Glasgow University, and is
10 entitled, "Delays in Trials: the implications for
11 victim-survivors of rape and serious sexual assault:
12 an update". It is dated December 2021.
13 If that could be just put on the screen, and go to
14 page 2 of that document. I think at the head of page 2
15 we can see:
16 "Concerns about the effects of Covid-19 on the
17 processing of sexual offence cases in Scotland and the
18 disproportionate impact delays have on women and
19 children were flagged early in the pandemic ..."
20 That is the same authors' paper from the previous
21 year.
22 "The cessation of jury trials for three months
23 during the first Covid-19 lockdown in 2020 significantly
24 exacerbated the existing back log of these cases."
25 That is, briefly, the context of what is there.

1 I would like you to go to page 5 within that
2 document. Mid-way down page 5, there is a paragraph
3 which begins:
4 "Research has also highlighted ..."
5 Could you just read the first two sentences of that
6 out, please.
7 DR SCOTT: "Research has also highlighted the extent to
8 which the children of those who have experienced serious
9 violence are themselves affected by this experience ..."
10 That is research done by Jane Callaghan in Stirling,
11 2015.
12 "Where cases are delayed, there are particular
13 implications for children, in light of their age and the
14 proportion of their lives spent with a parent involved
15 in criminal proceedings, and who may be called to give
16 evidence in court."
17 MR GALE: Yes. Now, this, I think, Dr Scott, is something
18 that you have taken up particularly, and I would ask you
19 to look, if you would, at another document, please.
20 This is SCI-SWRO-000005.
21 DR SCOTT: Oh, that one.
22 MR GALE: You gave evidence before a Parliamentary
23 Committee, the Scottish Parliamentary Committee, the
24 Equalities and Human Rights Committee. You gave this on
25 Thursday, 28 May 2020, so very early in the pandemic.

1 I think if we can see, on numbered page 1 of that
2 document, this is the Equalities and Human Rights
3 Committee, and what it was considering was COVID-19
4 implications on equalities and human rights.
5 Could you go on in that document, please, to
6 page 28, numbered in the top right-hand corner. Sorry,
7 it is column 28, but the number is in the right-hand
8 corner. Column 28. (Pause)
9 We have found it.
10 In the right-hand column, column 28 of that
11 Parliamentary report, I think if one goes just below
12 halfway down, you find your name, Dr Scott.
13 Can you just read out what you said to the committee
14 at that stage.
15 DR SCOTT: Yes. So the reference here is to Giri Polubothu,
16 who is manager of Shakti Women's Aid, which is here in
17 Edinburgh:
18 "I echo everything that Giri ... has said,
19 and I have a few other things to highlight. First,
20 children and young people risk being considered as
21 collateral damage when we discuss domestic abuse. In
22 reality, they are victims just as much as their mothers
23 are. Not only are they not safe at home when they are
24 living with an abuser; all the places where they are
25 usually safest, including school, nursery or

1 after-school club, have been whisked away from them. We
2 are really struggling to get them in-school places."
3 And this would have been in the hub schools.
4 "There are some ..."
5 MR GALE: I'm sorry, you go on and you made one of
6 the points that I think you made earlier about remote
7 and rural areas.
8 DR SCOTT: Indeed. Do you want me to read that?
9 MR GALE: Please do, yes.
10 DR SCOTT: "There are some complexities with that. It is
11 particularly difficult to do that in very remote and
12 rural areas. I am happy to share some details on that.
13 The failure to recognise that children are in situations
14 of domestic abuse concerns a very large proportion of
15 the vulnerable children in Scotland ..."
16 MR GALE: I think we can probably just pause there.
17 To a certain extent, this is going slightly
18 off-piste from what you are talking about in relation to
19 the damage on children, but perhaps it's a useful point
20 at which to give an opportunity to emphasise a point
21 that I think you make and continue to make.
22 Could you go to column 31. That is the left-hand
23 column on the page. Down towards the bottom again, your
24 name appears, Dr Scott, and I think again it would be
25 useful if you would just read what you said to the

1 Parliamentary Committee at that point.
2 DR SCOTT: Well, it references a question above. Can you
3 just go up a little bit so I can see what the question
4 was that I was answering? Okay, that's good. (Pause)
5 I think it's about government guidance in lockdown.
6 MR GALE: Yes, I think we are on the wrong page. 31.
7 DR SCOTT: Ah, thank you.
8 MR GALE: It's what you say at the bottom of column 31 and
9 on to column 32.
10 DR SCOTT: "It would be remiss of me not to point out that,
11 at the end of the day, we want to stop putting sticking
12 plasters on domestic abuse, whether we are in a pandemic
13 or not. Domestic abuse is, itself, a pandemic. In
14 order to end domestic abuse, we need refuge and
15 services, but we also really need to choke what I call
16 the feeder system for domestic abuse – [which is]
17 women's poverty, and the failure to have them at the
18 table when decisions are made about the economy and
19 issues such as local housing policy. We need to grasp
20 the nettle on all of the things that Engender points out
21 again and again. The reality is that women have so few
22 choices, in the context of domestic abuse, because they
23 are constrained by unpaid care, having to find ways to
24 put food on the table for their kids, and other issues.
25 I always need to put that marker down."

1 Do you want the next one?
2 MR GALE: We can pause there, as I think that is -- we can
3 obviously read the remainder of what you say, and it's
4 obviously of considerable significance, but I think it
5 was helpful we just got that little -- I won't say
6 "little point", but that brief point in your evidence
7 across.
8 Right, can we go back to your statement, please, at
9 paragraph 26. You are dealing here with housing and
10 homelessness.
11 DR SCOTT: Can I go back just on one thing that we didn't
12 quite touch on when we were in that earlier section --
13 MR GALE: Yes, certainly.
14 DR SCOTT: -- on children, which is one of the systems that
15 I think is most intolerant of gender differences in
16 Scotland is civil court decisions around child custody
17 and child visitation in the context of domestic abuse,
18 and all of that was exacerbated during the pandemic. We
19 heard multiple stories on our helpline and through our
20 services about abusers who had visitation with their
21 children and did not return their children. The system
22 often -- parents -- women would call the police and say,
23 "My children haven't been returned", and the police
24 would say, "This is a civil matter, we can't get
25 involved", or the abuser would say, "Well, we have had

1 COVID and we can't bring the child home because of
2 shielding", and all kinds of excuses that were based
3 on -- and some of them were probably real, I am not
4 arguing that, but the system was really insensitive to
5 the risk to children in the context of child contact
6 that had been court-ordered which was risky to begin
7 with, because the usual mechanisms of monitoring and
8 protecting children in terms of returns to their primary
9 caregiver just did not work.
10 And we saw multiple examples of either perpetrators
11 who threatened not to return children in order to
12 enforce control over their mothers, or the children
13 themselves being exposed to extended periods with
14 fathers who were not holding them in their own
15 interests.
16 MR GALE: Do you see that as being, because of the
17 restrictions on court access during the pandemic, one of
18 the difficulties with the availability and the access to
19 civil courts, rather than just, as you have been
20 emphasising earlier, the access to criminal courts?
21 DR SCOTT: And I very much want to talk about criminal
22 courts and the problems with that, but I guess what I'm
23 saying is that it was already a perilous situation
24 because of the tendency in Scotland to award contact in
25 unsafe situations, but the protections that -- the few

1 protections that were in place just did not work in the
2 context of the pandemic, and that will be because
3 elements of the system, whether it was police, whether
4 it was sheriffs, whoever it was, misunderstood or
5 minimised the risk to children of allowing unfettered
6 access to them by their abusive parent.
7 MR GALE: Right, can we go back to housing and homelessness,
8 please. To a certain extent, I suppose that follows on
9 from what you have been talking about.
10 Again, if you could read through paragraphs 26 to
11 29, please.
12 DR SCOTT: Sure.
13 Some of this I referenced earlier, but the pandemic
14 increased the risk of homelessness and insecure or
15 unsuitable housing for women, including women seeking to
16 leave abusive partners. There was an increase in women
17 seeking crisis accommodation or moving in with family
18 members for safety, notwithstanding lockdown
19 restrictions.
20 There was an increase in stalking and harassment
21 from ex-partners, physical and online, which resulted in
22 more women looking to move home for safety.
23 Almost all local authorities in Scotland froze
24 housing allocation processes, which significantly
25 compounded issues for women. Women's refuges were full

1 and there was no scope to move women and children into
2 permanent housing and a consequent inability to provide
3 accommodation and support to new referrals. A quarter
4 of refuge protection provision in Scotland is shared,
5 and social isolation measures resulted in a reduction of
6 available spaces. This was the back door issue I was
7 referencing before.
8 There was particular difficulty for women with
9 insecure immigration status and women subject to the No
10 Recourse to Public Funds condition in accessing housing.
11 MR GALE: Can I put to you a scenario which I think we have
12 seen in a number of the statements that we have seen and
13 also some of the information we have been given.
14 You have a relationship, man and woman living
15 together, and perhaps at the time it was contrary to
16 some of the lockdown restrictions. Did you come across
17 situations where one of the partners in that
18 relationship would, if it were an abusive
19 relationship -- and let's assume it is the man who is
20 being abusive -- in that situation, there would be
21 a threat of exposing the other partner for breaching
22 lockdown restrictions?
23 DR SCOTT: Yes, I think we reference that, actually, in our
24 statement.
25 MR GALE: You have. I would just like to understand that

1 that is something that you came across.
2 DR SCOTT: We came across accounts of abusers threatening
3 to -- when a woman, for instance, tried to move in with
4 her family, but also threats to call the police if
5 she -- as I said in the case with the woman who was
6 trying to take her two children on the train to her
7 mother's to get away, that he was going to call the
8 police because she was breaking lockdown restrictions.
9 And again, we saw cases -- the few court cases that did
10 go ahead -- where there were perpetrators who -- the
11 proceedings were delayed two and three times because of
12 supposed two and three cases of COVID.
13 So, you know, abusers have a very big kit of tools
14 that they use to control children and women, and
15 lockdown restrictions just was like a Christmas gift for
16 them, because not only were they trying to control them,
17 but now the state was, and the state was underscoring
18 that women and children had even fewer choices.
19 MR GALE: Okay.
20 Could we return to your statement again and to the
21 labour market and financial equality.
22 You have set out, in paragraph 30, a summary of the
23 various features of this. Perhaps you would just go
24 through the a to g points that you have set out in
25 paragraph 30.

1 MS MURPHY: Sure.
2 So the pandemic exacerbated existing gender
3 inequalities in Scotland. In terms of financial
4 equality and the labour market, women in Scotland were
5 more likely to have been furloughed and for a longer
6 period of time; less likely to have their pay topped up
7 by their employers while on furlough; more likely to
8 work in a sector that was shut down or significantly
9 restricted by public health measures, such as
10 hospitality or retail, and this was especially the case
11 for women from ethnic minority backgrounds and younger
12 women; were more likely to have lost their job or had
13 their hours reduced; bearing the brunt of the increase
14 in unpaid childcare, home learning supervision and care
15 for adults in the home when schools and nurseries were
16 closed and social care packages were reduced, making it
17 difficult to do their paid work from home where this was
18 required by their employer; more likely to be key
19 workers, representing about 80% of those in Scotland,
20 but were under-valued, underpaid and under-protected;
21 and were also significantly more likely to have
22 long COVID.
23 MR GALE: Just on that last point about long COVID, is that
24 something in the work that you have done that has been
25 brought home to you?

1 MS MURPHY: Yes, and it's emerging more as things progress.
2 But, yes, there has been research that women were
3 disproportionately exposed to COVID as the majority of
4 key workers and have had more experience of long COVID,
5 and women experience already existing health
6 inequalities. So there is no clear evidence yet on what
7 has been the driver for that. Women are, for example,
8 more likely to experience autoimmune disease, for
9 example, and post-viral illnesses, so that could be
10 a factor in it. But there is also certainly a driver
11 from the perspective that the vast majority of jobs
12 where there was high levels of exposure to COVID were
13 done by women.
14 MR GALE: You give then two examples of situations that have
15 been presented. Please don't think that I am minimising
16 them, but I would like to just take those as read.
17 MS MURPHY: Sure.
18 MR GALE: And can we go on to paragraph 31, where you
19 conclude about the disproportionate impact.
20 MS MURPHY: Sure.
21 So the disproportionate impact of the pandemic on
22 women's employment and job disruption has potentially
23 far-reaching consequences for women's equality in
24 Scotland across a number of policy areas, including
25 employment, poverty, including child poverty, social

1 security, violence against women and health. COVID
2 exacerbated gendered patterns of care, worsened women's
3 poverty and rolled back progress made on women's
4 equality and rights. COVID-19 job disruption had
5 a particular effect on low-paid women, disabled women,
6 racially minoritised women and younger women.
7 MR GALE: Can you just give some context to what you say,
8 that COVID rolled back progress made on women's equality
9 and rights?
10 MS MURPHY: Yes. I mean, it's a big question right
11 across --
12 MR GALE: I realise that, yes.
13 MS MURPHY: It's a big question right across these areas.
14 But with regard to -- so there was impact in terms of
15 violence against women, there was impact in terms of
16 women's experience of health. But in the labour market,
17 there is a high level of occupational segregation in the
18 labour market in Scotland, where men tend to be
19 employed -- or predominate within higher paid, higher
20 status jobs, and women predominate in lower paid jobs,
21 much of which made up these high-exposure jobs during
22 COVID. They tend to be on lower pay, zero hours
23 contracts within this job -- within these particular
24 areas of employment.
25 And we had seen some deterioration in that over the

1 austerity period in terms of the quality of work,
2 for example in the social care sector, but the pressure
3 that has been put on the social care sector, which was
4 underfunded, undervalued, and wasn't as strong as it
5 could be prior to the COVID pandemic, that has been
6 exacerbated by the extreme pressure it has been put
7 under, and it is even weaker now in many ways, and
8 women's employment within that sector -- women have
9 suffered quite significantly from that.
10 So, actually, occupational segregation has always
11 existed in Scotland, but we think that it is probably
12 even more pronounced because of the way things have
13 happened within the pandemic. Women were more likely to
14 be in sectors that were shut down, they were more likely
15 to be made redundant, for example. So across the
16 employment piece, we are still actually trying to catch
17 up with what the consequences have been for the very
18 gendered way that the employment sector was interrupted.
19 People didn't experience those interruptions in the
20 same way. So, for example, men were far more likely to
21 be in jobs where they could work from home; women were
22 more likely to have to go out to work. So we are still
23 trying to understand the full impact. But it has been
24 pretty severe, and things that we had worked for for
25 many years to try and address occupational segregation,

1 it has moved the needle back, to a certain degree.
2 MR GALE: Could I just follow that up, Ms Murphy.
3 MS MURPHY: Yes, of course.
4 MR GALE: Given the rolling back of progress, the falling
5 back of the needle, since the effective end of the
6 pandemic, has it gone in the other direction or is it
7 going in the other direction?
8 MS MURPHY: I think to some degree, some areas may have seen
9 improvement, but I think one of the things we are most
10 concerned about at that kind of macro level is that,
11 first of all, the COVID pandemic laid bare the
12 weaknesses in the system for women and it compounded and
13 exacerbated those weaknesses, and it is going to take
14 some time to recover. So I don't think we are fully
15 expecting it to jump back.
16 But one of the things we are also concerned about is
17 it really compounded one of the things that is the
18 biggest driver of women's inequality, and that is gender
19 norms and social roles. So women -- and I said earlier
20 that when things shut down, it was a transference from
21 the state's responsibility onto the shoulders of women,
22 ultimately, all across the world, and what happened was
23 that women took on a far disproportionate amount
24 of childcare activities, home schooling, these things
25 that had an impact on their working lives, their

1 careers, their ability to earn money, their ability to
2 progress in their careers, and it really compounded
3 almost kind of like a model of care and gender roles
4 that we thought we had left behind in the 1950s, to
5 a certain extent, that there was a kind of resurgence in
6 that in terms of the inequity of how things were shared,
7 and I think it is going to take some time for us to get
8 back to where we were before the pandemic around that.
9 MR GALE: Dr Scott, I think you wanted to say something.
10 DR SCOTT: Yes, just two points, one related to the labour
11 market issues.
12 It is pretty clear from economic analysis that, if
13 we are talking about women's poverty and children's
14 poverty -- and children's poverty is really women's
15 poverty in Scotland -- the single biggest thing that
16 could improve women's poverty is improved access to the
17 paid labour market. As Cat has just pointed out so
18 cogently, the reality is that not only was that access
19 to the paid labour market not good prior to the
20 pandemic, but all of the things that happened in it have
21 really reduced it, and we still can't tell what -- our
22 colleagues at Close the Gap tell us it's so unclear
23 exactly what the lasting effects are on the labour
24 market because the data is really confusing at this
25 point.

1 But the other issue I wanted to say is that in terms
2 of domestic abuse, one of the -- which is a driver of
3 women's poverty, as poverty is a driver of women's
4 domestic abuse -- is that we worked for -- it had been
5 probably 10 to 15 years to reduce -- to change the way
6 the courts operated to reduce the time to court for
7 a domestic abuse case, and this will -- I know we will
8 get into the justice issues later, but it's such a good
9 example of how we lost some progress we had made. And
10 we have lots of evidence that -- especially from the
11 research that was done in the specialist court in
12 Glasgow years ago, which says that if you get a domestic
13 abuse case to court within eight to ten weeks of the
14 police report, then you have pretty much eliminated
15 witness attrition in terms of the complainer, and the
16 attrition will be from the defence side, and you improve
17 outcomes and evidence for all of those cases. And it
18 took us 10 to 15 years, but we got it from what was
19 about an average of 26 weeks down to about 12 weeks
20 prior to the pandemic. And then, with the consequences
21 of court closures and court delays, that improvement was
22 just wiped out in, you know, a matter of months.
23 MR GALE: We are particularly interested in the Inquiry in
24 unpaid carers, it's a specific part of one of our terms
25 of reference, and you refer to this at paragraph 32.

1 It's a short paragraph, so can I just ask one of you
2 to read it so we have it.
3 MS MURPHY: Sure.
4 So women are the majority of paid and unpaid carers
5 in Scotland. The pandemic significantly increased the
6 burden of unpaid caring responsibilities on women,
7 particularly due to the closure of schools and other
8 care services, and the introduction of isolation
9 measures. Women provide most of the primary care and
10 educational support for women[sic]. Other unpaid work,
11 such as housework or household management, is
12 predominantly done by women. The extent of women's
13 unpaid work is central to their capacity to work within
14 the formal labour market and has significant
15 implications for their financial security.
16 MR GALE: I think that probably encapsulates very briefly
17 but very clearly the position. You want to say
18 something further?
19 MS MURPHY: Just very, very quickly. I just want to -- two
20 very quick things. One was the measures that we use to
21 track progress, so gender pay gap -- the gender pay gap
22 reporting responsibilities and the reporting
23 responsibilities under the public sector equality duty,
24 were suspended during COVID. They have been picked up
25 again now, but there was a suspension which interrupted

1 how we measure these things, and also we worry sent the
2 message that these things can be quite easily dispensed
3 of in moments of pressure.
4 But just to pick up on one point I really want to
5 make around unpaid care is that we were quite a way into
6 the pandemic before the furlough scheme took any
7 cognisance of people that might have to furlough because
8 of the additional care duties that they have. And
9 also -- so that was then introduced, and I know it is
10 UK Government, but even when it was introduced, there
11 was such a low level of awareness among employers about
12 the fact they were obliged to give people furlough if
13 they needed it for care responsibilities, and there was
14 an extremely low rate of take-up for that, and there was
15 a really high proportion -- I think it was in the region
16 of -- yes, 71% of requests working mothers made for
17 furlough for care duties were refused.
18 So just to -- and then the other thing is that
19 the furlough scheme wasn't originally designed to take
20 into account part-time work, the vast majority of which
21 is done by women. So just going back to that competency
22 and design issue, the support for people who were under
23 enormous pressure to deliver care was really not there
24 from the start in the way that it should have been. But
25 I appreciate that largely sits with the UK Government.

1 MR GALE: Can I just put to you something that I have seen,
2 and see whether or not this is something with which you
3 agree.
4 I saw some time ago a report by Dr Curry of
5 Edinburgh University on unpaid carers, in which she
6 indicated that, during the pandemic to presumably the
7 date of whenever the report was, which was earlier this
8 year, there had been an increase in unpaid carers from
9 round about 750,000 to over 1 million in Scotland. Is
10 that something that you recognise?
11 MS MURPHY: Yes. That study -- we followed that study
12 carefully, and yes, there was -- there is now
13 1.1 million unpaid carers in Scotland, and there was an
14 increase of nearly 400,000 in the first kind of year or
15 so of the pandemic. We don't -- I don't have access to
16 data about how that might have come down, but we think
17 that there is -- we don't think it has come down as
18 quickly as it went up. Certainly not.
19 MR GALE: Thank you.
20 Right, can we go on to impact on access to services,
21 and to some extent we have been touching on this all the
22 way through. But I think one of the points you make in
23 paragraph 33 is that data from May 2020 shows that calls
24 to Scotland's Domestic Abuse and Forced Marriage
25 Helpline were up 70% from the previous year. Was that

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1 something you expected?
2 DR SCOTT: Well, we didn't expect a pandemic, to be honest.
3 It wasn't surprising --
4 MR GALE: Let's accept there was a pandemic.
5 DR SCOTT: We weren't surprised and, as I mentioned earlier,
6 we didn't really see an increase until about two weeks
7 after the initiation of lockdown, for the reasons that
8 I have mentioned. But it was not surprising to us once
9 we heard from the women calling the helpline and the men
10 calling the helpline, but also from our services, that
11 the lack of good information about the pandemic, the
12 lack of clear messaging from police and justice
13 officials about what the arrangements were for accessing
14 court, and how restrictions on movement were to be
15 applied if you were a domestic abuse survivor, were all
16 just added to the mass of uncertainty, and that is what
17 a helpline is for: to provide information and access.
18 But it was really -- we had a call, for instance,
19 I remember really clearly hearing from one of the call
20 handlers, and this is -- when you were talking about
21 putting the responsibility for the pandemic on women and
22 children, what I observed repeatedly in sessions with
23 Parliamentary Committees is that what we saw was that
24 risk was routinely and systematically moved outwith
25 services onto the shoulders of the least powerful and

1 the most vulnerable. A really good example of that
2 I think would be court closures where courts were -- and
3 during -- just prior to the second lockdown, the court
4 service gave -- announced, with 24-hour notice, that
5 cases -- that courts were going to be closed. And when
6 we enquired how witnesses, who often would be -- in
7 domestic abuse cases would be complainers and their
8 children, perhaps, being called to give evidence, would
9 be notified about that, the response we got was, "We
10 don't have the capacity to do that, we will tell the
11 judges and the witnesses and the sheriffs and the
12 witnesses for the cases we will hear".
13 So what we would get would be multiple calls from
14 women saying, "I went on a bus at 7 o'clock this
15 morning" -- and remember about public transport and risk
16 for COVID -- "on a bus with my children, and we
17 travelled for two and a half hours to the court and it
18 was closed. What was going on?" Or they would be --
19 the risk to staff in the courts was managed by making
20 people queue outside the building. Now, there was one
21 queue, and that included perpetrators, accused and
22 complainers, and children. So, once again, we are
23 seeing the risk being moved from the most powerful in
24 Scotland down to the least powerful and most vulnerable.
25 So to come back around, the uncertainty about how

1 the systems were going to respond to risk in the context
2 of sexual assault and domestic abuse meant that both our
3 helpline and Rape Crisis through the Scottish Women's
4 Rights Centre had multiple, multiple, many calls from
5 women saying, "Who is going to protect me? Do I have to
6 go to court? Who is going to tell me whether I have to
7 go to court? Can I bring my children? Do I have to
8 bring my children?", all of those questions, which were
9 the usual things that women shouldn't have to be
10 worrying about when they were worrying about actually
11 protecting themselves from a perpetrator.
12 MR GALE: Can we go on to access to justice. Again, some of
13 this we have already touched upon, and in paragraph 36,
14 for example, you quote from the paper that we looked at
15 earlier.
16 DR SCOTT: Yes.
17 MR GALE: And, again, we can take, without any disrespect,
18 that as read.
19 I think also you make the point at paragraph 37 that
20 the access to legal advice agencies, solicitors and less
21 formal agencies, was reduced or had limited capacity.
22 That would apply both for the perpetrator of domestic
23 abuse, but also those who wanted to ascertain what their
24 rights would be to avoid that.
25 DR SCOTT: It was a terrible situation, to be honest, and it

1 has not recovered. Between lack -- I mean, in the best
2 of times, lack of access to legal aid is a big problem
3 for complainers, for women and children experiencing
4 domestic abuse. But -- so, for instance, one of our
5 services is in Shetland, and they haven't had
6 a legal aid office in Shetland for five years.
7 All of our services reported difficulty in accessing
8 legal advice for women and children across the criminal
9 and civil settings, and one of the issues that came up
10 in the island communities was that even though there
11 were now services -- for instance, so solicitors in
12 Glasgow were offering to provide services in Shetland
13 and Orkney because it was provided by video link and
14 remotely. They were taking so many cases, first in part
15 because the supply of solicitors had dropped, and women
16 solicitors, which are often overrepresented in family
17 law and public sector law, were affected by the same
18 labour market issues that Cat was describing, but also
19 women were being represented or advised by a solicitor
20 in Glasgow who had no conception of the local situation,
21 or women would be told -- we had cases where women were
22 being -- the solicitor was mixing up cases, and in court
23 talking about a case that actually was a different case
24 than the one that was being heard because they were
25 taking so many cases from outwith Glasgow.

1 So I think it is really hard to underestimate how
2 harmful the lack of access to legal aid and legal
3 representation and services was, but also the impact on
4 the industry is extraordinary, and we are still
5 struggling. We have staff who make 50 calls before they
6 can find a solicitor.
7 MR GALE: I think you summarise that in paragraph 39, where
8 you say that the suspension of court proceedings -- and
9 I suppose one factors in the difficulties in obtaining
10 legal advice, etc -- has had and continues to have
11 a hugely negative effect on those seeking access to
12 justice.
13 DR SCOTT: Absolutely.
14 I just want to say -- and I have been talking a lot
15 about domestic abuse, because it is what I know best,
16 but really significant issues for Rape Crisis Scotland
17 and the survivors that they supported. They were --
18 court delays were already an issue prior to the
19 pandemic, but it was made significantly worse by COVID.
20 Survivors told their helpline and their staff about
21 difficult -- how difficult it was waiting months or even
22 sometimes years for their cases to reach court, and they
23 are still dealing with those court backlogs.
24 MR GALE: Yes.
25 I think in paragraph 40 you make a specific

1 reference to those women who were engaged in the, as you
2 say, judicial and administrative processes, but in
3 particular delays in asylum and immigration decisions
4 prolonged individual experiences of precarious
5 immigration status, increasing risks around homelessness
6 and destitution.
7 Now, I don't want to take that much further at this
8 stage because we are going to be looking at asylum
9 seekers and refugees as a distinct topic in this
10 Inquiry, so we will be looking at that, but we will be
11 mindful of what you said in that respect. We will take,
12 if you don't mind, for the sake of brevity at the
13 moment, the two quotations as read.
14 We go on at 41 to intersecting equalities, and
15 I think we have already touched on this, and I think
16 again that is something we can take as read.
17 So at 42 you look at an overview of concerns
18 regarding Scottish Government decision-making. Again,
19 something we have already briefly touched on, but
20 I would like to understand this as fully as possible.
21 Could you read on from paragraph 42, or one of you
22 read on from paragraph 42.
23 MS MURPHY: It is vital that lessons are learned from the
24 COVID-19 pandemic and that systemic improvements
25 are introduced to protect the most vulnerable members of

1 our society. This requires a genuine commitment on the
2 part of those in power to realise the human rights of
3 those most likely to have their rights violated and to
4 ensure the decision-making includes intersectional
5 gender competence.
6 MR GALE: Can you please continue.
7 MS MURPHY: Yes, sure.
8 The Scottish Women's Rights Organisations recognise
9 the need for rapid decision-making in response to
10 an exceptional event like the pandemic, but the evidence
11 indicates that, in working at pace, public bodies often
12 neglected critical safeguards in equitable
13 decision-making, overlooked the primary differences
14 between men and women's lives, entrenching and
15 exacerbating women's inequality in the longer term.
16 MR GALE: Just picking up one thing you say there: "evidence
17 indicates that in working at pace"; is that a real
18 issue, that so many decisions were having to be taken so
19 quickly that other issues such as those that you
20 identify were ignored?
21 MS MURPHY: I think that we would accept and -- you know, we
22 would accept that difficult decisions had to be made and
23 they had to often be made at pace, and they will at
24 times be imperfect as a result of that. But where our
25 concern is, is that we had been advocating for decades

1 prior to the COVID crisis for better gender
2 mainstreaming in decision-making processes in the UK and
3 in Scotland, and the evidence has been available around
4 this and very detailed approaches to it have been
5 available from the 1990s onwards, and the fact that we
6 didn't have a decent gender mainstreaming approach in
7 Scotland or in the UK and that the work hadn't been done
8 in the decades prior to the COVID crisis meant that it
9 wasn't baked into the system.
10 That can be done. That is not something -- the
11 system does not need to exist the way that it does at
12 the moment, thinking about these things as somewhat of
13 an afterthought. There are ways to make decision-making
14 that absolutely integrates the differences between men
15 and women and the intersectional differences for certain
16 groups of women or vulnerable individuals. That can be
17 done and the mechanisms exist to do that. We understand
18 what they are, we know what they are, we know what needs
19 to be done, we have been advocating for it for decades,
20 and it wasn't done to the extent it should have been in
21 the UK and Scotland, and it meant we went into that
22 rapid decision-making process with systems that we knew
23 weren't going to deliver what we needed to deliver in
24 that respect.
25 So I do take on board that when decisions are made

1 quickly, they will be by their very nature imperfect.
2 But the bigger issue is that there could have been
3 better systems in place to make those very quick
4 decisions.
5 DR SCOTT: Can I just add one thing to that?
6 MR GALE: Yes, please.
7 DR SCOTT: So an example, in a meeting that I had with
8 senior officials and stakeholders -- so, you know,
9 charities -- in the children and young people's area,
10 and we were talking about decisions around key workers
11 and hub schools and what was happening for the education
12 of children, and it was a meeting in which I was saying
13 so much of what I have said here about my concerns about
14 the failure to consistently understand the impact of
15 domestic abuse on children and their mothers and to
16 incorporate that into who were key workers, how were hub
17 schools run, etc, etc, and I was asked: what would have
18 made a difference? I said, "Well, do you have
19 an equality impact assessment for your decisions?" And
20 I was told very firmly by a senior official that, "We
21 didn't have time for that and I won't apologise".
22 For me, that is a perfect example of equalities for
23 Christmas. Do you know what I mean? So in other words:
24 we care about equality until it's too hard. I think
25 that is what underscores what Cat was saying, which is

1 you can't do equality in 20 minutes at the end of your
2 decision-making.
3 In Scotland, under the specific duties under the
4 public sector equality duty, is very clear in law about
5 the requirements to do equality impact assessments
6 before you make policy. If, even prior to the pandemic,
7 people had been routinely doing decent equality impact
8 assessments, or even doing them at all often at the time
9 they were supposed to, those decisions would have been
10 so much easier for them. But because they had continued
11 to treat it as an add-on, they didn't have the skills
12 that were necessary for it. It wasn't intentional, but
13 it was harmful. Deeply harmful.
14 MR GALE: Your experience, was the impression that you got
15 from the dealings you had with decision-makers that the
16 intersectional basis for decision-making was not
17 embedded at the outset; it was just brought in as a,
18 "Well, does it comply?" once the decision is taken?
19 MS MURPHY: I think --
20 THE CHAIR: On the basis of what you have already said, it
21 was a failure as a matter of law not to have had such
22 a survey. So it's a rather odd situation, in that the
23 mechanism, had it been used, was already in place. So
24 I understand that. It's perfectly clear, but it's
25 an interesting situation.

1 I think possibly you were on the right lines or
2 perhaps nailed it by saying if there had been
3 a different attitude, because if the relevant
4 decision-makers or policy-makers had complied with
5 existing law, then there might have been a better
6 framework to make decisions at pace.
7 DR SCOTT: Absolutely.
8 THE CHAIR: Possibly, of course, that could be applied to
9 many other things away from the subject we are
10 discussing this morning.
11 DR SCOTT: Indeed.
12 MS MURPHY: Just to reiterate that, I think there are -- the
13 public sector equality duty, these are legal duties on
14 public authorities. There is also -- arguably, there's
15 also duties under the European Convention on Human
16 Rights around these things, non-discrimination. So they
17 are not -- they shouldn't be the cherry on top of the
18 cake; they should be baked into the cake.
19 We have said throughout this that we know the
20 components of what they should look like, so they are
21 competency -- a general level of competency in
22 decision-making across the board, not just certain
23 equalities champions that sit and -- who are often
24 excellent but are vastly outnumbered and the vast
25 majority of decision-makers don't have that basic

1 competency.
2 The other thing that we know is needed is quality
3 data, so data that looks at the different experiences of
4 men and women; data that is gendered, it is not just
5 counting men and women, it is looking at the differences
6 in their experiences, and we can call upon data to try
7 and give us some insight into that, but also data that
8 looks at the specific experiences of, for example, black
9 and minority ethnic women. And there have been decades
10 of delay in Scotland, in the UK and in other parts of
11 the world where we just are not giving enough attention
12 and resources to developing these data systems that will
13 inform the decision-making that is required, and that
14 has a very serious impact.
15 So these are things that are well known, they are
16 part of the legal obligations that should be delivered
17 and they are not being delivered.
18 Just one final thing is that I think, prior to the
19 COVID pandemic, the public sector equality duty is
20 imperfect. It is something and we've got it and it's
21 a legal obligation; it is not everything we would want
22 it to be. And to their great credit, Scottish
23 Government have recognised that. There was a review of
24 the public sector equality duty due before the COVID
25 pandemic. It was delayed. It has been picked up again

1 now, but we're being told that it will probably be less
2 than we had hoped for in terms of reviewing and
3 enhancing the public sector equality duty and its
4 provisions. And also in between times, for example, the
5 team within Scottish Government that were working on it
6 were seconded to work on the Ukraine crisis. Now, I am
7 not saying there is anything wrong with that per se, but
8 we do have a suspicion that equality is always one of --
9 these equality provisions are always -- within
10 government, in the UK or Scotland, they're always
11 something that will be dealt with after we have got to
12 this stuff, and that is what got us to the point in the
13 COVID pandemic where decisions were made at pace, the
14 competency wasn't there, the data wasn't there, the
15 mainstreaming wasn't there, and the failures to deliver
16 on legal obligations were a reality, unfortunately.
17 MR GALE: Just following on that, and this is perhaps
18 a rather unfair question because I don't think it has
19 necessarily been prefaced in material that you have
20 looked at or been asked. We do know and we are
21 investigating that there was a degree of pre-pandemic
22 planning in Scotland for a type of pandemic. I think it
23 was essentially an influenza-based preparation, but that
24 was what was being looked at.
25 Were any of your groups or any of the women's rights

1 groups involved in that pre-pandemic planning?
2 DR SCOTT: That is such a good question, because it comes --
3 MR GALE: I am glad it is. I was rather concerned it might
4 not be.
5 DR SCOTT: It comes back around -- no, the answer is to
6 that, and it comes back around to -- when we talk about
7 women's lack of access to power and resources, it is
8 about being at the table when decisions are made, when
9 problems are identified, when solutions are identified,
10 and when resources are allocated to deal with that. The
11 absolute lack of inclusion of gender experts in things
12 like planning for pandemics means that you are
13 reverse-engineering so much when it actually happens,
14 and I think that that is a really good -- and that is
15 repeated over and over.
16 I do just want to say there were some wonderful
17 exceptions in all of this. I think that the equality
18 unit, which was and is continually deeply
19 under-resourced, was working really hard with the few
20 people that were left to help gender what was happening
21 in other aspects of government, and I would say in terms
22 of the violence against women team, and the minister at
23 the time, Christina McKelvie, we found
24 an extraordinarily deep understanding and a really rapid
25 response from that element of government. But -- and,

1 you know, I will say in my discussions with my
2 counterparts in England, Wales and Northern Ireland that
3 it was like night and day, and we were offered immediate
4 funding to help us deal with the pandemic, and they
5 were, at best, many months later still having to argue
6 about that.
7 So I think it's really important that we not --
8 point out that the government has the capacity and the
9 courts and the police and everybody has the capacity to
10 do this well, but if they don't resource it, and they
11 don't hold people accountable for the law, for applying
12 the law, then, as we have said, they will have learned
13 nothing from this pandemic.
14 MR GALE: Thank you.
15 To a certain extent we can take some parts of this
16 as read because we have already dealt with it.
17 Can we go to paragraph 46, please, which I think is
18 really a bit of a summary of some of the matters that
19 you have been raising.
20 Perhaps you would just read from paragraph 46
21 onwards.
22 DR SCOTT: Existing systems and processes within the
23 Scottish Government were insufficient to mainstream
24 gender and equalities considerations into crisis
25 management, ongoing strategy and policy responses,

1 crisis funding, programme development, service design
2 and recovery plans. This failing entrenched the unequal
3 impacts that were affecting women and marginalised
4 groups across Scotland.
5 MR GALE: Continue on, please.
6 DR SCOTT: Mainstreaming equality is a requirement of the
7 Scottish specific duties under the public sector
8 equality duty. The failure to use the tools available,
9 such as equality impact assessments, which are a legal
10 requirement, resulted in a lack of understanding on the
11 impact of crisis management proposals. This inevitably
12 led to unintended negative consequences for already
13 marginalised people, failed to prevent harm, and wasted
14 time and resources by having to mitigate or change
15 approaches during the pandemic. Disadvantage was
16 exacerbated instead of ameliorated, which increased
17 disproportionate harm and tragedy in certain families
18 and communities.
19 MR GALE: I would like you just to read to the end of that
20 section, so if you could keep going.
21 DR SCOTT: Keep going.
22 The government had an obligation to monitor
23 the impact of measures taken to address the pandemic for
24 any disproportionate negative impacts on particular
25 groups that could constitute discrimination. However,

1 monitoring data was inadequate and should have been
2 disaggregated by gender and other relevant factors such
3 as ethnicity, age, disability and socio-economic status,
4 to enable assessment of the impact on groups potentially
5 suffering from intersectional discrimination, such as
6 women from ethnic minority backgrounds, disabled women,
7 older women or women living in remote and rural areas.
8 There was also a failure of policy-makers to take
9 a step back and look across all policy areas to evaluate
10 how the policy decisions taken during the pandemic
11 cumulatively contributed to the enormous harm that women
12 and children were experiencing, especially as a result
13 of domestic abuse.
14 For example, the Scottish Government and "Equally
15 Safe" cite gender inequality as a cause and consequence
16 of domestic abuse and consistently reiterate that
17 domestic abuse is a critical priority. However,
18 government messaging, especially early in the pandemic,
19 to "stay safe at home", without caveats that movement
20 restrictions did not apply to those dealing with
21 domestic abuse, caused significant concern.
22 There then came a misleading narrative from
23 government messaging and media reporting that COVID-19
24 and lockdown were causing domestic abuse in Scotland.
25 Lockdown created a situation favourable to abusers and

1 presented considerable obstacles for women seeking to
2 access services. However, lockdown did not cause
3 domestic abuse. This problematic messaging was apparent
4 in the initial daily COVID-19 updates, although
5 following advice from organisations like the Scottish
6 Women's Rights Organisations, this messaging changed.
7 However, it remained a recurrent narrative in
8 Scottish Government media accounts and reporting from
9 Police Scotland.
10 Keep going?
11 MR GALE: Yes, please.
12 DR SCOTT: The disproportionate and damaging impact on women
13 could have been mitigated to a greater extent if
14 intersecting gendered inequalities had been mainstreamed
15 as a core concern of the Scottish Government's
16 decision-making processes.
17 The key problems were a lack of gender competence
18 within the Scottish Government, a lack of prioritisation
19 around women's equality by senior officials, inadequate
20 data use, especially intersectional gender sensitive
21 sex-disaggregated data, a lack of attention given to
22 gendered impacts in guidance and advice developed
23 forward employers and a failure to mainstream gender
24 equality, which is a legal requirement under the
25 Scottish specific duties.

1 MR GALE: Can I just go back to paragraph 50 and the
2 messaging that is referred to there. You highlight the
3 problem with the initial message that was being put out
4 and then you indicated that you gave certain advice and
5 the messaging changed. Was it possible that the
6 messaging just became embedded before the change and it
7 was somewhat difficult to counter what was the initial
8 impression of the messaging?
9 DR SCOTT: Undoubtedly. Absolutely. So if you ask people
10 today, they would still say that COVID caused more
11 domestic abuse in Scotland; just like they used to say
12 it's the drink or Old Firm games or -- a real
13 misunderstanding of the dynamics of domestic abuse. If
14 you recall, we had daily updates from the
15 Scottish Government, often the First Minister, and I am
16 happy to say that officials in those updates began to
17 adjust the messaging. So when they talked about taking
18 protective measures and including, you know, staying at
19 home, they became "... unless, of course, you are
20 experiencing domestic abuse" or other forms. But the
21 damage was done, as I think you have pointed out. Then
22 the reality is that that messaging was not certainly
23 consistent across multiple public sector institutions.
24 So the damage, while ameliorated -- and it could
25 have so been avoided, as we have said, if people had

1 just for one minute thought about how the lockdown
2 restrictions were going to be affecting different people
3 differently.
4 MR GALE: In your conclusion you indicate what you -- it is
5 a rather useful conclusion because it tells us what you
6 said at the beginning, which is that you feel somewhat
7 constrained by the brevity of the statement. As I said,
8 we will undoubtedly ask you to give further evidence to
9 the Inquiry and information to the Inquiry. You set out
10 at the end the various documents that you have provided
11 to the Inquiry and, as I have said, all of those
12 documents are now with the Inquiry. They will be
13 considered in detail and analysed and will input into
14 our eventual recommendations and report.
15 But subject to that Dr Scott, Ms Murphy, who I think
16 wants to say something else?
17 MS MURPHY: Is it okay if I just make two quick points?
18 MR GALE: Yes, please.
19 MS MURPHY: Just an overarching one that possibly we should
20 have made at the start. I think that within the
21 pandemic, and it is not unique to Scotland but it
22 certainly played out in Scotland, as it did in many
23 other countries, was this kind of assumption that,
24 because this is an urgent public health crisis, kind of
25 all bets are off to a certain degree, with equality

1 requirements and human rights requirements, and I think
2 legally that is not the reality. It will be obviously
3 for this Inquiry to interrogate that, but I think there
4 were some things that were also done that sent a message
5 very much that this is not as important as this public
6 health crisis. So, for example, when the reporting for
7 the public sector equality duty was cancelled in 2020,
8 that sent a very strong message that equality isn't as
9 important, and what we would very much argue is that
10 equality and human rights become even more important
11 within a public health crisis. It is not something that
12 sits at the side of a public health crisis, and I think
13 that is something we would really want to leave with
14 you, and I know it's an overarching issue.
15 The other thing, just one quick thing, is that
16 around gender mainstreaming within Scottish Government,
17 Scottish Government have -- and there has been quite
18 significant leadership right from the top within
19 Scottish Government to try and make change. So the
20 equality unit has been expanded into an equality and
21 human rights directorate, and I just want to acknowledge
22 that. There has also been a National Advisory Council
23 for women and girls that was instituted by the former
24 First Minister which has been very welcome.
25 But one thing I would just finish up with is that

1 I don't know if you are familiar with the phrase that
2 "culture eats strategy for breakfast" --
3 MR GALE: I have heard that.
4 MS MURPHY: I would include in that "culture and resources
5 eat strategy for breakfast" and one of the things -- or
6 lack thereof. One of the things that, even though we
7 have had some degrees of leadership, there has been
8 consistent lack of resources and addressing a culture
9 that can sometimes play out as obstruction. I think
10 Marsha's example of kind of like, well, EQI is not
11 needed here and we are not going to apologies for it,
12 that is culture as much as it is anything else. So
13 I would just say as well that, within that, it's not
14 just about commitments at leadership level, it is making
15 sure the culture follows suit and that there are
16 resources behind it to deliver.
17 MR GALE: Thank you very much to both of you.
18 THE CHAIR: Yes, thank you both.
19 DR SCOTT: You are welcome.
20 MR GALE: My Lord, 2 o'clock?
21 THE CHAIR: Yes. I don't know, is it possible -- just to
22 make some more time for us, to be perfectly frank, we
23 could start earlier. We have an hour and a half.
24 MR GALE: The witness is giving evidence remotely.
25 THE CHAIR: Ah, right.

1 MR GALE: I think the arrangements may be in place. We can
2 see.
3 THE CHAIR: I appreciate that it might not be possible. It
4 is just simply ...
5 MR GALE: I appreciate that.
6 THE CHAIR: Good. Thank you.
7 (12.26 pm)
8 (The short adjournment)
9 (2.00 pm)
10 THE CHAIR: Good afternoon. Mr Gale.
11 MR GALE: Thank you, my Lord.
12 The next witness is Helen Goss. She is joining us
13 remotely to give her evidence. She has provided the
14 Inquiry with a statement. The reference to that is
15 SCI-WT0568-000001.
16 THE CHAIR: Very good.
17 MR GALE: She is giving evidence on behalf of Long Covid
18 Kids Scotland, and this is an impact statement.
19 MS HELEN GOSS (called)
20 (By video link)
21 THE CHAIR: Now, I think possibly Ms Goss is on the screen
22 in front of me; is that correct?
23 MR GALE: She is, hopefully.
24 THE CHAIR: Can you hear me, Ms Goss?
25 THE WITNESS: I can, hi.

1 THE CHAIR: Good, hello. Good afternoon.
2 Right. Now, you are going to be asked some
3 questions about your statement by Mr Gale, and I think
4 probably you will be able to see Mr Gale in a minute or
5 two, if you can't already. The technology here is a bit
6 beyond me, as you can gather.
7 THE WITNESS: It's fun being the first.
8 Questions from MR GALE
9 MR GALE: There are benefits in not seeing me, Ms Goss,
10 I can assure you.
11 Right, Ms Goss, your full name is Helen Goss,
12 I think?
13 A. Yes.
14 Q. Can you just tell us how old you are, please.
15 A. 39.
16 Q. You are the chief operating officer for Long Covid Kids
17 Scotland; is that right?
18 A. Chief operating officer for Long Covid Kids, and I run
19 the Long Covid Kids Scotland part of the charity.
20 Q. Right, thank you. How long have you been doing that?
21 A. Oh my goodness. I first found Long Covid Kids as
22 a group, a charity, in January 2021, and then I joined
23 the team in June 2021 and opened up Long Covid Kids
24 Scotland as a group, and we applied for charity status
25 in 2022 and then got charity status in 2023.

1 Q. I think, Ms Goss, you have Long COVID yourself; is that
2 right?
3 A. I do. Not nearly as bad as my daughter, but yes.
4 Q. Your interest, obviously, in Long Covid Kids, as you
5 have just alluded to, is inspired through your interest,
6 obviously, in the condition of your daughter.
7 Can I just pause and ask, just for various reasons,
8 that you don't name your daughter, but just refer to her
9 as your daughter, if you wouldn't mind doing that for
10 us.
11 Right, you provided us with a statement, Ms Goss.
12 Can I just preface what I have to ask you by saying you
13 have also provided us with a number of documents which
14 you have drawn our attention to. We are very grateful
15 for you providing us with these documents, and
16 can I assure you that all these documents will be
17 considered and analysed by the Inquiry team, and taken
18 along with the evidence that you are giving. So please
19 don't think that these are filed and put away and never
20 looked at again. They will not be. They will be looked
21 at in great detail by us.
22 Can I also say that the Inquiry will be looking at
23 the subject of long COVID in general terms, not just
24 relating to Long Covid Kids. So you can be assured of
25 that as we are progressing in our investigations.

1 Can I also say that a number of witnesses have
2 already mentioned and alluded to long COVID, so we are
3 aware of the concept of long COVID, the condition, the
4 symptoms, so we are aware of that.
5 Can I also say to you at the outset that if you
6 require and would like to take a break at any time
7 during the giving of your evidence, please just say so.
8 A. Thank you.
9 Q. Don't soldier on feeling that you have to do so. If you
10 would like a break, please let us know and that will be
11 facilitated for you.
12 A. I will do. Thank you very much.
13 Q. Right, Ms Goss, can I ask you to tell us a little bit
14 about Long Covid Kids.
15 You start this really in paragraph 0.2 of your
16 statement, and I wonder if you would just help us by
17 reading that out so that we get a flavour of Long Covid
18 Kids as an organisation.
19 A. Yes, of course.
20 Long Covid Kids Scotland was established to support
21 and guide Scottish families with children and young
22 people with long COVID. We advocate for the
23 recognition, support and recovery for long COVID in
24 children and young people. Currently, the Scottish
25 branch provides support to over 250 families, with this

1 number growing all the time. The importance of my
2 previous sentence cannot be more emphasised. Long COVID
3 isn't something that happens to (a) already unwell
4 children -- quite the opposite, in fact; in our
5 experience, the children affected were very healthy,
6 with active, busy social lives filled with
7 extracurricular activities -- and (b) only as a result
8 of the peak of the pandemic. Long COVID is still a real
9 and live risk.
10 Q. Can I just pause there, Ms Goss.
11 I think you emphasise this point, because you quite
12 clearly want to emphasise this point. Is that because
13 there is a perception in the wider community that really
14 long COVID only affects children with pre-existing
15 conditions?
16 A. Yes, you're right. I think from the very beginning of
17 the pandemic, we were told by our governments, by our
18 public health bodies, that children were not at risk or
19 were extremely low risk, and while that may be true for
20 acute infection -- children often have mild infection or
21 asymptomatic COVID-19 infection -- but they never talk
22 about the long-term consequences of that infection.
23 Q. Right.
24 A. And, yes, I think people don't realise that, actually,
25 you can develop long COVID on any subsequent infection.

1 So while you may have been fine with your first, second,
2 third COVID infection, on your fourth infection you may
3 develop long COVID, and I don't think the consequences
4 of that are really understood.
5 You have to think about your children, your
6 grandchildren, your nieces, your nephews, and what they
7 are doing right now. They are going to school, they are
8 enjoying their hobbies, they are socialising, they are
9 living their best lives. And then imagine they get
10 COVID and you think, "Oh, it's not too bad, it is just
11 a cold", as we are told. Then a month later, two months
12 later, perhaps, they can't go to school, they can't do
13 their hobbies, they can't socialise, they are very, very
14 sick, and that could last a very long time. Years.
15 Q. I think in paragraph 0.3 of your statement, you
16 essentially emphasise that point again.
17 I think you also indicate that Long Covid Kids is
18 supported by expert advisers, also has lived in
19 experience from peers via advocacy, and you provide
20 assistance trying to navigate the various systems we
21 have come to cross.
22 Now, again, I don't want you to name the advisers
23 that you have, but I understand you have both medical
24 and legal advisers; is that correct?
25 A. Yes.

1 Q. You put it in this way: you provide "assistance trying
2 to navigate the various systems we now have to cross".
3 That is perhaps a rather loaded way of putting it.
4 What do you mean when you say you have to cross?
5 Would it be fair to say it is just the systems that you
6 have to encounter, or is it more difficult than that?
7 A. Encounter, fight with, battle. It's ridiculous at the
8 moment, Mr Gale. I cannot emphasise this enough.
9 Okay, so it's really upsetting that we are having
10 new families join our support services in 2023 who are
11 still facing the same obstacles and challenges that we
12 faced in 2020 and 2021 and 2022. Nothing has changed.
13 Navigating the systems; by that I mean trying to access
14 healthcare, trying to access social care, trying to
15 access accessible education. It is almost impossible
16 sometimes, depending on where you live, depending on the
17 level of understanding of long COVID in children,
18 depending on local government, local authorities. It's
19 just an absolute battle every single day to try and get
20 your child the help and support that they need.
21 Q. Thank you.
22 Could we go to paragraph 0.4 of your statement, and
23 could I now trouble you to read some of that, please.
24 A. Yes.
25 When people talk now about COVID-19, often it is

1 around lockdowns, restrictions, and how happy they are
2 to be back to "normal". For many children and young
3 people, they have never and may never go back to what
4 normal looked like to them. There is this misconception
5 even to this day that COVID-19, let alone long COVID, is
6 only a risk to the infirm or elderly, which is simply
7 not true. This is a misconception held by people in
8 positions of healthcare, policy and education, people in
9 positions that should know better by now. For those who
10 didn't die, or weren't hospitalised at the peak of the
11 pandemic, but are still suffering our injuries today, we
12 have been forgotten.
13 Q. Could you continue on reading until I ask you to stop,
14 and we will clarify one or two things. Just continue on
15 reading, please.
16 A. As of May 2022, there was believed to be over 10,000
17 children in Scotland suffering from long COVID. In the
18 same vein that COVID-19 was not and is not just the flu,
19 long COVID is not just tiredness. People suffering with
20 long COVID struggle with what would have previously been
21 for them simple daily tasks, with cognitive dysfunction
22 so severe they can forget basic personal information.
23 In children and young people, long COVID causes
24 neurological, musculoskeletal, gastrointestinal and
25 cardiovascular symptoms, serious cognitive impairment,

1 headaches, migraines and muscle ache. Symptoms also
2 overlap with conditions such as ME/CFS, PEN, PANS and
3 MCAS. Some go on to develop PIMS-TS.
4 Q. I think we are aware of those acronyms, so I don't need
5 to ask you to explain them all, but could I just go back
6 to the beginning of that paragraph and the figure of
7 over 10,000 children in Scotland.
8 You have given a number of footnotes to your
9 statement, and the footnote to that is a reference to
10 Jackie Baillie MSP and a long COVID debate in the
11 Scottish Parliament.
12 So that figure, is that a figure that has had any
13 official recognition and, as a second part to my
14 question, is it a figure that you consider to be
15 accurate?
16 A. I will note this down because I will forget your second
17 question.
18 Okay, so that figure comes from -- it is
19 an estimate. That figure is based on the Office of
20 National Statistics data, where we believe that there
21 are around 170,000 people in Scotland in total suffering
22 from long COVID, and it is a percentage of that based on
23 the evidence that exists on prevalence in long COVID in
24 children.
25 The reason that it is an estimate and not a fact is

1 because the Scottish Government have failed to and
2 continue to fail to gather data on long COVID in
3 Scotland. So, in truth, we have absolutely no idea how
4 many children are suffering from long COVID.
5 Your second part: is it accurate? I think I just
6 covered that.
7 Q. It's an estimate. It obviously has to be an estimate.
8 Do you know why Scottish Government has failed to
9 produce data on this?
10 A. Incompetence? Laziness? I don't know. You will have
11 to ask them, Mr Gale. We've brought it up a number of
12 times, several times. In fact, we have asked them until
13 we are blue in the face to count long COVID, and they
14 still are not doing it.
15 Q. Have they given an explanation as to why they are not
16 doing it?
17 A. No.
18 Q. Can you surmise as to why they are not doing it?
19 A. I suspect it is because the numbers are very large, and
20 if there is a large number, then they have a problem
21 they have to deal with, and that is probably quite
22 an unsavoury thing to have to face.
23 Q. Right, can you go back to your statement, please, at
24 paragraph 0.6, and could you read on from that, please.
25 A. Long Covid Kids Scotland are supported and championed by

1 practising experts and professionals in a range of
2 fields, such as law, paediatrics, occupational therapy,
3 immunology and virology. We work closely with academia
4 and other charities, and are recognised by organisations
5 such as the World Health Organisation, the Centre for
6 Disease Control, and we are a recommended resource in
7 the NICE guidelines. We are key stakeholders in
8 high-level meetings with the Scottish Government, the
9 NHS, and in research collaborations such as with Derby
10 University on healthcare and education. The
11 organisation is unique in that it documented and tracked
12 the post-COVID-19 impacts on children in real time as
13 the pandemic unfolded. We provide evidence and concerns
14 on the risk of long COVID as a post-COVID condition,
15 that is as a long-term chronic illness and/or
16 disability.
17 Q. Can I just pause there, Ms Goss.
18 This may be a difficult question to answer, and if
19 you can't, please just tell me.
20 You say there that your organisation has tracked the
21 post-COVID-19 impacts on children in real time as the
22 pandemic unfolded. Are you able to give us
23 an indication as to when the issue of long COVID in
24 children started to manifest itself?
25 A. Oh, goodness, right at the beginning, Mr Gale. Our CEO

1 and founder, she -- Sammie McFarland, she started Long
2 Covid Kids in August 2020, and there were already
3 families joining all the time whose children had not
4 recovered from COVID-19 infection in the first wave. So
5 it became very apparent very early on.
6 Q. Thank you. That is very helpful. Thank you.
7 Can we go back to your statement, please, at
8 paragraph 0.7. Would you read on from that, please.
9 A. Our position strongly is that the Scottish Government's
10 measures and key decision-making did not, and still does
11 not, go far enough to safeguard the health and
12 development of children and young people. This is in
13 contrast to their own "Getting it right for every
14 child", GIRFEC. Children and young people living with
15 long COVID are dismissed and ignored to the detriment
16 and expense of their health, education and welfare.
17 Policy has not changed for the better and new evidence
18 is being ignored, with mitigation measures that were
19 already poor being dropped. Our position is that the
20 Scottish Government have been negligent, both in the
21 discharge of their responsibilities and their failure to
22 keep up to date with contemporary research. We make
23 particular reference here to the Jason Leitch letter
24 of March 2022, where at page[sic] 4 evidences they only
25 took mortality into account and not morbidity -- that

1 is, long-term consequences like long COVID -- and his
2 further letter of April 2022 at paragraph 5, where he
3 advises children can go into school if they are
4 symptomatic.
5 Q. Again, can I pause there, Ms Goss, because obviously you
6 make some fairly trenchant criticisms of government in
7 that paragraph.
8 Can I just go, however, to something you say at the
9 beginning of the paragraph, where you say:
10 "Children and young people living with Long Covid
11 are dismissed and ignored to the detriment and expense
12 of their health, education, and welfare."
13 Now, obviously from the point of view of these
14 hearings, we are looking very much at health, and
15 can I emphasise to you that other colleagues within the
16 Inquiry team will be looking at issues of education and
17 welfare. I think in previous discussions with you,
18 I have explained that, and also I am aware that you do
19 say something about that in your statement.
20 However, what I am interested to know is what you
21 say about, "Children and young people living with Long
22 Covid are dismissed and ignored". Who do you feel they
23 are dismissed and ignored by?
24 A. They are dismissed and ignored by the very public bodies
25 who are there who are supposed to protect and support

1 them. They are dismissed and ignored by the Scottish
2 Government, they are dismissed and ignored by NHS
3 Scotland, by Public Health Scotland, by local
4 authorities. There are no policies in place, and the
5 healthcare provision for long COVID does not exist. In
6 children, in paediatrics.
7 Q. So that dismissal and ignorance of children with
8 long COVID, how has that manifested itself to you?
9 A. To me personally or to --
10 Q. To you personally or as an organisation. And, again,
11 please be careful not to name your daughter.
12 A. Yes, okay. To me personally, I have spent many
13 an evening crying on the bathroom floor because I have
14 absolutely no idea what to do next because nobody is
15 helping us. And my child is extremely sick, she is not
16 getting any healthcare from NHS Scotland because they do
17 not understand long COVID and do not -- have not been
18 supported with the most recent evidence, so they are not
19 aware of treatments that can help improve quality of
20 life.
21 I have struggled for the entire time -- I know we
22 are not talking about education, but I have struggled
23 the entire time to get education for her, and only
24 recently has she started to get some.
25 And social care, again, we were referred

1 in January 2021, and we have only just been given
2 a caseworker in the last month.
3 And, honestly, this story is repeated over and over
4 and over again. The impact on families is
5 life-changing, devastating. It has broken up families,
6 it has -- parents and carers have lost their jobs
7 because they have to care full time now for their sick
8 child. Families have had to move house because if they
9 have gone down to one income, perhaps, they maybe can't
10 afford their house, they need to downsize. Families
11 have also had to move into more appropriate houses, such
12 as -- there is one family in Scotland who recently had
13 to move to a bungalow because the stairs were too much
14 for the child.
15 The impacts are so far-reaching that our lives are
16 completely different.
17 Q. Thank you very much for telling us that.
18 Would you go to paragraph 0.8 and just read that
19 paragraph, please.
20 A. Before I do that, can I maybe make reference to some of
21 the letters from March 2022 and April 2022?
22 Q. Yes, if you wish.
23 A. So previous to those, in September 2021 -- this is
24 relevant because it does give some kind of context and
25 maybe a little bit of insight into maybe the Scottish

1 Government's feelings towards long COVID at the time or
2 feelings to advocacy and campaigners in the public
3 arena.
4 So in September 2021, the National Parent Forum of
5 Scotland held a webinar, an online webinar, with a Q&A
6 opportunity with the clinical director, Jason Leitch.
7 I attended this webinar just to listen, initially.
8 Unfortunately, I signed in very early and all the
9 cameras and mics were on, and as far as I am aware,
10 Jason Leitch was not aware that his camera and his mic
11 was on, because the host of the webinar said to him,
12 "I hope that everyone is nice to you with their
13 questions this evening", and he said in reply, "I hope
14 so" -- what did he say, sorry ... I am just reading my
15 notes here. Well, he referred to parents, advocates and
16 campaigners who were campaigning for mitigations and
17 public health measures as "extremists", and he said that
18 there were either the extremists on one end who were
19 telling him that he was destroying children's education
20 and keeping schools closed, and on the other end the
21 extremists who were saying that he is harming their
22 children -- harming our children and that he needed to
23 do more.
24 So I sent a little message into the chat function of
25 that webinar, and I said, you know, "I don't think

1 Mr Leitch was aware that we heard his comments about
2 extremist parents before the recording started", and
3 I said that was very unpleasant to hear. He sent
4 a private response -- I don't think he was aware it was
5 me. I am still not sure he was aware it was me. He
6 sent a private response apologising for his language.
7 I just think it is really important to highlight
8 that, because I think that shows potentially what the
9 government were feeling at the time, that people who
10 were campaigning for the health and wellbeing of
11 children had extreme views, and I don't believe that the
12 health of children is an extreme view.
13 Q. Thank you very much for that amount of detail, Ms Goss.
14 Can we go back, as I asked you to, to paragraph 0.8,
15 and you talk about the strategic network which was
16 established in March 2022, with a budget of £10 million,
17 a support fund from the Scottish Government over
18 a three-year period.
19 I think one of the points you are making and make
20 further is that you are unclear as to the extent to
21 which that has been devoted or utilised in relation to
22 long COVID, and particularly long COVID in relation to
23 kids.
24 A. Yes. This has been a problem. The long COVID strategic
25 network was set up to assist the 14 health boards in

1 developing -- planning, developing and implementing
2 long COVID services in Scotland. Unfortunately, they
3 started planning, developing and implementing adult
4 services, and in a meeting -- I can't remember exactly
5 who -- what the meeting was for, but in a meeting this
6 year -- which I know is out of the scope of the Inquiry,
7 but it is good for context -- in a meeting in February
8 this year, one of the lead clinicians -- yes, one of
9 the lead clinicians for one of the health boards said
10 that they didn't realise they needed to develop
11 paediatric services.
12 I really fail to understand how we have come this
13 far and they still don't know that we need paediatric
14 services, when I -- Long Covid Kids has been having
15 regular meetings with the Scottish Government. The
16 Scottish Government are very well aware that children
17 develop long COVID and need some healthcare and support
18 and treatment, so why has this not translated down to
19 the very network who are supposed to be implementing
20 this? So that is one problem with the network.
21 The £10 million is over the three years, so that
22 equates to roughly about 3 million per year. So if you
23 divvy up 3 million between 14 health boards, and
24 obviously it is done proportionately by population, it
25 really is not very much at all, and it certainly isn't

1 enough.
2 Again, we have told the Scottish Government time and
3 time again: this is not enough funding, you need to put
4 in more money because at the moment the health boards
5 are struggling to actually plan these services, because
6 they cannot afford to recruit, they struggle to recruit
7 because these are on short-term contracts which nobody
8 wants, they cannot recruit enough people in the right
9 specialities. It is such a mess, quite honestly.
10 It does feel as though the Scottish Government have
11 just said: right, here's a pot of money, go and figure
12 it out yourselves. There is no direction from them,
13 they've just sort of -- I think they believe they've
14 done enough, honestly. And they certainly haven't.
15 They are not prioritising it how they should be, and
16 there needs to be a lot more attention on long COVID.
17 Shall I go on to talk more about the network?
18 Q. I would like you to -- well, we can read what you say at
19 0.8. Could I ask you to go on to your key areas of
20 concern, which you do in -- you start at 0.9, but then
21 it becomes paragraph 1 and 1.1.
22 The first is in relation to lack of public health
23 information and communication. Now, the Inquiry has
24 already heard a good deal about communication, and will
25 continue to hear about communication, but we would like

1 to hear from you about your impression and understanding
2 of the level of communication you have had, or your
3 organisation has had.
4 So would you read on at 1.1, please.
5 A. Yes, sure.
6 It became apparent early in the pandemic that
7 children transmitted COVID-19. However, there was and
8 still is poor public awareness of the risks of long-term
9 sequelae associated with COVID-19 infection in children
10 and young people, and the increased risk associated with
11 reinfections. The Scottish Government continued to
12 repeat the narrative that the risk of children
13 contracting and transmitting COVID-19 was low, despite
14 evidence to the contrary. There was also no accurate
15 data on the prevalence of COVID-19 and long COVID
16 amongst children and young people in Scotland. Public
17 Health Scotland modelling, which has now ceased,
18 reflected the ongoing and escalating problem, but this
19 did not measure prevalence. ONS findings were also only
20 good for the whole of the UK. There is no
21 Scotland-specific focus.
22 Q. Continue on, please.
23 A. Symptoms were being presented beyond the three
24 "cardinal" ones, yet the Scottish Government would not
25 permit attendance at testing. Additionally, children

1 and young people do not present the same in acute
2 infection. The Scottish Government and NHS Scotland did
3 not update their symptoms list on their websites in
4 a timely manner. There was also a discrepancy between
5 NHS boards and local authorities in relation to their
6 symptoms list. This led to many families not
7 prioritising testing, especially in instances of
8 asymptomatic acute infections or missing symptoms.
9 Q. Go on, please. Would you read on until we get to the
10 next subheading of "Lack of access".
11 A. Public Health Scotland, in their three-part survey "Are
12 the Kids Alright?", excluded the direct harms on
13 children and young people experiencing long COVID.
14 Their response to questioning was that the EAVE II study
15 addressed this. However, this is false as it only
16 covered prevalence of long COVID at baseline population
17 level and did not take account of age, gender,
18 demographics, let alone the views, feelings or lived
19 experience of children and young people suffering from
20 long COVID.
21 In December 2020, the Scottish Government published
22 "Coronavirus (COVID-19) framework for decision making -
23 assessing the four harms". There was another failure to
24 address long COVID within any section of the framework;
25 it was excluded entirely.

1 Q. Can I ask you what level of communication and guidance
2 would you wish to see in relation to long COVID in kids?
3 A. Yes, absolutely. I would be glad to say.
4 Well, first of all, I think we need to get really
5 back to the basics. Public health messaging needs to
6 acknowledge that SARS-CoV-2 is an airborne virus and
7 that that is the primary route of transmission. They
8 also need to acknowledge that COVID is a vascular
9 disease, that it causes organ damage, cardiovascular
10 complications, immune disregulation, brain inflammation,
11 it can cause diabetes, epilepsy, so many conditions, and
12 this has not been communicated to the public. And
13 I believe this is why the public believe that now
14 COVID-19 is just a cold or a flu. It certainly is not
15 either of those things; it is far more damaging.
16 It is also really important that there is public
17 health messaging about the risks of long COVID. Nobody
18 seems to be aware that you can develop long COVID with
19 a subsequent infection, and parents and carers need to
20 have this information so that they can make their own
21 informed risk assessment for their own family. How can
22 families make informed decisions if they don't have all
23 the information?
24 So I think that has been a really big failure on the
25 part of our public bodies, unfortunately. They have not

1 communicated the risks, and that means everybody is just
2 thinking that COVID-19 is quite a benign infection, when
3 it really isn't.
4 Q. Okay, thank you.
5 You then go on to talk about lack of access to
6 health and social care, and again, I think it is
7 probably easier and more effective if you would read
8 from paragraph 2.1 onwards. We will interrupt it with
9 a reference to the diagram that you provided in your
10 statement, just to get a little detail, but if you just
11 read through that section, please.
12 A. Yes. We recognise that healthcare professionals have
13 been left unsupported and untrained, which results in
14 many not recognising long COVID symptoms and failing to
15 refer patients to appropriate care. Because healthcare
16 professionals are not appropriately trained, they are
17 not recognising symptoms, therefore no diagnostics. No
18 diagnostics means no treatment. There is also a culture
19 of failing to refer patients or refusing to refer
20 patients where they or their family have conducted their
21 own research. This further results in inconsistent care
22 across NHS health boards, leaving children and young
23 people at a postcode lottery of what diagnostic testing,
24 treatment and support they will receive. Families are
25 having to learn about long COVID alone, with many

1 resorting to private healthcare in a desperate attempt
2 to find some relief for their children. They then face
3 further barriers, with NHS staff refusing to collaborate
4 with private healthcare.
5 Q. Continue on, please, Ms Goss.
6 A. There is nothing being done at policy level to ensure
7 long COVID is tracked. Primary and secondary care each
8 have their own individual systems, both where the
9 condition is often listed as Post COVID Syndrome or Post
10 Acute Sequelae of COVID, so many can't find when they
11 search for long COVID. This has obvious and serious
12 implications for data collection, with an
13 under-reporting of the prevalence of long COVID, and the
14 assumption that paediatric long COVID is not of
15 significant concern. It is paramount that partnerships
16 are created through the NHS, private practitioners and
17 families, and we consider this can only be appropriately
18 managed at government level.
19 Q. Continue on, please.
20 A. We are also suffering inappropriate treatment such as
21 graded exercise therapy, even though this is not
22 recommended in NICE guidelines, which state the harm in
23 doing so. Healthcare professionals are also
24 recommending cognitive behavioural therapy. You cannot
25 exercise your way out of a chronic condition with

1 untreated underlying pathology. Similarly, CBT may be
2 beneficial as a supportive measure, but it is not
3 a treatment. Children and young people who have
4 long COVID may also suffer from symptoms such as chronic
5 pain that leaves them immobile, yet they are not being
6 provided with mobility aids.
7 Q. Before we come to your diagram, could I just go back to
8 one of the points that you make in that section.
9 You observe that there have been difficulties in
10 accessing treatment and care where individuals have
11 been, as it were, conducting their own research into
12 long COVID and presumably then presenting that to
13 healthcare professionals. Is that something that has
14 manifested itself on a number of occasions, in your
15 understanding? And can you hazard a guess as to why
16 that might be?
17 A. Could you ask that in a different way? I am not
18 understanding what you are asking.
19 Q. Okay.
20 You have made reference in your statement to where
21 families have had to conduct their own research, and
22 what I am wanting to know is: has that been a difficulty
23 insofar as accessing treatment that has occurred in more
24 than a few cases? Is it something you have come across
25 in a number of situations? And the second part of

1 question is: can you hazard a guess as to why that might
2 be?
3 A. Right, okay. Sorry. I understand.
4 Yes, it has happened in every situation, with every
5 family. So because in the first couple of years --
6 first three years, I suppose, of the pandemic, the
7 Scottish Government insisted on "strengthening" existing
8 services instead of choosing to create clinics. The
9 problem with strengthening existing services is that
10 that model would require every single healthcare
11 clinician in Scotland to be knowledgeable on long COVID.
12 That is completely unfeasible. It is a new condition,
13 it is something that has -- there is constant research
14 coming out, there is constant learning. You can't
15 expect every single person in NHS Scotland to be
16 studying that in their free time, and they certainly
17 don't get any paid time off to be doing it.
18 So that is where the problem lies, is that there has
19 been no education given to healthcare professionals, and
20 it's implied that everybody should know about this.
21 So, yes, families go to their primary care provider,
22 and of course they are not up to date on the latest
23 research. How could they possibly be? GPs are already
24 under immense pressure. They simply do not have the
25 time to be hunting down the research. Whereas the

1 patients and parents, we do. So we have become patient
2 experts in our own condition. But then there is a bit
3 of a power struggle when you go to your GP or your
4 paediatrician or whoever you are seeing and you present
5 them with this research that you have found, or a bundle
6 of research, and say, "Right, okay, I think this is what
7 is happening, I think this is what we need to do, here's
8 how we solve the problem", and them not really actually
9 willing to listen or to act on that.
10 So it's a case of: if patients can't convince their
11 clinicians to accept that they are the expert on their
12 own illness, the Scottish Government needs to make sure
13 the education is there and then they need to educate the
14 clinicians. So, yes.
15 Q. Might it also be that clinicians are perhaps suspicious
16 of the work that patients might be doing, particularly
17 if it is informed online rather than in different
18 sources? Do you think there is an element of suspicion?
19 A. Yes, and quite rightly so. Not every research paper is
20 made equal. There is good and bad research. And that
21 is where Long Covid Kids comes in. We have our expert
22 advisers. They can go through the research papers and
23 say: okay, this is a good one because of these reasons;
24 this is a bad one because of these reasons. So we try
25 to collate the research which is going to be helpful,

1 and make sure -- and kind of direct families to that
2 research, rather than something else that may not be
3 quite as useful.
4 But, yes, there is definitely a suspicion -- I would
5 say unwillingness to accept that we know what we are
6 talking about.
7 Q. Just in relation to your diagram, first of all can I
8 compliment you on the diagram, because many times we, in
9 this profession, look at diagrams and think: I have no
10 idea what that is about. But in your case, it is very
11 clear.
12 There are two aspects that I would like to ask you
13 about. The first is mental health. I am not ignoring
14 any of the others, but I would like to ask you
15 particularly about mental health.
16 Are you talking here about the mental health of
17 children or the mental health of their parents?
18 A. Everyone involved. Where I talk about that, it's
19 actually really interesting, because we -- I remember
20 making this -- and we still use it now. I remember
21 making this in 2021, I think it was, and it's so
22 devastating to realise that it is still entirely
23 relevant today. So there is nothing different. Nothing
24 has changed.
25 So, yes, it would be the mental health of the whole

1 family. It is an incredibly difficult situation for
2 a family to be in, particularly when there is such
3 stigma attached to long COVID. You will find that even
4 your own family members, your own immediate and extended
5 family members, will not actually understand or perhaps
6 be a little suspicious that: how could a child possibly
7 be this unwell? It's very difficult to understand
8 long COVID in children if you haven't seen it and
9 experienced it.
10 So there is a lot of isolation because there is very
11 little understanding in the general community, and that
12 also ties into the lack of public health communication,
13 from our public bodies. They have not informed the
14 public about how bad long COVID can be, so nobody is
15 really aware of that and nobody is understanding it. So
16 there is -- it is incredibly isolating.
17 It's also -- it's a massive impact on the child's
18 mental health when they are going to their -- you know,
19 the doctor is somebody who is there to help you and is
20 there to make you better and healthy and well, and when
21 a child is faced with a clinician who has not been
22 supported with training, and they are saying -- they are
23 shrugging their shoulders and saying, "Well, you know,
24 your blood tests are fine, there is nothing wrong with
25 you; go back to school, you will feel better", or, "It's

1 just anxiety so, you know, you just basically have to
2 deal with it", or send you to a website to look at, the
3 dismissal in a young child is devastating for them. The
4 medical trauma that the children have been through in
5 their long COVID case support group. You can't measure
6 it.
7 There is a massive distrust now and resentment from
8 the children themselves, and that is just so hard when
9 my own daughter, you know, she will tell -- we have had
10 to get private healthcare because we just have -- we
11 have given up trying to get any NHS support. Even with
12 private healthcare, who are experts in long COVID, they
13 know what they are doing, she is saying, "Well, they are
14 not going to do anything, are they? What's the point?"
15 That is her whole attitude and opinion is: "What's the
16 point, they are not going to help anyway and they are
17 just going to say there is nothing wrong with me."
18 You know, these children are going to -- God
19 willing -- turn into adults, and what is going to happen
20 when we have a proportion of these adults who have had
21 long COVID when they were children having this distrust
22 and resentment towards these public bodies who are
23 supposed to be helping and looking after them and caring
24 for them. They have a duty of care, and that duty of
25 care has not been upheld.

1 Q. Could I also just ask you about the physical side of
2 this, which you mention in your chart, your diagram.
3 I think you mentioned earlier that there is
4 a perception that long COVID equals fatigue, and I think
5 what you are saying in that little block there is that
6 the symptoms are much wider than fatigue. Obviously,
7 fatigue may be one of them, but the symptoms are wider,
8 and perhaps you could just indicate what your experience
9 as a representative of Long Covid Kids is in relation to
10 the physical symptoms that can be manifested.
11 A. Yes, so within our support services, we see groupings of
12 symptoms, really; constellations of symptoms, we call
13 it. So there will be a subset of children who are
14 having very severe gastrointestinal symptoms and perhaps
15 new allergies, things like that, and that will be
16 a subset of those children. There are children like my
17 own daughter whose symptoms are very much neurological
18 and brain-based, basically, so there is that subset of
19 children and their long COVID manifests in that way.
20 And then there are other children who will manifest in
21 more of a -- perhaps musculoskeletal and they are
22 struggling to walk and they are having to use
23 wheelchairs now, which by the way the NHS won't give
24 them. Sometimes you get some children who have all of
25 these things.

1 So I think when people say long COVID is different
2 for everyone, that is true, and that is, you know,
3 within the nature of the virus. I mean, the virus can
4 affect any part of your body, which then makes sense
5 that long COVID can manifest in different ways,
6 depending on what has been more damaged, essentially.
7 So the symptom burden can be absolutely enormous.
8 I mean, for example, my daughter is asleep right
9 now. She didn't sleep all night -- she is living in
10 Australia, apparently, she didn't tell me -- and she
11 will sleep now until the evening, and there's very
12 little I can do about it. Just got to let her sleep.
13 Her body needs the rest.
14 She needs a wheelchair to get around. She has
15 a condition called POTS, which is postural orthostatic
16 tachycardia syndrome, which is very common in children
17 after COVID, so she is on a lot of medication, and she
18 is bed-bound right now.
19 You know, there are children at varying degrees of
20 severity and disability, it fluctuates and it wanes,
21 remit and remission. It's a very confusing condition,
22 extremely debilitating, and this just is not widely
23 known. It's not widely known at all in the public
24 space.
25 Q. Thank you.

1 Now, I think in paragraph 2.4 -- most of what you
2 say in paragraph 2.4 are matters you have already
3 touched upon and I don't intend to repeat that.
4 Obviously everybody can read that section.
5 You conclude at paragraph 2.5 that -- I suppose
6 criticising the absence of high quality and biomedical
7 paediatric research has led to poor outcomes.
8 Do you know if there is a level of improvement in
9 that type of research going on now or is it static?
10 A. Yes, there is, but not in this country. I am not really
11 up to date on what funding calls are going on in
12 Scotland right now, but when they did do the funding
13 call at the beginning of the pandemic, most of the
14 research studies were based on either social research,
15 really, and -- I am not a researcher, I can't -- I don't
16 know how to term it properly, but psychosomatic, mental
17 health; there is no biomedical research looking into the
18 mechanisms underlying long COVID to understand what
19 long COVID is and why it's happening.
20 At the moment, I don't know if there is any research
21 going on at all. It could be -- there could be, so
22 don't quote me on that. But there is no paediatric
23 research at all. At all. So ... That I do know.
24 Q. Okay.
25 The next two sections of your statement deal firstly

1 with inadequate education provisions, then lack of
2 mitigation measures in schools and hospitals, and then
3 lack of flexible employment, carers and cumbersome
4 welfare system.
5 Now, I think as I have indicated to you, Ms Goss,
6 these are areas that my colleagues within the Inquiry
7 team will be specifically looking at, and I have
8 referred what you have said in this section of your
9 statement to them and they will be looking at it in more
10 detail in the context of, specifically, education and
11 welfare.
12 So just for today's purposes, I am going to ask you
13 to take those passages as read. We have all got it in
14 front of us.
15 I would like to take you on to the final part of
16 your statement, which is about human rights failures,
17 and if you could --
18 A. Could I possibly speak to the hospital side of that?
19 Q. Yes, if you wish. Yes.
20 A. That would fit into healthcare.
21 Q. Right, okay.
22 A. Very, very briefly.
23 The fact that mitigations and protections have been
24 taken away in our NHS means that attending medical
25 appointments for children with long COVID is one of

1 the most dangerous places that they can go. We know
2 that reinfection will more likely than not make your
3 long COVID worse. That certainly has been with my
4 daughter and plenty of others -- most others. If there
5 are no mitigations in the hospital, and they catch
6 COVID-19 in the hospital, as a hospital-acquired
7 infection -- which I don't know if that is still being
8 even recorded anymore with COVID-19 -- then it is
9 harmful to them to even attend any appointments.
10 So I think it is important to have that noted, that
11 we have been campaigning for mitigations in healthcare.
12 Q. Right. Well, we will have that noted, certainly,
13 Ms Goss.
14 Can we go on to human rights failures, please,
15 section 6 of your statement. I would like you to read
16 those three paragraphs, please, so that we have it
17 before us.
18 A. Yes.
19 Prolonged illnesses such as long COVID have
20 implications on children's rights to life, survival and
21 development, education and health, and their well-being.
22 Children and young people have a right to have their
23 best interests considered and implemented at policy
24 level. We urge the Scottish Government to recognise the
25 significance of long COVID in children, and call upon it

1 to address its human rights implications in line with
2 GIRFEC, the Children and Young People (Scotland) Act
3 2014 and the United Nations Convention on the Rights of
4 the Child.
5 On 6 August 2020, the UN Committee on the Rights of
6 the Child published a statement expressing concern about
7 children globally due to the effects of COVID-19. The
8 Scottish Government set out its approach in relation
9 to 11 areas highlighted by the committee, yet there are
10 no mention of children and young people suffering from
11 long COVID.
12 The lynchpin of our organisation is that
13 multi-layered protections against contracting COVID-19
14 are the only way to drive case rates down and reduce the
15 spread of the virus, which would in turn reduce the
16 incidence of long COVID. It is vital that
17 the Scottish Government leads this and upholds their
18 duties.
19 MR GALE: Ms Goss, that is really all I want to ask you
20 today. Thank you very much for taking the time. I know
21 it has been difficult, and we are very grateful as
22 an inquiry that you have taken the time to put your
23 statement together and to give the time to engage with
24 us today. So thank you very much indeed.
25 THE WITNESS: Thank you very much and thank you for having

1 me.
2 THE CHAIR: Thank you very much indeed, Ms Goss. We are
3 very grateful.
4 Good.
5 MR GALE: My Lord, that is business for today.
6 THE CHAIR: Very good. Thank you very much indeed, Mr Gale.
7 We are not sitting tomorrow --
8 MR GALE: We are not.
9 THE CHAIR: -- because the owners of this building require
10 it for something else, to be blunt about it. It is
11 theirs, although we are paying rent. So we are not
12 sitting until Tuesday.
13 Tuesday at 10 o'clock. Thank you very much.
14 (3.02 pm)
15 (The Inquiry adjourned until 10.00 am on Tuesday,
16 7 November 2023)
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19
20
21
22
23
24
25

1 INDEX
2 DR MARSHA SCOTT (called) 1
3 MS CATHERINE MURPHY 1
4 (called)
5 Questions from MR GALE 1
6 MS HELEN GOSS (called) 87
7 Questions from MR GALE 88
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

A

ability (3) 44:10 60:1,1
able (5) 19:9 37:16 38:17 88:4 97:22
abortion (12) 34:8,9,15,15,16,20 35:23 36:4,10,12 37:14,21
above (2) 14:9 49:2
absence (1) 119:6
absolute (3) 22:25 78:11 93:19
absolutely (16) 11:18 14:21 22:18 25:8 26:21 27:20 36:7 41:4 69:13 72:14 75:7 83:9 96:3 100:14 108:3 118:7
abuse (57) 12:8,25 13:13,15,23 15:10 17:6 19:7 21:22 22:15 23:7,10 26:17,21,23,25 30:10,20,24 37:25 40:25 43:2,6,8,13,16,22,24 47:21 48:14 49:12,13,14,16,22 50:17 61:2,4,7,13 64:24 65:15 66:7 67:2,23 68:4 69:15 73:15 81:13,16,17,21,24 82:3 83:11,13,20
abuser (5) 22:18 26:18 44:18 47:24 50:25
abusers (9) 19:25 37:19 43:23 44:4,10 50:20 54:2,13 81:25
abusive (4) 52:6,16 53:18,20
academia (1) 97:3
academic (2) 3:25 33:4
accept (5) 65:4 71:21,22 113:11 114:5
access (44) 9:17 12:1,4 13:3 16:6 17:22 22:19 31:21 32:3 33:5,15 35:12 37:16,21 38:4,5 42:4,4,8,12 44:5,6,12 51:17,18,20 52:6 60:16,18 64:15,20 65:17 67:12,20 68:2 69:2,11 78:7 82:2 93:13,14,15 107:10 109:5
accessed (1) 41:22
accessible (1) 93:15
accessing (7) 36:10,11 53:10 65:13 68:7 111:10,23
accommodation (5) 13:21 14:15 15:9 52:17 53:3
accompanying (1) 4:7
account (6) 4:11,13 6:14 63:20 98:25 107:17
accountable (1) 79:11
accounts (3) 32:23 54:2 82:8
accurate (3) 95:15 96:5 106:14
accused (1) 66:21
ache (1) 95:1
acknowledge (3) 85:21 108:6,8
acknowledgement (1) 19:16
acronyms (1) 95:4
across (28) 6:8 11:25 13:7,19 14:10 17:10 18:10 21:3,25 32:14 33:13 35:10 50:7 53:16 54:1,2 56:24 57:11,13 58:15 59:22 68:8 75:22 80:4 81:9 83:23 109:22 111:24
action (3) 8:13 30:21 31:8
active (1) 91:6
activities (2) 59:24 91:7
actually (12) 25:11 53:23 58:10,16 67:10 68:23 78:13 91:24 105:5 113:8 114:19 115:5
acute (4) 91:20 107:1,8 110:10
add (8) 6:3 15:14,15 19:24 35:6 36:8 37:18 73:5
added (1) 65:16
addition (1) 3:24
additional (3) 19:24 44:4 63:8
additionally (1) 106:25
addon (1) 74:11
address (8) 2:2,20 8:13 44:1 58:25 80:23 107:24 122:1
addressed (2) 9:22 107:15
addressing (2) 4:22 86:8
adjourned (1) 123:15
adjournment (1) 87:8
adjust (1) 83:17
administrative (1) 70:2
adult (1) 104:3
adults (3) 55:15 116:19,20
advances (1) 34:7
adverse (1) 25:4
advice (12) 12:3,7 16:3 18:17 31:24 32:6 67:20 68:8 69:10 82:5,22 83:4
advise (1) 32:9
advised (1) 68:19
advisers (4) 92:18,22,24 113:22
advises (1) 99:3
advisory (2) 11:5 85:22
advocacy (8) 8:10 9:15 13:4,6,6,18 92:19 102:2
advocate (1) 90:22
advocated (2) 34:10,24
advocates (2) 13:1 102:15
advocating (2) 71:25 72:19
affect (1) 118:4
affected (7) 12:8 21:12 29:23 43:10 46:9 68:17 91:5
affecting (2) 80:3 84:2
affects (2) 23:8 91:14
afford (2) 101:10 105:6
after (8) 30:5,7 31:2 39:14 65:7 77:11 116:23 118:17
afternoon (2) 87:10 88:1
afterschool (2) 44:20 48:1
afterthought (1) 72:13
again (34) 1:3 2:18,20 6:25 15:14 24:14 31:17 34:9 38:8 43:3 48:23,24 49:21,21 52:10 54:9,20 62:25 66:22 67:12,17 70:16,18 76:25 89:20 92:16,22 99:5 100:10,25 101:4 105:2,3 109:6
against (6) 28:1 37:22 57:1,15 78:22 122:13
age (8) 1:23 2:18 36:11 40:16 41:18 46:13 81:3 107:17
aged (1) 36:9
agencies (2) 67:20,21
ago (2) 61:12 64:4
agree (2) 6:23 64:3
agreement (1) 7:3
ah (2) 49:7 86:25
ahead (1) 54:10
aid (12) 2:6,13 13:10,11,19 14:3 16:18 22:8 47:16 68:2,6 69:2
aids (1) 111:6
aims (1) 12:1
airborne (1) 108:6
allergies (1) 117:15
alliance (3) 3:9,10 9:7
allocate (1) 10:12
allocated (2) 22:17 78:10
allocation (2) 9:23 52:24
allocations (3) 14:23 15:6 23:14
allow (1) 5:3
allowed (1) 38:4
allowing (1) 52:5
alluded (2) 89:5 90:2
almost (7) 6:1 15:7 18:19 21:9 52:23 60:3 93:15
alone (6) 28:15,21 32:5 94:5 107:18 109:25
along (2) 34:5 89:18
already (22) 3:7,24 18:1 35:22 51:23 56:5 67:13 69:18 70:15,19 74:20,23 79:16 80:12 88:5 90:2 91:3 98:2,19 105:24 112:23 119:2
alright (1) 107:12
also (65) 4:6 8:18 14:11 16:1 19:23 20:3,15 21:3 22:17 26:12 27:10 32:21 33:14 34:8 36:2,24 37:15 39:20 40:18,23 42:6 46:4,7 49:15 53:13 54:4 55:21 56:10 59:16 63:1,9 65:10 67:19,23 68:18 69:3 75:14,15 76:7 77:4 81:8 85:4,22 89:13,22 90:1,5 92:17,18 95:1 99:18 101:11 106:14,19 107:4 108:8,16 109:18 110:20,23 111:4 113:15 115:12,17 117:1
although (7) 17:2 18:16 21:18 37:24 41:9 82:4 123:11
always (5) 49:25 58:10 77:8,9,10
ameliorated (2) 80:16 83:24
amend (1) 7:1
amendments (1) 15:23
amina (3) 3:18 9:2 21:23
among (3) 19:15 36:9 63:11
amongst (1) 106:16
amount (4) 27:6 36:20 59:23 103:13
amounts (1) 20:7
analysed (3) 4:13 84:13 89:17
analysis (1) 60:12
andor (1) 97:15
announced (1) 66:4
anonymous (2) 29:7 38:8
another (3) 6:9 46:19 107:23
answer (2) 78:5 97:18
answering (1) 49:4
anticipate (1) 36:16
anticipated (3) 5:25 24:15,21
anxiety (8) 5:8,9 18:25 20:9 23:1 24:8 36:23 116:1
anxious (2) 28:18 38:24
anybody (1) 23:6
anymore (1) 121:8
anything (6) 4:12 6:21 29:11 77:7 86:12 116:14
anyway (1) 116:16
apologies (1) 86:11
apologise (1) 73:21
apologising (1) 103:6
apparent (4) 24:9 82:3 98:5 106:6
apparently (1) 118:10
appears (1) 48:24
appended (1) 22:2
applied (3) 65:15 75:8 88:24
apply (2) 67:22 81:20
applying (2) 25:2 79:11
appointment (1) 34:5
appointments (5) 32:2 33:15 38:18 120:25 121:9
appreciable (1) 19:11
appreciate (3) 63:25 87:3,5
approach (2) 72:6 122:8
approaches (2) 72:4 80:15
appropriate (4) 18:5 25:19 101:11 109:15
appropriately (3) 39:16 109:16 110:17
april (4) 43:12,14 99:2 101:21
arbitrary (1) 33:17
area (6) 8:2 28:24 35:16 36:14 39:7 73:9
areas (17) 17:10 18:10 20:23 33:14,24 35:8 48:7,12 56:24 57:13,24 59:8 81:7,9 105:19 120:6 122:9
arena (1) 102:3
arguably (1) 75:14
argue (2) 79:5 85:9
arguing (1) 51:4
around (21) 20:8 21:20 31:25 34:20 36:24 44:10 50:16 60:8 63:5 66:25 70:5 72:3 73:10 75:16 78:5,6 82:19 85:16 94:1 95:21 118:14
arrangements (2) 65:13 87:1
arrest (1) 31:6
ascertain (1) 67:23
ask (22) 4:17 6:25 24:7 30:8 46:18 62:1 83:9 84:8 89:7,12 90:13 94:13 95:5 96:11 105:19 108:1 111:17 114:12,14 117:1 120:12 122:19
asked (6) 40:22 73:17 77:20 88:2 96:12 103:14
asking (3) 20:24 31:3 111:18
asleep (1) 118:8
aspects (3) 37:12 78:21 114:12
assault (4) 12:25 23:7 45:11 67:2
assessing (1) 107:23
assessment (4) 40:22 73:19 81:4 108:21
assessments (3) 74:5,8 80:9
assist (2) 4:9 103:25
assistance (2) 92:20 93:1
associated (2) 106:9,10
assume (2) 33:22 53:19
assumes (1) 25:16
assumption (3) 24:17 84:23 110:14
assure (2) 88:10 89:16
assured (1) 89:24
asylum (2) 70:3,8
asymptomatic (2) 91:21 107:8
attached (1) 115:3
attempt (1) 110:1
attempted (1) 29:12
attempting (1) 28:14
attend (2) 38:17 121:9
attendance (1) 106:25
attended (1) 102:7
attending (1) 120:24
attention (6) 23:22 35:9 76:11 82:21 89:14 105:16
attitude (2) 75:3 116:15
attract (1) 39:22
attrition (2) 61:15,16
august (2) 98:2 122:5
austerity (3) 17:20 27:11 58:1
australia (1) 118:10
authorities (5) 52:23 75:14 93:18 100:4 107:5
authority (3) 14:22 15:4,5
authors (1) 45:20
autoimmune (1) 56:8
autonomous (1) 13:17
availability (1) 51:18
available (8) 6:9,10 7:19 34:23 53:6 72:3,5 80:8
average (2) 40:10 61:19
avoid (1) 67:24
avoidable (1) 23:3
avoided (1) 83:25
award (1) 51:24
aware (18) 2:2 3:19 16:19,21 32:11 90:3,4 95:4 99:18 100:19 102:9,10 103:1,4,5 104:16 108:18 115:15
awareness (3) 12:24 63:11 106:8
away (7) 18:7 44:20 48:1 54:7 75:9 89:19 120:24
awful (1) 38:13

B

b (1) 91:7
back (41) 6:1,24 15:6 16:12,22 17:20 19:17 24:14 25:11 29:8 31:7 35:21 38:25 41:16 45:24 50:8,11 52:7 53:6 57:3,8 59:1,4,5,15 60:8 63:21 66:25 78:5,6 81:9 83:1 94:2,3 95:5 96:23 98:7 103:14 108:5 111:7 115:25
backgrounds (2) 55:11 81:6
backlogs (1) 69:23
bad (6) 25:19 89:3 92:10 113:20,24 115:14
baillie (1) 95:10
baked (2) 72:9 75:18
bare (1) 59:11
barriers (1) 110:3
based (6) 8:24 37:3 51:2 95:19,22 119:14
baseline (1) 107:16
basic (2) 75:25 94:22
basically (2) 116:1 117:18
basics (1) 108:5
basis (4) 9:18 22:20 74:16,20
bathroom (1) 100:13
battle (2) 93:7,19
bearing (1) 55:13
became (5) 24:9 83:6,19 98:5 106:6
become (4) 21:7 24:23 85:10 113:1
becomes (1) 105:21
bedbound (1) 118:18
before (15) 3:7,23 7:21 46:22 53:7 60:8 63:6 69:5 74:6 76:24 83:6 101:20 103:2 111:7 121:17
began (4) 29:13 30:18 31:1 83:16
begin (3) 1:19 3:3 51:6
beginning (9) 30:5 31:9 42:10 84:6 91:16 95:6 97:25 99:9 119:13
begins (1) 46:3
behalf (2) 1:10 87:17
behaviour (1) 43:22
behavioural (1) 110:24
behind (2) 60:4 86:16
being (33) 16:9 19:22,23 22:16 25:17 32:18 33:7 37:16 38:12,20 39:15 40:22 47:20 51:13,16 53:20 66:8,23 68:19,22,24 76:17 77:1,24 78:8 83:3 88:7 98:18,19 106:23 110:6 111:5 121:7
believe (7) 13:12 34:17 95:20 103:11 105:13 108:13,13
believed (1) 94:16
below (1) 47:11
belt (1) 8:5
beneficial (1) 111:2
benefit (1) 26:7
benefits (1) 88:9
benign (1) 109:2
best (8) 5:11,16 37:3 68:1 69:15 79:5 92:9 121:23
bets (1) 84:25
better (9) 13:1 42:13 72:1 73:3 75:5 94:9 98:17 115:20,25
between (9) 9:20 23:8 37:11 68:1 71:14 72:14 77:4 104:23 107:4
beyond (5) 4:12 14:9 42:16 88:6 106:23
big (5) 54:13 57:10,13 68:2 108:24
bigger (1) 73:2
biggest (4) 5:8,9 59:18 60:15
biomedical (2) 119:6,17
birth (5) 1:23 38:19,22,23 39:4
births (2) 38:21,21
bit (11) 6:17 21:19 34:1,18 37:23 49:3 79:18 88:5 90:13 101:25 113:2
biweekly (1) 22:20
black (5) 3:15,19 21:24 42:7 76:8
block (1) 117:5
blood (1) 115:24
blue (1) 96:13
blunt (1) 123:10
bme (1) 14:12
board (3) 33:24 72:25 75:22
boards (8) 35:10,11 103:25 104:9,23 105:4 107:5 109:22
bodies (6) 71:11 91:18 99:24 108:25 115:13 116:22
body (3) 39:4 118:4,13
borderline (1) 38:25
bosss (1) 41:5
both (15) 3:24 6:15 9:24 28:10 29:11 37:20 38:4 40:2 67:2,22 86:17,18 92:23 98:20 110:8
bottom (2) 48:23 49:8
bought (1) 42:11
bound (1) 34:20
boys (1) 10:10
brain (1) 108:10
brainbased (1) 117:18
branch (1) 90:25
brave (1) 33:7
breaching (1) 53:21
breadth (1) 5:10
break (3) 42:21 90:6,10
breakfast (2) 86:2,5
breaking (2) 28:21 54:8
breast (1) 31:23
brevity (4) 5:1 8:20 70:12 84:7
brief (2) 4:23 50:6
briefly (5) 27:4 45:25 62:16 70:19 120:22
bring (5) 29:4 34:4 51:1 67:7,8
british (1) 31:6
broad (1) 29:16
broader (1) 28:2
broken (2) 29:3 101:5
brookshay (1) 45:9
brought (4) 5:12 55:25 74:17 96:11
brunt (2) 40:19 55:13
budget (2) 27:13 103:16
building (2) 66:20 123:9
built (1) 25:22
bundle (1) 113:5
bungalow (1) 101:13
burden (4) 18:23 40:8 62:6 118:7
burman (1) 45:8
bus (2) 66:14,16
business (1) 123:5
busy (3) 40:18,21 91:6

C

cake (2) 75:18,18
call (11) 24:25 49:15 50:22 54:4,7 65:18,19 76:6 117:12 119:13 121:25
callaghan (1) 46:10
called (11) 1:11,14,15 3:18 46:15 66:8 87:19 118:15 124:2,4,6
calling (3) 25:15 65:9,10
calls (7) 30:4 31:2 64:23 66:13 67:4 69:5 119:11
came (9) 20:14 27:15 31:2 41:13,14 54:1,2 68:9 81:22
camera (1) 102:10
cameras (1) 102:9
campaigners (3) 34:10 102:2,16
campaigning (3) 102:16 103:10 121:11
cancelled (1) 85:7
cannot (5) 91:2 93:8 105:6,8 110:24
cant (19) 4:3 13:12 38:16 50:24 51:1 60:21 74:1 88:5 92:12,12,13 97:19 101:9 104:4 110:10 112:14 113:10 116:5 119:15
capacity (7) 14:21 29:9 62:13 66:10 67:21 79:8,9
capture (1) 21:13
car (1) 35:23
cardinal (1) 106:24
cardiovascular (2) 94:25 108:9
care (38) 34:8 39:6,11,13,25 40:3,7,10,12 42:3,7,14 49:23 55:14,16 57:2 58:2,3 60:3 62:8,9 63:5,8,13,17,23 73:24 93:14 100:25 101:7 109:6,15,21 110:7 111:10 112:21 116:24,25
cared (1) 22:11
careers (2) 60:1,2
careful (1) 100:11
carefully (1) 64:12
caregiver (1) 51:9
carers (13) 20:6 21:2 23:21,22,23 61:24 62:4 64:5,8,13 101:6 108:19 120:3
caring (3) 18:24 62:6 116:23
carried (2) 18:24 31:9
carry (3) 40:4,4 43:21
carrying (1) 41:13
cases (16) 45:17,24 46:12 54:9,9,12 61:17 66:5,7,12 68:14,21,22,25 69:22 111:24
caseworker (1) 101:2
cast (1) 6:21
cat (6) 5:9 22:24 23:5 60:17 68:18 73:25
catastrophic (1) 35:3
catch (2) 58:16 121:5
catherine (4) 1:7,15 2:17 124:3
causal (1) 37:11
cause (4) 43:24 81:15 82:2 108:11
caused (2) 81:21 83:10
causes (3) 8:14 94:23 108:9
causing (1) 81:24
caveat (1) 4:22
caveats (1) 81:19
cbt (1) 111:1
ceased (1) 106:17
central (2) 8:5 62:13
centre (4) 12:5 45:6 67:4 97:5
centres (1) 13:3
ceo (2) 2:13 97:25
certain (16) 3:7 6:1 15:3 26:9 34:19 41:18 48:17 52:8 59:1 60:5 72:15 75:22 79:15 80:17 83:4 84:25
cervical (1) 31:23
cessation (1) 45:22
chair (21) 1:3,13,17 6:17 42:18,23 74:20 75:8 86:18,21,25 87:3,6,10,16,21,24 88:1 123:2,6,9
challenge (1) 14:8
challenges (1) 93:11
championed (1) 96:25
champions (1) 75:23
change (5) 26:22 61:5 80:14 83:6 85:19
changed (6) 33:16 82:6 83:5 93:12 98:17 114:24
chapter (1) 10:5
charitable (2) 7:13 24:1
charities (2) 73:9 97:4
charity (4) 88:19,22,24,25
chart (1) 117:2

SCI-TRNSPT-000018_0033

chat (1) 102:24
cherry (1) 75:17
chief (3) 2:6 88:16,18
child (17) 22:21 31:25 50:16,17 51:1,5 56:25 93:20 98:14 100:15 101:8,14 115:6,21 116:3 122:4,6
childcare (5) 16:7 19:21 24:20 55:14 59:24
children (119) 5:6 7:14 10:19 13:15,18,22 15:13 17:5,11,14 21:21 22:13,14,18,23 23:9 28:14,19 30:15,25 31:4 43:7 44:8,11,16,17 45:19 46:8,13 47:20 48:13,15,19 50:14,21,21,23 51:5,8,11,12 52:5 53:1 54:6,14,18 65:22 66:8,16,22 67:7,8 68:3,8 73:9,12,15 81:12 90:21,24 91:4,5,14,18,20 92:5 93:17 94:2,17,23 95:7,24 96:4 97:12,21,24 98:3,12,14 99:3,10,21 100:6,7 102:22,22 103:11,12 104:16 106:7,9,12,16,25 107:13,19 109:22 110:2 111:3 114:17 115:8 116:4,8,18,21 117:13,16,16,19,20,24 118:16,19 120:25 121:22,25 122:2,7,10
childrens (5) 22:12 60:13,14 102:19 121:20
childs (1) 115:17
chip (1) 27:3
chipped (1) 18:7
choice (2) 37:22 38:20
choices (5) 30:19,20 35:25 49:22 54:18
choke (1) 49:15
choosing (1) 112:8
chopped (1) 33:16
christina (1) 78:23
christmas (2) 54:15 73:23
chronic (4) 29:10 97:15 110:25 111:4
circles (1) 26:7
circumstances (1) 23:2
cite (1) 81:15
civil (4) 50:16,24 51:19 68:9
claire (1) 6:5
clarify (1) 94:14
clarity (1) 16:25
clean (1) 5:15
clear (7) 26:14 56:6 60:12 65:12 74:4,24 114:11
clearly (3) 62:17 65:19 91:12
clients (1) 40:20
clinic (1) 12:6
clinical (1) 102:6
clinician (2) 112:11 115:21
clinicians (5) 104:8,9 113:11,14,15
clinics (1) 112:8
close (6) 2:11 8:4,9,11 28:21 60:22
closed (4) 55:16 66:5,18 102:20
closely (1) 97:3
closing (1) 23:12
closure (2) 44:1 62:7
closures (2) 61:21 66:2
club (1) 48:1
clubs (1) 44:20
coalface (1) 22:9
coerced (1) 37:25
coercive (1) 44:16
cogently (1) 60:18
cognisance (1) 63:7
cognitive (3) 94:21,25 110:24
cold (2) 92:11 108:14
collaborate (1) 110:3
collaboration (1) 12:5
collaborations (1) 97:9
collaboratively (1) 11:25
collate (1) 113:25
collateral (1) 47:21
colleagues (4) 39:24 60:22 99:15 120:6
collection (1) 110:12
college (1) 41:25
coloured (1) 8:7
column (8) 47:7,8,10,10 48:22,23 49:8,9
come (15) 3:2 6:24 15:1 20:16 23:15 33:15 43:18 53:16 64:16,17 66:25 92:21 104:12 111:7,24
comes (7) 8:6 9:25 78:2,5,6 95:18 113:21
coming (5) 17:19 19:17 20:12 26:4 112:14
comments (2) 4:5 103:1
commitment (1) 71:1
commitments (1) 86:14
committed (1) 11:4
committee (8) 46:23,23,24 47:3,13 49:1 122:5,9
committees (1) 65:23
committing (1) 6:1
common (1) 118:16
communal (1) 14:18
communicated (2) 108:12 109:1
communication (6) 105:23,24,25 106:2 108:1 115:12
communities (3) 17:8 68:10 80:18
community (6) 3:16 13:1 38:14 44:13 91:13 115:11
compared (4) 40:1,12 43:12,14
competence (12) 10:4,8 11:8,13 16:14 18:5 24:14 25:8,9 27:23 71:5 82:17
competency (5) 63:21 75:21,21 76:1 77:14
competent (3) 10:12,21 11:2
complainer (1) 61:15
complainers (3) 66:7,22 68:3
completely (3) 28:20 101:16 112:12
complexities (1) 48:10
complicated (1) 45:2
complications (1) 108:10
complied (1) 75:4
compliment (1) 114:8
comply (2) 39:3 74:18
components (1) 75:20
compounded (5) 18:22 52:25 59:12,17 60:2
compromised (1) 41:24
concentrate (1) 29:11
concept (2) 24:24 90:3
conception (1) 68:20
concern (7) 17:12 71:25 81:21 82:15 105:20 110:15 122:6
concerned (5) 5:21 24:11 59:10,16 78:3
concerns (6) 41:25 45:16 48:14 70:17 73:13 97:13
conclude (2) 56:19 119:5
conclusion (2) 84:4,5
condition (10) 53:10 89:6 90:3 97:14 110:9,25 112:12 113:2 118:15,21
conditions (3) 91:15 95:2 108:11
conduct (1) 111:21
conducted (2) 21:3 109:20
conducting (1) 111:11
conflicting (1) 32:23
confusing (2) 60:24 118:21
congratulating (1) 33:7
connection (1) 37:11
consequence (1) 81:15
consequences (8) 23:4 56:23 58:17 61:20 80:12 91:22 92:3 99:1
consequent (1) 53:2
consider (3) 11:15 95:14 110:17
considerable (3) 18:9 50:4 82:1
considerably (1) 4:9
considerations (1) 79:24
considered (5) 22:16 47:20 84:13 89:17 121:23
considering (2) 23:11 47:3
consistent (3) 19:16 83:23 86:8
consistently (3) 20:12 73:14 81:16
constant (2) 112:13,14
constantly (1) 28:18
constellations (1) 117:12
constituencies (1) 24:3
constitute (1) 80:25
constrained (4) 30:21 35:25 49:23 84:7
constricted (1) 14:21
contact (5) 2:3,20 28:19 51:5,24
contacted (1) 3:17
contemporary (1) 98:22
context (12) 21:21 27:4 45:25 49:22 50:17 51:5 52:2 57:7 67:1 101:24 104:7 120:10
contextually (1) 17:19
continually (1) 78:18
continue (11) 44:7 48:21 71:6 80:5 94:13,14 96:2 105:25 106:22 110:5,19
continued (2) 74:10 106:11
continues (2) 20:15 69:10
contraception (3) 37:16,21 38:6
contracting (3) 39:19 106:13 122:13
contracts (2) 57:23 105:7
contrary (3) 11:16 53:15 106:14
contrast (1) 98:13
contributed (1) 81:11
control (9) 37:23 43:24 44:4,9,17 51:12 54:14,16 97:6
convention (2) 75:15 122:3
convince (1) 113:10
coordinates (1) 13:5
core (1) 82:15
corner (2) 47:6,8
coronavirus (1) 107:22
correct (2) 87:22 92:24
correctly (1) 34:17
cost (1) 36:18
couldnt (3) 16:6 40:18 41:2
council (2) 11:5 85:22
count (1) 96:13
counter (1) 83:7
counterparts (1) 79:2
counting (1) 76:5
countries (1) 84:23
country (1) 119:10
couple (2) 30:7 112:5
course (10) 6:11,22 24:9 39:19 40:6 59:3 75:8 83:19 90:19 112:22
courtordered (1) 51:6
courts (9) 44:3 51:19,20,22 61:6 66:2,5,19 79:9
cover (1) 8:2
covered (2) 96:6 107:16
covid (130) 6:5 10:19,20,20 11:3 14:17 17:19 18:2,3 29:8 37:12 43:10 51:1 54:12 55:22,23 56:3,4,12 57:1,8,22 58:5 59:11 62:24 66:16 69:19 72:1,8 76:19,24 77:13 83:10 87:17 88:16,18,19,21,23 89:1,4,23,24 90:2,3,14,17,20,22,23 91:2,8,14,25 92:2,3,10,17 93:17 94:5,17,19,20,23 95:10,22,23 96:2,4,13,25 97:14,23 98:2,15 99:1,10,22 100:5,8,17 102:1 103:22,22,24 104:2,14,17 105:16 106:15 107:13,16,20,24 108:2,8,17,18 109:14,25 110:7,9,10,11,13,14 111:4,12 112:11 113:21 115:3,8,14 116:5,12,21 117:4,9,19 118:1,5,17 119:18,19 120:25 121:3,19,25 122:11,16
covid19 (28) 17:6 18:16 31:25 36:24 40:9 45:16,23 47:3 57:4 70:24 81:23 82:4 91:21 93:25 94:5,18 98:4 106:7,9,13,15 107:22 108:14 109:2 121:6,8 122:7,13
cpn (1) 38:14
create (2) 24:21 112:8
created (2) 81:25 110:16
credit (1) 76:22
crime (2) 43:12 45:6
criminal (4) 46:15 51:20,21 68:8
crisis (27) 2:12 8:3 12:5,16,19,24 17:19 18:2,3 22:8 27:8,10,17 36:18 52:17 67:3 69:16 72:1,8 77:6 79:24 80:1,11 84:24 85:6,11,12
critical (4) 8:5 33:12 71:12 81:17
criticising (1) 119:6
criticisms (1) 99:6
cross (3) 92:21 93:2,4
crying (1) 100:13
culture (6) 86:2,4,8,12,15 109:18
cumbersome (1) 120:3
cumulative (4) 17:13,16 18:4,9
cumulatively (1) 81:11
currently (1) 90:24
curry (1) 64:4
custody (1) 50:16
cut (1) 17:21
cuts (3) 17:21,23 27:14

D

daily (4) 26:16 82:4 83:14 94:21
damage (6) 26:12 47:21 48:19 83:21,24 108:9
damaged (1) 118:6
damaging (2) 82:12 108:15
dangerous (1) 121:1
data (23) 8:6 21:13 27:12 43:18,19 60:24 64:16,23 76:3,3,4,6,7,12 77:14 81:1 82:20,21 95:20 96:2,9 106:15 110:12
date (6) 1:23 4:3 64:7 98:22 112:22 119:11
dated (1) 45:12
daughter (10) 29:1 89:3,6,8,9 100:11 116:9 117:17 118:8 121:4
day (9) 21:6,6 26:18 29:2 41:1 49:11 79:3 93:19 94:5
dead (1) 22:21
deal (7) 11:21 78:10 79:4 96:21 105:24 116:2 119:25
dealing (4) 42:25 50:9 69:23 81:20
dealings (1) 74:15
dealt (4) 4:20 11:13 77:11 79:16
death (2) 39:20 40:9
debate (1) 95:10
debilitating (1) 118:22
decade (2) 17:20 27:11
decades (4) 71:25 72:8,19 76:9
december (2) 45:12 107:21
decent (2) 72:6 74:7
decision (4) 25:22 33:8 74:18 107:22
decisionmakers (5) 25:6 33:23 74:15 75:4,25
decisionmaking (24) 9:18,22 10:20 15:22 16:13,21 25:9 33:19,21 34:1,20 70:18 71:4,9,13 72:2,13,22 74:2,16 75:22 76:13 82:16 98:10
decisions (26) 18:4,6,7 23:4,5 24:18 25:10,23 35:10 36:1 40:22 49:18 50:16 70:3 71:18,22 72:25 73:4,10,19 74:9 75:6 77:13 78:8 81:10 108:22
decreased (1) 29:9
deep (1) 78:24
deeply (4) 22:11 25:23 74:13 78:18
default (3) 25:16,22 41:18
defend (1) 11:24
defining (1) 24:25
definitely (2) 14:6 114:4
degree (5) 34:19 59:1,8 77:21 84:25
degrees (2) 86:7 118:19
delay (1) 76:10
delayed (3) 46:12 54:11 76:25
delays (5) 45:10,18 61:21 69:18 70:3
delighted (1) 6:4
deliver (7) 13:17 19:21 63:23 72:23,23 77:15 86:16
delivered (3) 37:1 76:16,17
delivering (2) 12:22 33:6
delivers (1) 13:6
delivery (1) 19:17
demographics (1) 107:18
depending (4) 93:16,16,18 118:6
depression (1) 18:25
depth (2) 5:22 9:12
derby (1) 97:9
described (1) 22:24
describing (2) 25:5 68:18
design (3) 10:11 63:22 80:1
designed (7) 25:17,18 41:21,21,23 42:11 63:19
desperate (1) 110:1
desperation (1) 20:9
despite (2) 39:1 106:13
destitution (1) 70:6
destroying (1) 102:19
detail (7) 3:2 5:4 84:13 89:21 103:13 109:10 120:10
detailed (2) 3:13 72:4
details (1) 48:12
deteriorated (1) 23:24
deteriorating (1) 19:18
deterioration (1) 57:25
detriment (2) 98:15 99:11
devastating (3) 101:5 114:22 116:3
develop (10) 6:20,22,25 14:1 91:25 92:3 95:3 104:10,17 108:18
developed (1) 82:22
developing (4) 76:12 104:1,1,3
development (3) 80:1 98:12 121:21
devoted (1) 103:21
diabetes (1) 108:11
diagnostic (1) 109:23
diagnostics (2) 109:17,18
diagram (5) 109:9 111:7 114:7,8 117:2
diagrams (1) 114:9
didnt (15) 14:9 23:1 30:6 33:12 50:11 58:19 65:2,6 72:6 73:21 74:11 94:10 104:10 118:9,10
die (1) 94:10
difference (3) 1:24 22:5 73:18
differences (5) 50:15 71:13 72:14,15 76:5
different (16) 8:24 10:10 11:2 20:23 25:12 33:17 68:23 75:3 76:3 84:2 101:16 111:17 113:17 114:23 118:1,5
differently (1) 84:3
difficult (13) 38:7 40:24 48:11 55:17 69:21,21 71:22 83:7 93:6 97:18 115:1,7 122:21
difficulties (3) 51:18 69:9 111:9
difficulty (3) 53:8 68:7 111:22
dimensions (2) 8:22 19:24
direct (7) 12:2,9 13:17 16:3,10 107:12 114:1
direction (3) 59:6,7 105:12
directly (5) 15:19 19:4 26:25 27:15 33:10
director (2) 2:25 102:6
directorate (1) 85:21
disability (5) 8:25 41:19 81:3 97:16 118:20
disabled (3) 36:22 57:5 81:6
disadvantage (1) 80:15
disaggregated (1) 81:2
discharge (1) 98:21
discrepancy (1) 107:4
discrimination (3) 19:3 80:25 81:5
discuss (2) 3:2 47:21
discussing (1) 75:10
discussion (2) 6:6 22:12
discussions (2) 79:1 99:17
disease (3) 56:8 97:6 108:9
dismissal (2) 100:7 116:3
dismissed (7) 98:15 99:11,22,23,24 100:1,2
disorder (3) 38:13,25 39:1
dispensed (1) 63:2
disproportionate (11) 10:18 17:3,24 18:23 45:18 56:19,21 59:23 80:17,24 82:12
disproportionately (2) 39:8 56:3
disregulation (1) 108:10
disrespect (1) 67:17
disrupted (1) 37:2
disruption (2) 56:22 57:4
distance (1) 35:20
distinct (2) 39:2 70:9
distress (1) 19:6
district (1) 22:14
distrust (2) 116:7,21
divvy (1) 104:23
doctor (2) 35:20 115:19
doctors (1) 35:14
document (5) 45:14 46:2,19 47:2,5
documented (1) 97:11
documents (10) 4:8,9 28:8 44:25,25 84:10,12 89:13,15,16
does (9) 8:2 41:19 72:11,11 74:18 98:10 100:5 101:24 105:10
doesnt (1) 25:11
doing (20) 5:9 19:22 20:4,13,22 21:1,16 41:6 74:7,8 88:20 89:9 92:7 96:14,16,18 110:23 112:17 113:16 116:13
domestic (56) 13:13,15,23 15:10 17:6 19:7 21:22 22:15 23:7,10 26:17,21,23,25 30:10,20,24 37:19 40:25 43:1,6,8,13,15,16,22,24 47:21 48:14 49:12,13,14,16,22 50:17 61:2,4,7,12 64:24 65:15 66:7 67:2,22 68:4 69:15 73:15 81:13,16,17,21,24 82:3 83:11,13,20
done (23) 16:9 21:19 23:18,22 26:13 36:14 42:6 46:10 55:24 56:13 61:11 62:12 63:21 72:7,10,17,19,20 83:21 85:4 104:24 105:14 110:6
dont (41) 1:22 10:12 16:16 19:9 21:15 24:23 27:1 31:12 56:15 59:14 64:15,15,17 66:10 70:7,12 75:25 77:18 79:10,11 86:1,21 89:8,19 90:9 91:24 92:3,22 95:4 96:10 102:25 103:4,11 104:13 108:22 112:17 119:3,15,20,22 121:7
door (3) 15:6 38:23 53:6
down (18) 30:9 33:19 46:2 47:12 48:23 49:25 55:8 58:14 59:20 61:19 64:16,17 66:24 95:16 101:9 104:18 112:25 122:14
downsize (1) 101:10
dr (81) 1:7,8,14,19,21,24 2:4,7,10,14 3:15 4:17 5:1 6:3,13 7:2,20 8:9 10:5 11:18 12:19 13:9,11,25 14:6 21:17 22:4 25:7 26:2,6,9 29:19 35:6,7,8 37:18 43:5,20,22 44:8 45:3,6 46:7,17,21 47:12,15 48:8,10,24 49:2,7,10 50:11,14 51:21 52:12 53:23 54:2 60:9,10 64:4 65:2,5 67:16,25 69:13 73:5,7 75:7,11 78:2,5 79:22 80:6,21 82:12 83:9 84:15 86:19 124:2
draw (1) 23:21
drawn (1) 89:14
dread (1) 40:17
drink (1) 83:12
drive (1) 122:14
driver (5) 56:7,10 59:18 61:2,3
drivers (3) 36:15,16 37:5
drives (1) 10:18
dropped (2) 68:15 98:19
due (6) 18:20 19:2 44:8 62:7 76:24 122:7
during (19) 10:20 11:3 14:4 15:8 39:12,14,19 43:9 44:17 45:23 50:18 51:17 57:21 62:24 64:6 66:3 80:15 81:10 90:7
duties (8) 63:8,17 74:3 75:13,15 80:7 82:25 122:18
duty (10) 62:23 74:4 75:13 76:19,24 77:3 80:8 85:7 116:24,24
dynamics (1) 83:13
dysfunction (1) 94:21

E

earlier (14) 16:17 24:14 33:25 41:16 48:6 50:12 51:20 52:13 59:19 64:7 65:5 67:15 86:23 117:3
early (11) 24:9 30:1,2 34:13 44:2 45:19 46:25 81:18 98:5 102:8 106:6
earn (1) 60:1
earning (1) 36:20
earth (1) 14:3
easier (2) 74:10 109:7

SCI-TRNSPT-000018_0034

easily (3) 23:2 24:21 63:2
eat (1) 86:5
eating (2) 38:13,25
eats (1) 86:2
eave (1) 107:14
echo (1) 47:18
economic (3) 9:16 36:17 60:12
economy (1) 49:18
edge (1) 28:18
edinburgh (3) 14:14 47:17 64:5
educate (1) 113:13
educated (1) 33:2
education (19) 12:23 17:11 37:1,2 73:11 93:15 94:8 97:10 98:16 99:12,16 100:22,23 102:19 112:19 113:13 120:1,10 121:21
educational (1) 62:10
effect (3) 18:10 57:5 69:11
effective (3) 13:14 59:5 109:7
effects (3) 45:16 60:23 122:7
efforts (1) 14:9
eight (1) 61:13
either (6) 20:19 33:23 51:10 102:18 108:15 119:14
elderly (1) 94:6
element (3) 16:8 78:25 113:18
elements (1) 52:3
eliminated (1) 61:14
else (5) 26:16 84:16 86:12 114:2 123:10
embed (1) 11:6
embedded (2) 74:17 83:6
embedding (1) 10:8
emergency (4) 15:2,9,24 38:18
emerging (1) 56:1
emphasise (6) 48:20 91:11,12 92:16 93:8 99:15
emphasised (1) 91:2
emphasising (1) 51:20
employed (1) 57:19
employee (1) 28:18
employees (1) 8:13
employer (1) 55:18
employers (4) 8:12 55:7 63:11 82:23
employment (8) 17:11 56:22,25 57:24 58:8,16,18 120:3
enable (2) 8:13 81:4
encapsulates (1) 62:16
encounter (2) 93:6,7
encountered (1) 28:17
encourage (1) 9:3
end (11) 7:4 12:20 13:13 49:11,14 59:5 74:1 80:19 84:10 102:18,20
enduring (1) 32:4
enforce (1) 51:12
engage (4) 9:3 24:2 37:25 122:23
engaged (3) 15:19 33:11 70:1
engages (1) 9:18
engaging (1) 20:23
engender (9) 2:12,25 3:9 8:3,16 9:14,18 20:17 49:20
england (2) 31:5 79:2
enhancing (1) 77:3
enjoying (1) 92:8
enormous (6) 15:8 24:22 36:20 63:23 81:11 118:7
enough (9) 19:22 27:21 76:11 93:8 98:11 105:1,3,8,14
enquired (1) 66:6
ensure (3) 9:19 71:4 110:6
entailed (1) 40:23
entered (1) 18:1
entire (4) 7:3 8:2 100:21,23
entirely (5) 6:24 24:15 25:1 107:25 114:22
entitled (1) 45:10
entrenched (1) 80:2
entrenching (1) 71:14
epilepsy (1) 108:11
eqi (1) 86:10
equal (2) 9:17 113:20
equalities (7) 46:24 47:2,4 70:14 73:22 75:23 79:24
equality (34) 7:16 8:24 9:16 27:19 54:21 55:4 56:23 57:4,8 62:23 73:19,24 74:1,4,5,7 75:13 76:19,24 77:3,8,9 78:17 80:6,8,9 82:19,24 84:25 85:7,8,10,20,20
equally (1) 81:14
equals (1) 117:4
equates (1) 104:22
equipment (1) 39:17
equitable (2) 9:22 71:12
escalating (1) 106:18
especially (7) 26:17 55:10 61:10 81:12,18 82:20 107:7
essential (1) 16:15
essentially (5) 10:8 26:23 77:23 92:16 118:6
established (3) 11:22 90:20 103:16
establishing (1) 23:12
estimate (4) 95:19,25 96:7,7
etc (12) 8:25 15:23 16:7 24:20 28:3 29:24 32:17 33:15 41:19 69:10 73:17,17
ethnic (7) 3:15,20 21:24 42:7 55:11 76:9 81:6
ethnicity (3) 8:25 29:23 81:3
european (1) 75:15
evaluate (1) 81:9
even (21) 16:2 22:16 41:6 42:4,8 54:18 58:7,12 63:10 68:10 69:21 74:6,8 85:10 86:6 94:5 110:21 115:3 116:11 121:8,9
evening (3) 100:13 102:13 118:11
event (1) 71:10
eventual (1) 84:14
every (8) 28:24 93:19 98:13 112:4,4,10,15 113:19
everybody (7) 1:3 5:17 8:5 79:9 109:1 112:20 119:4
everyone (3) 102:12 114:18 118:2
everything (5) 20:14 26:16 29:2 47:18 76:21
evidence (29) 1:10 3:10,13 6:25 7:5 8:19 14:2 27:10 46:16,22 50:6 56:6 61:10,17 66:8 71:10,16 72:3 84:8 86:24 87:13,17 89:18 90:7 95:23 97:13 98:17 100:18 106:14
evidences (1) 98:24
evolved (1) 32:15
exacerbated (8) 17:7 45:24 50:18 55:2 57:2 58:6 59:13 80:16
exacerbating (1) 71:15
exactly (4) 36:15 45:3 60:23 104:4
example (25) 15:24 16:4 19:25 27:13 32:5 33:24 34:4 36:21 44:11 56:7,9 58:2,15,20 61:9 66:1 67:14 73:7,22 76:8 77:4 81:14 85:6 86:10 118:8
examples (4) 11:11 32:24 51:10 56:14
excellent (1) 75:24
exceptional (1) 71:10
exceptions (1) 78:17
excessive (2) 19:20 20:7
excluded (2) 107:12,25
excluding (1) 16:16
exclusion (1) 19:2
excuse (1) 23:10
excuses (1) 51:2
executive (2) 2:6,25
exercise (3) 44:4 110:21,25
exhausted (1) 29:5
exist (3) 72:11,17 100:5
existed (3) 27:17 36:24 58:11
existing (10) 17:7 18:22 19:1 45:24 55:2 56:5 75:5 79:22 112:7,9
exists (1) 95:23
expanded (1) 85:20
expartners (1) 52:21
expect (2) 65:2 112:15
expected (1) 65:1
expecting (1) 59:15
expense (2) 98:16 99:11
experience (21) 8:24 13:15 18:25 30:9,22 32:8,25 33:1 38:24 39:4 46:9 56:4,5,8 57:16 58:19 74:14 91:5 92:19 107:19 117:8
experienced (6) 11:23 12:13 16:4 43:8 46:8 115:9
experiences (14) 8:6,23 9:5 20:5,6,25 21:2,20 32:4 33:12 70:4 76:3,6,8
experiencing (12) 15:10 17:6 19:1 22:10,15 26:25 30:24 38:1 68:3 81:12 83:20 107:13
expert (4) 8:9 92:18 113:11,21
expertise (1) 18:6
experts (5) 27:20 78:11 97:1 113:2 116:12
explain (4) 10:4 17:15 41:13 95:5
explained (1) 99:18
explanation (1) 96:15
explanations (1) 11:12
explore (2) 30:18 31:1
exposed (4) 29:24 39:20 51:13 56:3
exposing (1) 53:21
exposure (1) 56:12
expressing (1) 122:6
extend (1) 11:24
extended (2) 51:13 115:4
extent (11) 28:4 46:7 48:17 52:8 60:5 62:12 64:21 72:20 79:15 82:13 103:20
extracurricular (1) 91:7
extraordinarily (2) 26:19 78:24
extraordinary (1) 69:4
extreme (4) 19:19 58:6 103:11,12
extremely (4) 63:14 91:19 100:15 118:22
extremist (1) 103:2
extremists (3) 102:17,18,21

F

face (6) 30:20 38:16,16 96:13,22 110:2
faced (3) 40:7 93:12 115:21
facilitated (1) 90:11
facilities (1) 16:7
facing (1) 93:11
factor (1) 56:10
factors (2) 69:9 81:2
fail (2) 96:2 104:12
failed (3) 80:13 96:1,8
failing (5) 28:24,25 80:2 109:14,19
failure (13) 11:12 25:21 28:17 48:13 49:17 73:14 74:21 80:8 81:8 82:23 98:21 107:23 108:24
failures (3) 77:15 120:16 121:14
fair (2) 26:9 93:5
fairly (1) 99:6
fall (1) 36:11
falling (1) 59:4
false (1) 107:15
familiar (2) 24:24 86:1
families (19) 17:12 23:18 30:17 80:17 90:21,25 93:10 98:3 101:4,5,8,10 107:6 108:22 109:24 110:17 111:21 112:21 114:1
family (16) 14:20 28:20 39:24 40:17 44:13 52:17 54:4 68:16 101:12 108:21 109:20 112:5 115:1,2,4,5
fantastic (1) 27:20
far (9) 5:21 11:9 24:10 58:20 59:23 98:11 102:9 104:13 108:15
farreaching (2) 56:23 101:15
fathers (1) 51:14
fatigue (4) 29:10 117:4,6,7
favourable (1) 81:25
fear (7) 6:20 18:21 22:20 29:2 36:23 40:16 43:23
fears (1) 39:23
feature (1) 11:8
features (1) 54:23
february (1) 104:7
fed (1) 18:6
feed (1) 15:21
feedback (2) 24:4 32:22
feeder (1) 49:16
feel (7) 6:24 28:24 39:2 84:6 99:22 105:10 115:25
feeling (2) 90:9 103:9
feelings (3) 102:1,2 107:18
felt (4) 6:9 28:17,20 33:17
feminist (1) 9:14
fertility (2) 31:22 37:24
few (7) 3:4 47:19 49:21 51:25 54:9 78:19 111:24
fewer (1) 54:18
fields (1) 97:2
fight (1) 93:7
figure (8) 30:14 95:6,12,12,14,18,19 105:11
filed (1) 89:19
filled (2) 40:16 91:6
final (5) 4:14 29:6,7 76:18 120:15
finally (2) 4:6 27:24
finance (1) 38:5
financial (7) 18:8 27:7,9 28:2 54:21 55:3 62:15
find (12) 7:22 24:3 30:13 31:8 32:19 33:4 47:12 49:23 69:6 110:2,10 115:3
findings (1) 106:19
fine (2) 92:1 115:24
finish (1) 85:25
firm (1) 83:12
firmly (1) 73:20
first (20) 17:18 30:7 45:23 46:5 47:19 59:11 64:14 68:14 83:15 85:24 88:7,21 92:1 98:4 105:22 108:4 112:5,6 114:7,13
firstly (2) 8:18 119:25
fit (2) 41:23 120:20
fitted (2) 39:17 41:10
five (4) 1:11 2:8 7:12 68:6
flagged (1) 45:19
flavour (1) 90:17
flee (1) 44:11
flexible (1) 120:3
floor (1) 100:13
flu (2) 94:18 108:14
fluctuates (1) 118:20
focus (4) 9:4,11 21:5 106:21
focused (1) 8:23
follow (1) 59:2
followed (1) 64:11
following (4) 27:7 36:11 77:17 82:5
follows (2) 52:8 86:15
food (1) 49:24
footnote (1) 95:9
footnotes (1) 95:8
forced (2) 13:23 64:24
foreseeability (1) 24:25
foreseen (2) 25:6,8
forget (2) 94:22 95:16
forgotten (1) 94:12
formal (2) 62:14 67:21
former (1) 85:23
forms (1) 83:20
forum (1) 102:4
forward (2) 5:2 82:23
found (7) 23:23 27:14 43:11 47:9 78:23 88:21 113:5
founder (1) 98:1
four (1) 107:23
fourth (1) 92:2
framework (3) 75:6 107:22,24
frank (1) 86:22
free (3) 6:24 12:7 112:16
freely (1) 44:11
friends (1) 44:13
front (3) 35:20 87:22 120:14
frontline (1) 39:11
froze (1) 52:23
frozen (2) 14:23 15:6
full (10) 1:19 2:15 15:7 18:15 38:21 44:14 52:25 58:23 88:11 101:7
fully (4) 4:11 29:9 59:14 70:20
fun (1) 88:7
function (1) 102:24
fund (1) 103:17
funded (1) 21:20
funding (5) 79:4 80:1 105:3 119:11,12
funds (1) 53:10
furlough (6) 55:7 63:6,7,12,17,19
furloughed (2) 36:19 55:5
further (11) 3:20,23 5:4 6:18 62:18 70:7 84:8 99:2 103:20 109:21 110:3

G

g (1) 54:24
gale (138) 1:4,5,16,17,18,22 2:1,5,8,11,15,18,20,23 3:1 5:20 6:11,14,23 7:3 8:8,16 9:6,13,24 11:11,19 12:15 13:8,25 15:11,18 16:16 17:15 18:11 19:9 20:17 22:3 23:15 24:7,23 25:25 26:3,7 27:3 28:5 29:6,16 31:14,19 32:6,12 33:21 34:6 35:7 36:3 37:8,11 38:8 39:6 40:4 41:8 42:15,23,24 43:19,21 44:7,22 45:5,8 46:17,22 48:5,9,16 49:6,8 50:2,13 51:16 52:7 53:11,25 54:19 55:23 56:14,18 57:7,12 59:2,4 60:9 61:23 62:16 64:1,19 65:4 67:12,17 69:7,24 71:6,16 73:6 74:14 77:17 78:3 79:14 80:5,19 82:11 83:1 84:4,18 86:3,17,20,24 87:1,5,10,11,17,23 88:3,4,8,9 93:8 96:11 97:25 122:19 123:5,6,8 124:5,7
games (1) 83:12
gap (8) 2:11 8:4,9,11,15 60:22 62:21,21
gastrointestinal (2) 94:24 117:14
gather (2) 88:6 96:2
gathered (3) 27:6,12 42:1
gave (4) 46:22,24 66:4 83:4
gaze (1) 25:22
gender (41) 7:16 8:15,23 10:3,8,12,15,21 11:1,6,7,12,16 12:21 16:14 18:22 22:5 24:14 25:7,9,15 27:19 50:15 55:2 59:18 60:3 62:21,21 71:5 72:1,6 78:11,20 79:24 81:2,15 82:17,20,23 85:16 107:17
genderbased (4) 12:10,14 19:7 43:9
gendered (12) 9:22 16:12 18:5,15 23:3 31:16,20 57:2 58:18 76:4 82:14,22
general (7) 3:12 19:12,14 25:2 75:21 89:23 115:11
generalised (2) 27:22,23
generally (3) 14:25 17:5 20:21
genuine (1) 71:1
geographic (1) 8:2
geographically (1) 34:3
geography (2) 35:8,9
germane (1) 6:15
get (29) 5:12 7:9 14:7 15:3,23 16:6 35:1,19 42:8 48:2 50:24 54:7 60:7 61:8,12 66:13 90:17 92:9 93:19 100:23,24 107:9 108:4 109:10 112:17 116:10,11 117:24 118:14
getting (8) 22:19 24:4 29:17,18 38:3,6 98:13 100:16
gift (1) 54:15
girfec (2) 98:14 122:2
giri (2) 47:15,18
girl (1) 39:3
girls (9) 4:2 6:6 10:9 11:6,14 40:16 41:3,7 85:23
give (23) 2:15 4:3 5:4,23 6:25 11:11 19:12 27:13 28:6 41:4 46:15 48:20 56:14 57:7 63:12 66:8 76:7 84:8 87:13 97:22 101:24 117:23 122:23
given (12) 4:19 19:22 29:13 32:18 53:13 59:4 82:21 95:8 96:15 101:1 112:19 116:11
gives (1) 9:12
giving (8) 1:10 20:18 38:22 76:11 86:24 87:17 89:18 90:7
glad (3) 45:5 78:3 108:3
glasgow (6) 14:14 45:9 61:12 68:12,20,25
gleaned (1) 32:8
globally (2) 24:17 122:7
god (1) 116:18
goes (2) 16:12 47:11
going (48) 4:4 5:16 11:11 14:1 15:25 18:12 20:19 22:21 24:13,21 26:15 27:17 30:11 31:13 38:4 41:15 43:1 48:17 54:7 59:7,13 60:7 63:21 66:5,18 67:1,5,6 70:8 72:23 80:20,21 82:10 84:2 86:11 88:2 92:7 113:25 115:18 116:14,16,17,18,19 119:9,11,21 120:12
gone (2) 59:6 101:9
good (29) 1:3,5,13 6:9 10:17 25:18 29:21 32:25 33:11 39:3 49:4 60:19 61:8 65:11 66:1 78:2,14 87:6,10,16 88:1,1 104:7 105:24 106:20 113:20,23 123:4,6
goodness (2) 88:21 97:25
goss (20) 87:12,19,21,24 88:9,11,11 89:1,11 90:13 91:10 97:17 99:5 103:13 110:5 120:5 121:13 122:19 123:2 124:6
government (59) 7:24 10:23 11:4 15:20,22 21:20 26:4,10 27:18,24 34:14,18,19,21 43:10 49:5 63:10,25 70:18 76:23 77:5,10 78:21,25 79:8,23 80:22 81:14,18,23 82:8,18 83:15 85:16,17,19 93:18 96:1,8 97:8 98:20 99:6 100:2 103:9,17 104:15,16 105:2,10 106:11,24 107:2,21 110:18 112:7 113:12 121:24 122:8,17
governments (4) 82:15 91:17 98:9 102:1
gp (1) 113:3
gps (1) 112:23
graded (1) 110:21
grandchildren (1) 92:6
grasp (1) 49:19
grassroots (1) 13:17
grateful (5) 4:8 35:1 89:14 122:21 123:3
great (3) 33:1 76:22 89:21
greater (2) 9:12 82:13
greatly (1) 29:9
grief (1) 39:21
group (12) 1:10,11 7:17 11:23 15:15 20:7 23:20 27:13 36:11 88:22,24 116:5
groupings (1) 117:11
groups (10) 7:15 9:4,12 13:20 72:16 77:25 78:1 80:4,25 81:4
growing (1) 91:1
gryffe (1) 14:13
guess (7) 17:16 21:17 37:3,9 51:22 111:15 112:1
guidance (3) 49:5 82:22 108:1
guide (1) 90:21
guidelines (2) 97:7 110:22

H

hadnt (1) 72:7
half (2) 66:17 86:23
halfway (1) 47:12
handlers (1) 65:20
happen (2) 38:19 116:19
happened (6) 14:15 36:12 58:13 59:22 60:20 112:4
happening (5) 24:3 73:11 78:20 113:7 119:19
happens (2) 78:13 91:3
happy (5) 10:5,6 48:12 83:16 94:1
harassment (1) 52:20
hard (5) 33:22 69:1 73:24 78:19 116:8
harder (1) 21:7
harm (6) 10:18 17:14 80:13,17 81:11 110:22
harmful (5) 25:24 69:2 74:13,13 121:9
harming (2) 102:21,22
harms (2) 107:12,23
hat (1) 20:17
havent (5) 7:6 50:23 68:5 105:14 115:8
having (13) 5:2,11 49:23 71:18 79:5 80:14 93:9 104:14 109:25 116:21 117:14,22 122:25
hazard (3) 37:3 111:15 112:1
head (1) 45:14
headaches (1) 95:1
health (71) 13:1 17:11 18:13,15,18,20 19:5,11,18 20:8 21:5,10 22:25 23:24 24:5,8 28:3 29:14 31:22 33:24 34:8 35:10,11 37:20 38:6,15 39:6,11,12,14 40:2,2,25 55:9 56:5 57:1,16 84:24 85:6,11,12 91:18 97:5 98:11,16 99:12,14 100:3 102:17 103:10,12,25 104:9,23

105:4,22 106:17 107:11 108:5,17 109:6,22 114:13,15,16,17,25 115:12,18 119:17 121:21
healthcare (24) 31:16,20 32:2 33:1,6,10 93:14 94:8 97:10 100:5,16 104:17 109:12,15 110:1,4,23 111:13 112:10,19 116:10,12 120:20 121:11
healthy (2) 91:5 115:20
hear (6) 9:2 66:12 87:24 103:3 105:25 106:1
heard (11) 3:18 8:19 12:17 35:16 41:11 50:19 65:9 68:24 86:3 103:1 105:24
hearing (1) 65:19
hearings (1) 99:14
heightened (2) 39:1 44:9
heightening (1) 19:5
held (2) 94:7 102:5
helen (4) 87:12,19 88:11 124:6
hello (1) 88:1
help (9) 29:14 44:6 78:20 79:4 90:16 93:20 100:19 115:19 116:16
helpful (7) 6:11 8:8 18:11 43:3 50:5 98:6 113:25
helping (2) 100:15 116:23
helpline (12) 12:23 13:23 30:3,5,11 50:19 64:25 65:9,10,17 67:3 69:20
helplines (1) 30:10
hemat (1) 14:13
hence (1) 7:8
here (17) 2:9 6:2 8:4 14:3,9 30:23,25,25 47:15,16 50:9 73:13 86:11 88:5 98:23 102:15 114:16
heres (2) 105:11 113:7
hi (1) 87:25
hierarchy (1) 30:16
high (5) 38:1 56:12 57:17 63:15 119:6
higher (6) 12:23 21:8 40:10 43:13 57:19,19
highest (1) 26:22
highexposure (1) 57:21
highlevel (1) 97:8
highlight (3) 47:19 83:2 103:7
highlighted (3) 46:4,7 122:9
highly (1) 38:21
history (1) 27:7
hit (1) 40:15
hobbies (2) 92:8,13
hold (3) 29:3,15 79:11
holding (1) 51:14
home (28) 19:21 22:23 26:1,5,18 27:2 28:15 30:15 31:7 34:16 35:21 38:20 40:16,19 41:2 44:2,18 47:23 51:1 52:22 55:14,15,17,25 58:21 59:24 81:19 83:19
homelessness (6) 14:7 17:12 50:10 52:7,14 70:5
homeschool (1) 28:14
honest (2) 65:2 67:25
honestly (3) 101:3 105:9,14
hope (3) 7:22 102:12,13
hoped (1) 77:2
hopefully (1) 87:23
hospital (6) 28:16 35:14,19 120:18 121:5,6
hospitalacquired (1) 121:6
hospitalised (1) 94:10
hospitality (1) 55:10
hospitals (1) 120:2
host (1) 102:11
hour (2) 42:18 86:23
hours (3) 55:13 57:22 66:17
house (3) 41:3 101:8,10
household (1) 62:11
households (1) 21:11
houses (1) 101:11
housework (1) 62:11
housing (13) 14:7,15,22 15:5 17:12 23:13 49:19 50:9 52:7,15,24 53:2,10
however (10) 11:10 43:13 80:25 81:17 82:2,7 99:8,20 106:7 107:15
hub (4) 22:17 48:3 73:11,16
huge (1) 27:5
hugely (1) 69:11
human (13) 11:23 30:22 46:24 47:2,4 71:2 75:15 85:1,10,21 120:16 121:14 122:1
hundreds (1) 10:15
hunting (1) 112:25
husband (1) 38:17
husbands (1) 40:18

I

iceberg (2) 29:19 43:7
idea (4) 45:4 96:3 100:14 114:10
ideas (2) 6:19,22
identified (2) 78:9,9
identify (1) 71:20
ignorance (1) 100:7
ignored (9) 71:20 98:15,18 99:11,22,23,24 100:1,2
ignoring (1) 114:13
ii (1) 107:14
illfitting (1) 42:5
illness (3) 41:1 97:15 113:12
illnesses (2) 56:9 121:19
im (9) 13:12 26:2 28:24,25 38:24 45:1,5 48:5 51:22
imagine (3) 19:25 37:4 92:9
immediate (2) 79:3 115:4
immediately (1) 15:7
immense (1) 112:24
immigration (3) 53:9 70:3,5
immobile (1) 111:5
immune (1) 108:10
immunology (1) 97:3
impact (41) 3:11 4:1 5:5 6:5 12:25 15:12 17:3,13,16,24 18:4 20:21 23:11 24:8,10 25:12 27:8 44:14,16 45:18 56:19,21 57:14,15 58:23 59:25 64:20 69:3 73:14,19 74:5,7 76:14 80:9,11,23 81:4 82:12 87:18 101:4 115:17
impacted (3) 19:4 32:3 40:1
impacting (1) 39:21
impacts (12) 16:23 18:12,15 25:4 30:1 31:21 80:3,24 82:22 97:12,21 101:15
impairment (1) 94:25
imperfect (3) 71:24 73:1 76:20
implementation (1) 11:7
implemented (1) 121:23
implementing (3) 104:1,3,19
implications (7) 45:10 46:13 47:4 62:15 110:12 121:20 122:1
implied (1) 112:20
importance (1) 91:1
important (11) 9:9 10:22 22:22 43:15 79:7 85:5,9,10 103:7 108:16 121:10
imposed (1) 37:13
impossible (1) 93:15
impression (3) 74:14 83:8 106:1
impressionable (1) 41:3
improve (5) 12:12,13 60:16 61:16 100:19
improved (1) 60:16
improvement (3) 59:9 61:21 119:8
improvements (1) 70:24
inability (2) 39:22 53:2
inadequate (3) 81:1 82:19 120:1
inappropriate (1) 110:20
inappropriately (1) 41:10
inbuilt (1) 24:17
incidence (1) 122:16
incidents (2) 43:13,15
include (1) 86:4
included (2) 31:21 66:21
includes (1) 71:4
including (9) 13:20 17:10 18:23 40:5 47:25 52:15 56:24,25 83:18
inclusion (1) 78:11
income (2) 21:11 101:9
incomes (1) 27:16
incompetence (4) 10:15 11:17 25:15 96:10
incompetent (1) 25:23
inconsistencies (3) 34:2 36:25 37:16
inconsistency (1) 32:13
inconsistent (6) 31:24 32:6,18 33:9 35:10 109:21
incorporate (1) 73:16
increase (14) 19:10 30:4,6,12 31:2 36:4 37:5,14 52:16,20 55:13 64:8,14 65:6
increased (8) 17:14 18:25 39:18 40:7 52:14 62:5 80:16 106:10
increasing (2) 12:1 70:5
incredibly (2) 115:1,16
index (1) 124:1
indicate (7) 2:23 3:17 4:21 40:9 84:4 92:17 117:8
indicated (3) 64:6 83:4 120:5
indicates (2) 71:11,17
indication (4) 9:7 19:12,14 97:23
indifferent (1) 25:19
individual (7) 5:2,18 18:4 33:19,21 70:4 110:8
individuals (2) 72:16 111:10
induce (1) 34:16
industry (1) 69:4
inequalities (4) 17:7 55:3 56:6 82:14
inequality (9) 6:7 8:14 9:20 10:18 12:2,21 59:18 71:15 81:15
inequity (1) 60:6
inevitably (1) 80:11
infection (13) 91:20,20,21,22,25 92:2,2 98:4 106:9 107:2 108:19 109:2 121:7
infections (1) 107:8
infirm (1) 94:6
inflammation (1) 108:10
influence (2) 8:13 12:11
influencing (1) 12:21
influenzabased (1) 77:23
inform (1) 76:13
information (28) 3:5,6,7,21 5:23 9:12 12:7 13:21 20:18 29:17 31:3 32:14,19,19,25 33:9,13,16 40:8 42:1 53:13 65:11,17 84:9 94:22 105:23 108:20,23
informed (7) 12:9 14:13 37:8 108:21,22 113:17 115:13
initial (5) 5:24 32:16 82:4 83:3,7
initially (1) 102:7
initiation (1) 65:7
inject (1) 6:17
injuries (1) 94:11
input (4) 4:14 6:4 16:20 84:13
inquiry (31) 2:2,20 3:8,17,25 4:9 5:20,21 6:5,23 7:9,22 10:7 41:11 44:24 61:23 70:10 84:9,9,11,12 85:3 87:14 89:17,22 99:16 104:6 105:23 120:6 122:22 123:15
inquirys (1) 23:21
inschool (1) 48:2
insecure (2) 52:14 53:9
insensitive (2) 26:19 51:4
insight (2) 76:7 101:25
insignificant (1) 41:9
insisted (1) 112:7
insisting (1) 37:21
insofar (1) 111:23
inspired (1) 89:5
instance (9) 5:3 7:25 21:23 23:4 35:11 54:3 65:18 68:4,11
instances (2) 32:4 107:7
instead (3) 26:24 80:16 112:8
instills (1) 43:23
instituted (1) 85:23
institutions (3) 11:1 25:10 83:23
insufficient (1) 79:23
integrates (1) 72:14
intelligent (1) 37:9
intend (1) 119:3
intensification (1) 43:8
intentional (1) 74:12
interest (2) 89:4,5
interested (3) 16:18 61:23 99:20
interesting (3) 28:12 74:25 114:19
interests (3) 11:14 51:15 121:23
intermediaries (1) 7:24
international (1) 9:19
internet (1) 33:3
interrogate (1) 85:3
interrupt (1) 109:8
interrupted (2) 58:18 62:25
interruptions (1) 58:19
intersecting (3) 19:3 70:14 82:14
intersectional (7) 8:22 9:8 71:4 72:15 74:16 81:5 82:20
intersectionality (1) 29:20
interventions (1) 38:22
into (36) 4:11,13,14 5:22 6:14 8:6 16:20 17:19 18:6 19:9 25:22 27:17 37:5 38:13 53:1 61:8 63:5,20 72:9,21 73:16 75:18 76:7 79:24 84:13 85:20 98:25 99:3 101:11,25 102:24 111:11 115:12 116:19 119:17 120:20
intolerant (1) 50:15
introduced (5) 34:14 35:2 63:9,10 70:25
introduction (1) 62:8
introductory (2) 4:20 5:21
investigating (1) 77:21
investigations (1) 89:25
investigative (1) 41:12
inviting (1) 9:2
involved (6) 35:21 39:8 46:14 50:25 78:1 114:18
ireland (1) 79:2
island (1) 68:10
isnt (5) 41:9 85:8 91:3 104:25 109:3
isolated (2) 17:9 28:21
isolating (1) 115:16
isolation (4) 18:21 53:5 62:8 115:10
issues (16) 5:10 20:8 21:14 28:2 31:16,20 49:19,24 52:25 60:11 61:8 68:9,18 69:16 71:19 99:16
its (49) 3:16 4:10,10 10:13 12:9 24:17 30:3 34:25 43:15 48:19 49:5,8 50:3 56:1 57:10,13 60:22 61:8,24 62:1 73:24 74:22,24,24 76:20 77:3 79:7 83:12 85:14 86:13 88:7 92:10 93:7,9,18 96:7 112:20 113:10 114:18,21 115:7,17,17,25 118:21,23 119:19 122:1,8
itself (5) 41:14 49:13 97:24 100:8 111:14

J

jackie (1) 95:10
jane (1) 46:10
january (4) 28:11,23 88:22 101:1
jason (3) 98:23 102:6,10
job (8) 27:20 40:18,23 41:1 55:12 56:22 57:4,23
jobs (8) 29:12 36:19 56:11 57:20,21 58:21 101:6
join (1) 93:10
joined (1) 88:22
joining (2) 87:12 98:3
jointly (1) 1:8
joy (1) 29:4
judges (1) 66:11
judicial (1) 70:2
jump (1) 59:15
june (1) 88:23
jury (1) 45:22
justright (6) 2:12 8:3 11:20,22 12:2,10

K

keen (1) 16:2
keep (4) 80:20,21 82:10 98:22
keeping (1) 102:20
kerfuffle (1) 5:13
key (14) 16:6,11 17:12 23:6,13 37:5 55:18 56:4 73:10,16 82:17 97:7 98:10 105:19
keyworker (1) 40:15
kids (21) 49:24 87:18 88:16,18,19,21,23 89:4,24 90:14,18,20 92:17 96:25 98:2 103:23 104:14 107:12 108:2 113:21 117:9
kind (15) 6:8 24:1,6 27:12 33:7 42:5 59:10 60:3,5 64:14 84:23,24 86:10 101:24 114:1
kinds (2) 6:7 51:2
kit (1) 54:13
knew (4) 27:16 35:23 40:18 72:22
know (65) 3:23 5:8,17 10:14 21:1,15,23 22:23 23:6 26:9 28:7 29:21 30:14,15 31:7,10,12 35:11 37:18 45:3 54:13 61:7,22 63:9 69:15 71:21 72:18,18 73:8,23 75:19 76:2 77:20 79:1 83:18 85:14 86:1,21 90:10 94:9 96:8,10 99:20 100:21 102:25 104:6,13 111:22 112:20 114:5 115:18,23 116:1,9,13,18 118:2,19 119:8,16,20,23 121:1,7 122:20
knowledge (2) 17:17 27:22
knowledgeable (1) 112:11
known (4) 36:2 76:15 118:23,23

L

labour (11) 8:10 54:21 55:4 57:16,18 60:10,17,19,23 62:14 68:18
lack (23) 33:13 36:25 39:16,25 65:11,12 68:1,2 69:2 78:7,11 80:10 82:17,18,21 86:6,8 105:22 107:10 109:5 115:12 120:1,3
laid (1) 59:11
language (1) 103:6
laptop (1) 5:14
large (7) 24:19 41:18,22,22 48:14 96:19,20
largely (1) 63:25
last (4) 21:7 55:23 92:14 101:2
lasting (1) 60:23
later (8) 9:25 10:3 25:25 26:3 61:8 79:5 92:11,12
latest (1) 112:22
lawyers (1) 11:23
laziness (1) 96:10
lead (2) 104:8,9
leadership (3) 85:18 86:7,14
leading (3) 12:19 13:11 18:24
leads (1) 122:17
learn (1) 109:25
learned (2) 70:23 79:12
learning (6) 27:6,10 36:14 37:6 55:14 112:14
least (4) 6:22 10:22 65:25 66:24
leave (5) 5:13 31:3 38:4 52:16 85:13
leaves (1) 111:5
leaving (1) 109:22
led (3) 80:12 107:6 119:7
left (4) 41:4 60:4 78:20 109:13
lefthand (1) 48:22
legal (19) 12:3,7 16:3 24:23 26:7 67:20 68:2,6,8 69:2,2,10 75:13 76:16,21 77:16 80:9 82:24 92:24
legally (1) 85:2
legislation (2) 15:24,24
leitch (4) 98:23 102:6,10 103:1
less (5) 42:4 44:12 55:6 67:20 77:1
lessons (1) 70:23
let (5) 8:18 90:10 94:5 107:18 118:12
lets (4) 3:18 8:19 53:19 65:4
letter (2) 98:23 99:2
letters (1) 101:21
level (16) 19:10 20:1,11 57:17 59:10 63:11 75:21 86:14 93:17 106:2 107:17 108:1 110:6,18 119:8 121:24
levels (5) 29:22 32:17 39:20,23 56:12
liaising (1) 6:12
lies (1) 112:18
life (4) 27:9 28:25 100:20 121:20
lifechanging (1) 101:5
lifesaving (1) 13:4
light (1) 46:13
like (40) 3:22 4:5 6:18 7:7 10:13 16:23 21:13 26:21 28:17,24 31:18 36:13 37:18 44:22 46:1 53:25 54:15 56:16 60:3 70:20 71:10 75:20 78:12 79:3 80:19 82:5 83:11 86:10 90:6,10 94:4 99:1 105:18,25 114:12,14 117:15,16 120:15 121:15
likely (20) 17:22 18:17,19 19:1 21:9 34:2 37:19 55:5,6,7,12,18,21 56:8 58:13,14,20,22 71:3 121:2
limitations (1) 37:13
limited (2) 44:10 67:21
line (1) 122:1
lines (1) 75:1
link (2) 68:13 87:20
linked (1) 18:22
list (2) 107:3,6
listed (1) 110:9
listen (2) 102:7 113:9
little (16) 6:3,17 38:20,23 41:11 49:3 50:5,6 90:13 101:25 102:24 109:10 115:6,11 117:5 118:12
live (4) 23:9 35:15 91:9 93:16
lived (2) 92:18 107:18
lives (9) 10:10 26:16 39:13 46:14 59:25 71:14 91:6 92:9 101:15
living (14) 19:25 22:18 26:17 36:18 44:16,18 47:24 53:14 81:7 92:9 98:14 99:10,21 118:9
loaded (1) 93:3
local (13) 13:19 14:22 15:4,5 29:14 35:18 49:19 52:23 68:20 93:18,18 100:3 107:5
lockdown (22) 17:4 21:7 29:13 30:7 32:2 38:12 44:1,8,17 45:23 49:5 52:18 53:16,22 54:8,15 65:7 66:3 81:24,25 82:2 84:1
lockdowns (1) 94:1
log (1) 45:24
long (101) 18:21 31:12 34:25 35:13,20 55:22,23 56:4 87:17 88:16,18,19,20,21,23 89:1,4,23,24 90:2,3,14,17,20,22,23 91:2,8,14,25 92:3,14,17 93:17 94:5,17,19,20,23 95:10,22,23 96:2,4,13,25 97:14,23 98:1,15 99:1,10,21 100:5,8,17 102:1 103:22,22,24 104:2,14,17 105:16 106:15 107:13,16,20,24 108:2,17,18 109:14,25 110:7,11,13,14 111:4,12 112:11 113:21 115:3,8,14 116:5,12,21 117:4,9,19 118:1,5 119:18,19 120:25 121:3,19,25 122:11,16
longer (2) 55:5 71:15
longerterm (1) 44:14
longterm (4) 91:22 97:15 99:1 106:8
loo (1) 30:13
look (8) 25:14 39:14 46:19 70:17 75:20 81:9 114:9 116:2
looked (6) 67:14 77:20,24 89:20,20 94:4
looking (15) 3:12 5:2 6:16 17:10 52:22 70:8,10 76:5 89:22 99:14,16 116:23 119:17 120:7,9
looks (2) 76:3,8
lords (1) 3:6
losing (1) 28:19
lost (5) 36:19 40:19 55:12 61:9 101:6
lot (11) 12:17 16:8 24:5 27:12 28:21 32:22 40:24 69:14 105:16 115:10 118:17
lots (5) 6:6 18:4 24:1,1 61:10
lottery (1) 109:23
loud (1) 26:14
low (4) 63:11,14 91:19 106:13
lower (4) 21:11 43:12 57:20,22
lowpaid (1) 57:5
lung (1) 29:9
lynchpin (1) 122:12

M

macro (1) 59:10
mainstream (2) 79:23 82:23
mainstreamed (1) 82:14
mainstreaming (6) 11:6 72:2,6 77:15 80:6 85:16

maintain (1) 43:23
majority (11) 14:19 22:6 24:22 25:20 27:14 31:1 56:3,11 62:4 63:20 75:25
makes (2) 22:5 118:4
making (11) 5:2 25:10,22 36:1 55:16 66:19 86:14 103:19 107:22 114:20,21
male (3) 25:16,18,21
man (3) 41:18 53:14,19
manage (1) 40:17
managed (3) 5:13 66:19 110:18
management (3) 62:11 79:25 80:11
manager (1) 47:16
manifest (3) 97:24 117:20 118:5
manifested (4) 41:14 100:8 111:14 117:10
manifests (1) 117:19
manner (1) 107:4
many (24) 23:2 33:11 34:10 36:19 40:21 43:25 58:7,25 67:4 68:14,25 71:18 75:9 79:5 84:22 94:2 96:4 100:12 107:6 108:11 109:14,25 110:10 114:8
march (5) 29:8 40:14 98:24 101:21 103:16
marginalisation (1) 19:2
marginalised (4) 7:15 17:25 80:3,13
marker (1) 49:25
market (11) 8:10 54:21 55:4 57:16,18 60:11,17,19,24 62:14 68:18
marriage (2) 13:23 64:24
marsha (5) 1:7,14,21 41:16 124:2
marshas (1) 86:10
maslows (1) 30:16
mass (2) 33:12 65:16
massive (2) 115:17 116:7
mate (1) 29:1
material (4) 4:10,20 6:14 77:19
maternity (4) 20:5 21:1 31:22 32:3
matter (7) 6:18 7:6 10:6 16:17 50:24 61:22 74:21
matters (3) 16:25 79:18 119:2
maybe (4) 101:9,20,25,25
mcas (1) 95:3
mcfarland (1) 98:1
mckelvie (1) 78:23
mean (11) 17:15 23:18 26:9 31:7 57:10 68:1 73:23 93:4,13 118:3,8
meaning (1) 39:18
meaningful (1) 29:13
means (7) 7:24 25:22 41:20 78:12 109:1,18 120:24
meant (5) 14:18 32:4 67:2 72:8,21
measure (4) 63:1 106:19 111:2 116:5
measures (13) 17:4,20 43:25 53:5 55:9 62:9,20 80:23 83:18 98:10,18 102:17 120:2
mecfs (1) 95:2
mechanism (2) 15:4 74:23
mechanisms (3) 51:7 72:17 119:18
media (5) 20:24 33:4 43:25 81:23 82:8
medical (6) 18:17 34:15 38:21 92:23 116:4 120:24
medicallyinduced (1) 35:23
medication (5) 34:15 35:15,18,19 118:17
medicine (1) 35:21
meeting (7) 30:16 73:7,12 104:4,5,5,7
meetings (2) 97:8 104:15
member (1) 13:3
members (7) 13:19 32:8 39:25 52:18 70:25 115:4,5
men (14) 9:17,20 18:17,19 21:8,9 41:23 57:18 58:20 65:9 71:14 72:14 76:4,5
mens (1) 10:9
mental (24) 18:12,20 19:5,11,18 20:8 21:5,10 22:25 23:24 24:5,8 29:14 38:15 39:21 40:2,25 114:13,15,16,17,25 115:18 119:16
mention (8) 7:21 8:22 34:7,8 36:3 41:9 117:2 122:10
mentioned (7) 7:7,7,8 65:5,8 90:2 117:3
mess (2) 38:25 105:9
message (10) 20:13 26:1,4,19,23 63:2 83:3 85:4,8 102:24
messages (2) 26:13 38:3
messaging (13) 65:12 81:18,23 82:3,6 83:2,5,6,8,17,22 108:5,17
mic (1) 102:10
mics (1) 102:9
middle (2) 30:2 31:10
midway (1) 46:2
might (12) 6:19 36:22 42:12 63:7 64:16 75:5 78:3 87:3 111:16 112:1 113:15,16
migraines (1) 95:1
mild (1) 91:20
million (6) 64:9,13 103:16 104:21,22,23
mind (6) 21:18 25:18 39:5 41:21 70:12 89:9
mindful (1) 70:11
minimised (1) 52:5
minimising (1) 56:15
minister (3) 78:22 83:15 85:24
minoritised (1) 57:6
minority (8) 3:15,20 21:24 42:7 43:16 55:11 76:9 81:6
minute (2) 84:1 88:4
minutes (1) 74:1
miracle (1) 22:25
miscarriage (1) 32:5
misconception (2) 94:4,7
misleading (1) 81:22
missing (1) 107:8
mistake (1) 26:11
misunderstanding (1) 83:13
misunderstood (1) 52:4
mitigate (1) 80:14
mitigated (1) 82:13
mitigation (2) 98:18 120:2
mitigations (4) 102:16 120:23 121:5,11
mixed (1) 38:3
mixing (1) 68:22
mmhmm (2) 2:4 43:20
mobility (1) 111:6
model (3) 25:18 60:3 112:10
modelling (1) 106:17
moment (7) 4:3 31:10 70:13 72:12 93:8 105:4 119:20
moments (1) 63:3
money (3) 60:1 105:4,11
monitor (1) 80:22
monitoring (3) 44:9 51:7 81:1
month (3) 34:4 92:11 101:2
months (8) 7:8 20:10 40:20 45:22 61:22 69:21 79:5 92:11
morale (1) 40:2
morbidity (1) 98:25
more (53) 3:12 17:8,22 18:7,8,17 21:11 33:25 34:2,2 35:4 36:13 37:6,6,23 38:7 41:5,6,19 42:4,8,12 52:22 55:5,7,12,18,21 56:1,4,8 58:12,13,14,20,22 83:10 85:10 86:22 91:2 93:6 101:11 102:23 105:4,16,17 108:15 109:7 111:23 117:21 118:6 120:9 121:2
morning (6) 1:3,5,6 29:2 66:15 75:10
mortality (1) 98:25
most (21) 14:20,23 17:7 28:15,16 29:3 30:22 41:24 50:15 59:9 62:9 66:1,23,24 70:25 71:3 100:18 119:1,13 121:1,4
mostly (1) 15:5
mother (4) 28:25 31:5,25 40:14
mothers (5) 47:22 51:12 54:7 63:16 73:15
move (8) 15:12 44:10 52:22 53:1 54:3 101:8,11,13
moved (3) 59:1 65:24 66:23
movement (3) 26:15 65:14 81:19
moving (1) 52:17
ms (82) 1:7,15 2:15,17,19,22,25 8:16,18 9:11,14 11:22 15:14,15,19 17:1,18 18:14 19:14 20:22 23:15,17 24:12 27:3,4 28:14 29:7 31:18,20 32:10,13 33:22 34:13 36:7 37:10,15 38:11 39:10 40:6 41:15 45:8,9 55:1 56:1,17,20 57:10,13 59:2,3,8 62:3,19 64:11 70:23 71:7,21 74:19 75:12 84:15,17,19 86:4 87:19,21,24 88:9,11 89:1,11 90:13 91:10 97:17 99:5 103:13 110:5 120:5 121:13 122:19 123:2 124:3,6
msp (1) 95:10
much (44) 5:4 8:7,8 9:10,12 14:13,21 15:20 25:11 26:13,15 29:23 38:7,16 41:20 42:1,10,15 47:22 51:21 57:21 61:14 70:7 73:13 74:10 78:13 85:5,9 86:12,17 90:12 99:14 101:13,17 103:13 104:25 117:6,17 122:20,24,25 123:2,6,13
multilayered (1) 122:13
multiple (7) 21:18 50:19 51:10 66:13 67:4,4 83:23
mum (1) 28:23
mundane (1) 11:15
murphy (63) 1:7,15 2:15,17,17,19,22,25 8:16,18 9:11,14 11:22 15:14,15,19 17:1,18 18:14 19:14 20:22 23:15,17 24:12 27:3,4 28:14 29:7 31:18,20 32:10,13 33:22 34:13 36:7 37:10,15 38:11 39:10 40:6 41:15 55:1 56:1,17,20 57:10,13 59:2,3,8 62:3,19 64:11 70:23 71:7,21 74:19 75:12 84:15,17,19 86:4 124:3
muscle (1) 95:1
musculoskeletal (2) 94:24 117:21
mystery (1) 38:19

N

nailed (1) 75:2
name (10) 1:19 2:15 3:14 4:18 47:12 48:24 88:11 89:8 92:22 100:11
narrative (3) 81:22 82:7 106:12
national (10) 7:23 11:5 12:11 13:6,16 33:25 40:8 85:22 95:20 102:4
nations (1) 122:3
nature (3) 18:15 73:1 118:3
navigate (2) 92:20 93:2
navigating (1) 93:13
nearly (2) 64:14 89:3
necessarily (3) 4:23 33:8 77:19
necessary (1) 74:12
need (17) 49:14,15,19,25 71:9 72:11 93:20 95:4 101:10 104:13,17 105:3 108:4,8,19 113:7,13
needed (7) 32:25 63:13 72:23 76:2 86:11 102:22 104:10
needle (2) 59:1,5
needs (12) 27:22,23 30:16 34:9 35:9 37:6 72:18 105:16 108:5 113:12 118:13,14
negative (4) 31:21 69:11 80:12,24
negatively (1) 40:1
neglected (1) 71:12
negligent (1) 98:20
nephews (1) 92:6
nettle (1) 49:20
network (6) 22:1 103:15,25 104:19,20 105:17
neurological (2) 94:24 117:17
never (5) 22:15 89:19 91:21 94:3,3
next (6) 20:10 50:1 87:12 100:14 107:10 119:25
nhs (14) 40:1 42:13 97:9 100:2,16 107:2,5 109:22 110:3,16 112:15 116:11 117:23 120:24
nice (3) 97:7 102:12 110:22
niche (1) 23:7
nieces (1) 92:6
night (2) 79:3 118:9
nightmares (1) 29:3
nights (1) 29:4
nobody (5) 100:14 105:7 108:17 115:14,15
nondiscrimination (1) 75:16
nonlawyers (1) 11:25
nor (1) 30:10
normal (2) 94:2,4
norms (2) 18:23 59:19
north (1) 35:16
northern (1) 79:2
note (2) 14:9 95:16
noted (2) 121:10,12
notes (2) 26:8 102:15
nothing (8) 41:4 79:13 93:12 110:6 114:23,23 115:24 116:17
notice (1) 66:4
noticed (1) 30:1
notified (1) 66:9
noting (1) 14:11
notwithstanding (1) 52:18
november (2) 1:1 123:16
nowhere (1) 41:7
nuance (2) 5:5,18
number (14) 4:7 34:7 44:24 47:7 53:12 56:24 89:13 90:1 91:1 95:8 96:11,20 111:14,25
numbered (2) 47:1,6
numbers (3) 19:9 45:1 96:19
nurse (1) 38:14
nurseries (1) 55:15
nursery (2) 44:19 47:25
nursing (1) 41:25

O

obligation (2) 76:21 80:22
obligations (2) 76:16 77:16
obliged (1) 63:12
observations (1) 3:5
observe (1) 111:9
observed (1) 65:22
obstacles (2) 82:1 93:11
obstruction (1) 86:9
obtain (1) 16:25
obtaining (3) 3:20,25 69:9
obvious (1) 110:11
obviously (17) 4:4 5:23 11:11 26:16 34:19 39:7 50:3,4 85:2 89:4,6 96:7 99:5,13 104:24 117:6 119:4
occasions (1) 111:14
occupational (4) 57:17 58:10,25 97:2
occupations (2) 40:11,13
occurred (2) 13:25 111:23
oclock (4) 42:16 66:14 86:20 123:13
october (4) 28:9,10 29:7 43:11
odd (1) 74:22
offence (1) 45:17
offer (1) 38:16
offered (1) 79:3
offering (1) 68:12
office (3) 41:5 68:6 95:19
officer (3) 2:6 88:16,18
official (2) 73:20 95:13
officials (7) 10:21 26:10 36:1 65:13 73:8 82:19 83:16
offloaded (1) 24:19
offpiste (1) 48:18
often (17) 15:2 16:5 37:23,24,25 41:19 50:22 66:6 68:16 71:11,23 74:8 75:23 83:15 91:20 93:25 110:9
oh (6) 26:9 45:6 46:21 88:21 92:10 97:25
okay (14) 11:19 49:4 54:19 84:17 93:9 95:18 100:12 109:4 111:19 112:3 113:6,23 119:24 120:21
old (3) 1:22 83:12 88:14
older (1) 81:7
once (3) 65:8 66:22 74:18
ones (2) 38:18 106:24
ongoing (2) 79:25 106:18
online (3) 52:21 102:5 113:17
ons (1) 106:19
onto (2) 59:21 65:25
onwards (4) 7:19 72:5 79:21 109:8
open (1) 34:1
opened (1) 88:23
operate (2) 13:22 14:4
operated (2) 15:16 61:6
operates (2) 12:4 25:15
operating (3) 14:24 88:16,18
opinion (1) 116:15
opportunities (2) 5:17 44:5
opportunity (3) 10:17 48:20 102:6
opposite (1) 91:4
option (1) 38:20
options (2) 30:19 35:25
order (2) 49:14 51:11
organ (1) 108:9
organisation (23) 2:13 3:10,18,21,22 5:4 8:1,10,17 9:15 12:17,20 13:9,12,16 17:2 90:18 97:5,11,20 100:10 106:3 122:12
organisations (27) 1:11,12 2:8,11,24 3:3 5:6 7:12,13 15:16 16:2,9,20 17:13 19:4,15 20:20,21 21:3 22:7 24:2 29:17 31:11 71:8 82:5,6 97:4
originally (1) 63:19
orkney (1) 68:13
orthostatic (1) 118:15
others (5) 35:13 40:21 114:14 121:4,4
otherwise (1) 12:3
outcomes (4) 12:13 18:18 61:17 119:7
outnumbered (1) 75:24
outset (3) 41:15 74:17 90:5
outside (1) 66:20
outwith (2) 65:24 68:25
over (18) 6:20,22 8:11 37:23 43:12 51:12 57:25 64:9 78:15,15 90:25 94:16 95:7 101:3,3,4 103:17 104:21
overarching (2) 84:19 85:14
overlap (1) 95:2
overlooked (1) 71:13
overrepresented (1) 68:16
oversized (1) 41:23
overview (3) 15:12 16:22 70:17
own (15) 39:4 51:14 98:13 108:20,21 109:21 110:8 111:11,21 113:2,12 115:4,4 116:9 117:17
owners (1) 123:9

P

pace (6) 14:24 71:11,17,23 75:6 77:13
packages (1) 55:16
paediatric (5) 104:11,13 110:14 119:7,22
paediatrician (1) 113:4
paediatrics (2) 97:2 100:6
pagesic (1) 98:24
paid (8) 35:9 55:17 57:19,20 60:17,19 62:4 112:17
pain (1) 111:5
pandemic (84) 3:11 4:1 5:5 11:13 14:5 15:9,13,17 17:4 18:16,20 20:14 21:11,14,21 23:25 24:10 25:3 30:1,6 32:15 33:18,20,25 34:13 35:1 36:18 37:12 38:2 39:12,15 40:15 43:9,10,24 44:1 45:19 46:25 49:12,13 50:18 51:17 52:2,13 55:2 56:21 58:5,13 59:6,11 60:8,20 61:20 62:5 63:6 64:6,15 65:2,4,11,21 69:19 70:24 71:10 74:6 76:19,25 77:13,22 79:4,13 80:15,23 81:10,18 84:21 91:8,17 94:11 97:13,22 106:6 112:6 119:13
pandemics (1) 78:12
pans (1) 95:2
paper (6) 30:14,14 45:8,20 67:14 113:19
papers (2) 5:12 113:22
paragraph (48) 4:19,21,22 7:11,18 11:20 28:6 31:15 34:7 36:3 39:9 40:5 41:10 43:2 46:2 50:9 54:22,25 56:18 61:25 62:1 64:23 67:13,19 69:7,25 70:21,22 79:17,20 83:1 90:15 92:15 93:22 95:6 96:24 98:8 99:2,7,9 101:18,19 103:14 105:21 109:8 119:1,2,5
paragraphs (2) 52:10 121:16
paramount (1) 110:15
parent (5) 23:18 28:18 46:14 52:6 102:4
parents (8) 23:19 50:22 101:6 102:15 103:2 108:19 113:1 114:17
parliament (1) 95:11
parliamentary (7) 11:9 15:23 46:22,23 47:11 49:1 65:23
part (18) 7:21 14:20,23 40:21 41:18,22,23 61:24 68:14 71:2 76:16 88:19 95:13 96:5 108:25 111:25 118:4 120:15
participation (1) 8:11
particular (12) 4:24 9:5 23:20 34:4 36:22 46:12 53:8 57:5,23 70:3 80:24 98:23
particularly (21) 3:8 14:4 16:10 17:5,25 19:3,6 20:20 24:5,7 36:9 42:3 44:15 46:18 48:11 61:23 62:7 103:22 113:16 114:15 115:2
partly (1) 36:17
partner (5) 3:9 16:1 28:15 34:5 53:21
partners (4) 32:3 33:14 52:16 53:17
partnerships (1) 110:15
parts (2) 76:10 79:15
parttime (1) 63:20
passages (1) 120:13
passing (1) 39:24
pathology (1) 111:1
patient (1) 113:1
patients (8) 39:14,24 109:15,19,20 113:1,10,16
pattern (1) 43:22
patterns (1) 57:2
pause (11) 9:6 16:24 44:22 47:8 48:16 49:4 50:2 89:7 91:10 97:17 99:5
pausing (1) 32:6
pay (5) 8:15 55:6 57:22 62:21,21
paying (1) 123:11
peak (2) 91:8 94:10
peers (1) 92:19
pen (1) 95:2
people (61) 7:15 8:24 12:3,22 13:15,18,22 17:5 19:17,24 20:1,9,24 22:6,11 23:3,20 27:19 30:8,22 44:16 47:20 58:19 63:7,12,22 66:20 74:7 78:20 79:11 80:13 83:9,25 84:2 90:22,24 91:24 93:25 94:3,7,8,19,23 95:21 98:12,14 99:10,21 103:9 105:8 106:10,16 107:1,13,19 109:23 111:3 118:1 121:22 122:2,10
peoples (8) 8:23 11:24 20:5,8,9 24:4 26:16 73:9
per (4) 40:11,12 77:7 104:22
percentage (1) 95:22
perception (2) 91:13 117:4
perfect (2) 14:16 73:22
perfectly (3) 6:19 74:24 86:22
perhaps (21) 6:17 8:16 12:18 14:2 20:17 31:16 48:19 53:15 54:23 66:8 75:2 77:17 79:20 92:12 93:3 101:9 113:15 115:5 117:8,14,21
perilous (1) 51:23
perinatal (2) 31:21 38:15
period (8) 15:3 17:24 30:5 31:2 36:10 55:6 58:1 103:18
periods (2) 18:21 51:13
permanent (1) 53:2
permit (1) 106:25
permitted (1) 3:4
perpetrator (2) 67:11,22
perpetrators (3) 51:10 54:10 66:21
person (3) 4:18 41:21 112:15
personal (2) 39:17 94:22
personality (1) 39:1
personally (3) 100:9,10,12
perspective (2) 10:22 56:11
phrase (1) 86:1
physical (4) 18:12 52:21 117:1,10
pick (2) 35:14 63:4
picked (3) 35:17 62:24 76:25
picking (1) 71:16

SCI-TRNSPT-000018_0037

picture (1) 11:2
piece (3) 6:8 20:18 58:16
pieces (1) 21:18
pills (1) 34:15
pimsts (1) 95:3
place (6) 26:24 52:1 73:3 74:23 87:1 100:4
places (4) 44:18 47:24 48:2 121:1
plan (1) 105:5
planning (5) 77:22 78:1,12 104:1,3
plans (1) 80:2
plasters (1) 49:12
play (1) 86:9
played (1) 84:22
please (51) 1:20 2:16,18 7:9,11 10:4 11:20 16:16,23 31:15,19 34:12 38:10 39:9 43:21 44:7 46:6,19 47:5 48:9 50:8 52:8,11 56:15 71:6 73:6 79:17 80:5 82:11 84:18 88:14 89:18 90:7,10 93:23 94:15 96:23,24 97:19 98:7,8 100:11 101:19 106:4,22 107:9 109:11 110:5,19 121:14,16
pleased (1) 9:2
plenty (1) 121:4
plus (1) 22:22
pm (3) 87:7,9 123:14
pointed (2) 60:17 83:21
points (11) 16:24 25:25 41:16 48:6 49:20 54:24 60:10 64:22 84:17 103:19 111:8
police (14) 10:25 26:12,20 31:6 43:17 50:22,23 52:3 54:4,8 61:14 65:12 79:9 82:9
policies (2) 25:17 100:4
policy (18) 8:9 9:14 10:10 12:11 13:14 16:20 17:10 18:10 49:19 56:24 74:6 79:25 81:9,10 94:8 98:17 110:6 121:23
policymakers (4) 8:12 9:19 75:4 81:8
policymaking (2) 9:21 11:8
political (1) 9:16
polubothu (1) 47:15
poor (3) 98:19 106:8 119:7
pop (1) 21:17
population (5) 25:20,21 29:22 104:24 107:16
populations (2) 23:11 25:13
position (6) 2:5 11:16 18:1 62:17 98:9,19
positions (2) 94:8,9
positive (2) 21:6 38:24
possible (6) 5:22 6:19 70:20 83:5 86:21 87:3
possibly (11) 9:24 15:20 19:21 32:18 75:1,8 84:19 87:21 112:23 115:6 120:18
post (2) 110:9,9
postcode (1) 109:23
postcovid (1) 97:14
postcovid19 (2) 97:12,21
postural (1) 118:15
postviral (1) 56:9
pot (1) 105:11
potentially (6) 25:4 35:3 42:13 56:22 81:4 103:8
pots (1) 118:15
poverty (11) 49:17 56:25,25 57:3 60:13,14,14,15,16 61:3,3
power (3) 71:2 78:7 113:3
powerful (5) 7:23 37:20 65:25 66:23,24
ppe (7) 39:17 41:6,11,21,22 42:5,8
practicality (1) 16:18
practice (2) 13:14 35:19
practising (1) 97:1
practitioners (1) 110:16
precarious (1) 70:4
precautions (1) 14:17
predominantly (1) 62:12
predominate (2) 57:19,20
preexisting (1) 91:14
preface (1) 89:12
prefaced (1) 77:19
pregnancies (1) 35:4
pregnant (5) 31:24 32:1,7 38:10,12
preliminary (1) 4:15
prepandemic (2) 77:21 78:1
preparation (2) 4:2 77:23
prepared (2) 1:9 45:8
present (2) 107:1 113:4
presented (4) 4:24 56:15 82:1 106:23
presenting (1) 111:12
pressure (15) 19:19,20 20:1,7,11 24:6 36:21,22 39:3,23 58:2,6 63:3,23 112:24
pressures (1) 18:22
presumably (2) 64:6 111:12
pretty (5) 26:12,15 58:24 60:12 61:14
prevalence (6) 12:25 95:23 106:15,19 107:16 110:13
prevent (1) 80:13
prevention (1) 12:22
previous (5) 45:20 64:25 91:2 99:17 101:23
previously (1) 94:20
primary (6) 51:8 62:9 71:13 108:7 110:7 112:21
prior (10) 10:20 58:5 60:19 61:20 66:3 69:18 72:1,8 74:6 76:18
priorities (1) 26:22
prioritisation (1) 82:18
prioritising (2) 105:15 107:7
priority (1) 81:17
prisoners (1) 44:2
private (7) 103:4,6 110:1,4,16 116:10,12
probably (15) 3:21 4:6 12:16 17:16 33:24 41:9 48:16 51:3 58:11 61:5 62:16 77:1 88:4 96:21 109:7
problem (11) 5:1 23:8 68:2 83:3 96:20 103:24 104:20 106:18 112:9,18 113:8
problematic (1) 82:3
problems (6) 4:24 19:5,11 51:22 78:9 82:17
proceedings (3) 46:15 54:11 69:8
process (3) 8:19 15:6 72:22
processes (9) 9:21 12:12 14:23 15:23 52:24 70:2 72:2 79:22 82:16
processing (1) 45:17
produce (1) 96:9
produced (2) 4:4,4
producing (1) 4:25
profession (1) 114:9
professional (1) 29:1
professionals (6) 97:1 109:12,16 110:23 111:13 112:19
programme (1) 80:1
programmes (2) 25:16 31:23
progress (7) 56:1 57:3,8 59:4 60:2 61:9 62:21
progressing (1) 89:25
project (1) 13:6
prolonged (2) 70:4 121:19
promote (2) 7:16 13:13
pronounced (1) 58:12
proper (1) 9:8
properly (2) 42:12 119:16
proportion (5) 39:10 46:14 48:14 63:15 116:20
proportionately (1) 104:24
proposals (1) 80:11
protect (5) 7:14 39:4 67:5 70:25 99:25
protecting (2) 51:8 67:11
protection (1) 53:4
protections (4) 51:25 52:1 120:23 122:13
protective (2) 39:17 83:18
provide (12) 3:12 13:4,20 35:12 38:8 53:2 62:9 65:17 68:12 92:19 93:1 97:13
provided (13) 4:7,11 28:8 43:19 44:3,24 68:13 84:10 87:13 89:11,13 109:9 111:6
provider (1) 112:21
providers (2) 19:16 21:15
provides (3) 12:2,7 90:25
providing (5) 16:3,10,11 22:9 89:15
provision (3) 34:22 53:4 100:5
provisions (3) 77:4,9 120:1
psychiatric (1) 38:14
psychological (1) 19:6
psychosomatic (1) 119:16
public (42) 11:1 17:22,23 27:15 53:10 55:9 62:23 66:15 68:17 71:11 74:4 75:13,14 76:19,24 77:3 80:7 83:23 84:24 85:5,7,11,12 91:18 99:24 100:3 102:2,17 105:22 106:8,16 107:11 108:5,12,13,16,25 115:12,13,14 116:22 118:23
published (2) 107:21 122:6
pure (1) 16:18
purposes (1) 120:12
push (1) 39:3
putting (3) 49:11 65:21 93:3

Q

q (43) 88:14,16,20 89:1,4 90:9,13 91:10,23 92:15 93:1,21 94:13 95:4 96:7,15,18,23 97:17 98:6 99:5 100:7,10 101:17,22 103:13 105:18 106:22 107:9 108:1 109:4 110:5,19 111:7,19 113:15 114:7 117:1 118:25 119:24 120:19,21 121:12
qa (1) 102:5
qualitative (1) 21:19
quality (6) 27:9 42:13 58:1 76:2 100:19 119:6
quarter (2) 42:18 53:3
question (14) 8:20 11:15 16:17 29:25 49:2,3 57:10,13 77:18 78:2 95:14,17 97:18 112:1
questioning (1) 107:14
questions (8) 1:16 37:24 67:8 88:3,8 102:13 124:5,7
queue (2) 66:20,21
quick (7) 26:11 27:25 35:12 62:20 73:3 84:17 85:15
quickly (6) 23:17 27:5 62:19 64:18 71:19 73:1
quite (19) 12:17 21:4,19 32:14 34:25 35:12,13 50:12 58:9 63:2,5 85:17 91:4,11 96:21 105:9 109:2 113:19 114:3
quo (1) 26:24
quotation (1) 38:8
quotations (2) 28:7 70:13
quote (3) 40:5 67:14 119:22

R

race (2) 8:25 29:23
racially (1) 57:6
raise (2) 12:24 41:8
raised (2) 26:10 41:25
raising (1) 79:19
range (7) 18:10 20:22 21:14 29:16 32:14 33:13 97:1
rape (12) 2:12 8:3 12:5,16,19,24,25 16:5 22:8 45:11 67:3 69:16
rapid (3) 71:9 72:22 78:24
rate (4) 36:4 37:14 40:9 63:14
rates (2) 38:1 122:14
rather (11) 11:15 19:12 45:1 51:19 74:22 77:18 78:3 84:5 93:3 113:17 114:2
reach (1) 69:22
reached (1) 42:25
react (1) 27:25
read (36) 7:18 16:23 28:13 31:18 33:4 38:10 39:9 43:3 46:5 47:13 48:8,25 50:3 52:10 56:16 62:2 67:18 70:13,16,21,22 79:16,20 80:19 93:23 96:24 98:8 101:18 105:18 106:4 107:9 109:7,11 119:4 120:13 121:15
reading (6) 13:12 40:5 90:17 94:13,15 102:14
ready (2) 1:17 42:23
real (10) 15:21 19:14 20:25 42:9 51:3 71:17 83:12 91:8 97:12,21
realise (7) 7:6 9:15 57:12 71:2 91:24 104:10 114:22
realised (1) 5:14
reality (9) 10:13,16 38:2 47:22 49:21 60:18 77:16 83:22 85:2
really (62) 3:5 4:17 9:2,3 10:16,22 14:8,16 16:17 22:5,22 24:6 26:12,14 30:3 31:12 35:9 36:1 38:1 42:14 43:15 48:2 49:15 51:4 59:17 60:2,14,21,24 63:4,15,23 65:6,18,19 66:1 69:1,16 78:14,19,24 79:7,18 85:13 90:15 91:13 92:4 93:9 103:7 104:12,25 108:4,16,24 109:3 113:8 114:19 115:15 117:12 119:10,15 122:19
reason (2) 7:22 95:25
reasonable (1) 24:25
reasonably (3) 25:5,8 27:25
reasons (5) 19:20 65:7 89:7 113:23,24
recall (1) 83:14
receive (1) 109:24
recent (2) 27:6 100:18
recently (2) 100:24 101:12
recognise (6) 16:14 48:13 64:10 71:8 109:12 121:24
recognised (8) 7:25 16:6,11,13 22:15 42:12 76:23 97:4
recognises (1) 5:20
recognising (2) 109:14,17
recognition (4) 17:3 39:25 90:23 95:13
recommendations (1) 84:14
recommended (2) 97:6 110:22
recommending (1) 110:24
recorded (3) 43:11,15 121:8
recording (1) 103:2
records (1) 40:8
recourse (1) 53:10
recover (1) 59:14
recovered (3) 29:9 68:1 98:4
recovery (3) 31:12 80:2 90:23
recruit (3) 105:6,6,8
recurrent (1) 82:7
redmond (1) 9:7
reduce (4) 61:5,6 122:14,15
reduced (6) 14:19 36:20 55:13,16 60:21 67:21
reducing (1) 12:2
reduction (1) 53:5
reductions (1) 44:3
redundant (3) 19:23 29:11 58:15
reentering (1) 38:12
refer (7) 3:15 10:3 61:25 89:8 109:15,19,19
reference (14) 1:9 6:9 27:5 45:1 47:15 53:23 61:25 70:1 87:14 95:9 98:23 101:20 109:9 111:20
referenced (1) 52:13
references (1) 49:2
referencing (1) 53:7
referrals (1) 53:3
referred (4) 83:2 100:25 102:15 120:8
refers (1) 32:10
reflect (2) 10:13 44:22
reflected (2) 18:18 106:18
reform (1) 12:21
refuge (4) 13:21 14:25 49:14 53:4
refugees (1) 70:9
refuges (5) 14:4,18,19 15:7 52:25
refused (1) 63:17
refusing (2) 109:19 110:3
regard (1) 57:14
regarding (3) 31:16,20 70:18
regardless (1) 20:12
regards (4) 11:14 24:20 28:1 35:3
region (1) 63:15
regular (1) 104:15
regularly (1) 22:13
rehoused (1) 15:3
reinfection (1) 121:2
reinfections (1) 106:11
reiterate (2) 75:12 81:16
relapsed (1) 38:13
related (4) 19:20 32:16,21 60:10
relating (1) 89:24
relation (14) 4:1 16:19 17:6 34:9 40:24 48:18 103:21,22 105:22 107:5 108:2 114:7 117:9 122:8
relationship (3) 53:14,18,19
relationships (1) 37:1
release (1) 44:2
relentless (1) 29:4
relevant (7) 36:5,8 37:15 75:3 81:2 101:24 114:23
relief (1) 110:2
remainder (1) 50:3
remained (1) 82:7
remarks (1) 4:15
remember (8) 22:11 30:3 34:17 65:19 66:15 104:4 114:19,20
reminder (1) 29:21
remiss (2) 14:8 49:10
remission (1) 118:21
remit (1) 118:21
remote (3) 48:6,11 81:7
remotely (3) 68:14 86:24 87:13
removed (1) 44:5
rent (1) 123:11
repeat (2) 106:12 119:3
repeated (2) 78:15 101:3
repeatedly (1) 65:22
reply (1) 102:13
report (9) 18:19 21:9 22:1 43:17 47:11 61:14 64:4,7 84:14
reported (2) 23:23 68:7
reporting (10) 19:10,16,18 33:9 43:10 62:22,22 81:23 82:8 85:6
reports (2) 30:9 43:25
represent (3) 16:9 29:16 39:10
representation (2) 12:8 69:3
representative (1) 117:9
represented (1) 68:19
representing (2) 2:9 55:19
represents (1) 3:19
reproductive (1) 34:8
requests (2) 11:6 63:16
require (3) 90:6 112:10 123:9
required (2) 55:18 76:13
requirement (3) 80:6,10 82:24
requirements (3) 74:5 85:1,1
requires (1) 71:1
requiring (1) 35:13
research (48) 3:25 4:2,10 12:11 15:21 20:4,13,19,19,22 21:1,16,19,19 27:11 32:10,22 33:5 36:14 37:6 45:7 46:4,7,10 56:2 61:11 97:9 98:22 109:21 111:11,21 112:13,23,25 113:5,6,19,20,22,25 114:2 119:7,9,14,14,17,20,23
researcher (1) 119:15
resentment (2) 116:7,22
resilience (1) 29:23
resorting (1) 110:1
resource (4) 6:10 9:23 79:10 97:6
resources (9) 9:17 10:11 76:12 78:7,10 80:14 86:4,8,16
respect (2) 70:11 72:24
respond (1) 67:1
responded (2) 21:6 28:3
responding (1) 11:5
response (10) 14:16 26:22 30:12 41:5 66:9 71:9 78:25 103:4,6 107:14
responses (4) 13:2,14 30:4 79:25
responsibilities (7) 18:24 24:18 62:6,22,23 63:13 98:21
responsibility (2) 59:21 65:21
rest (2) 25:19 118:13
restricted (2) 38:5 55:9
restricting (1) 37:20
restrictions (15) 26:14 32:2 37:13 38:17 44:8 51:17 52:19 53:16,22 54:8,15 65:14 81:20 84:2 94:1
result (4) 10:14 71:24 81:12 91:7
resulted (3) 52:21 53:5 80:10
resulting (1) 22:1
results (2) 109:13,21
resurgence (1) 60:5
retail (1) 55:10
return (3) 50:21 51:11 54:20
returned (1) 50:23
returns (1) 51:8
reverseengineering (1) 78:13
review (1) 76:23
reviewing (1) 77:2
ridiculous (1) 93:7
righthand (3) 47:6,7,10
rightly (1) 113:19
rights (30) 1:12 7:14 9:17 11:23,24 12:5 30:22 34:9 46:24 47:2,4 57:4,9 67:4,24 71:2,3,8 75:16 77:25 82:6 85:1,10,21 120:16 121:14,20 122:1,3,5
rise (1) 36:9
risk (22) 17:14 32:17 39:14,18 40:8 47:20 51:5 52:5,14 65:24 66:15,19,23 67:1 91:9,18,19 94:6 97:14 106:10,12 108:21
risks (5) 31:25 70:5 106:8 108:17 109:1
risky (1) 51:6
role (3) 2:23 7:25 40:23
roles (4) 3:2 18:23 59:19 60:3
rolled (2) 57:3,8
rolling (1) 59:4
roof (1) 30:11
roughly (1) 104:22
round (1) 64:9
route (1) 108:7
routine (1) 38:18
routinely (2) 65:24 74:7
royal (1) 41:25
run (2) 73:17 88:18
running (1) 12:23
rural (4) 35:15 48:7,12 81:7
rushed (2) 38:22,23

S

sad (1) 34:25
safe (10) 26:1,4 27:1,1 34:10 44:12,18 47:23 81:15,19
safeguard (1) 98:11
safeguards (1) 71:12
safest (2) 44:19 47:25
safety (6) 9:17 14:17 18:9 41:24 52:18,22
sake (2) 42:19 70:12
same (14) 6:7 9:18 14:22 19:22 28:4,4 30:5 41:3 45:20 58:20 68:17 93:11 94:18 107:1
sammie (1) 98:1
sara (1) 9:7
sarscov2 (1) 108:6
saw (8) 10:19 22:13 27:8 30:2 51:10 54:9 64:4 65:23
saying (19) 4:23 7:4 25:7 26:24 33:8 42:6 51:23 66:14 67:5 73:12,25 75:2 77:7 89:12 102:21 115:22,23 116:13 117:5
scans (1) 38:18
scared (1) 40:23
sccjr (1) 45:5
scenario (1) 53:11
scheme (2) 63:6,19
school (11) 22:13 28:20 30:15 37:1 40:16 44:19 47:25 92:7,12 99:3 115:25
schooling (2) 19:21 59:24
schools (12) 12:22 22:14,17 23:12 44:2 48:3 55:15 62:7 73:11,17 102:20 120:2
sciswro000005 (1) 46:20
sciswro00003 (1) 44:25
sciwt0568000001 (1) 87:15
sciwt0578000001 (1) 1:9
scope (2) 53:1 104:6
scotland (96) 2:12,12 6:15 8:2,3,3 9:15 11:4,9,21,22,25 12:2,5,9,11,16,19,20,24 13:7,13,19 14:10,19 15:13 23:9,18,19,21,22 25:13 26:12,20 34:22 35:5,16 36:4 38:15 40:9,11 45:17 48:15 50:16 51:24 52:23 53:4 55:3,4,19 56:24 57:18 58:11 60:15 62:5 64:9,13 66:24 69:16 72:3,7,21 74:3 76:10 77:10,22 80:4 81:24 82:9 83:11 84:21,22 87:18 88:17,19,24 90:20 94:17 95:7,21 96:3,25 100:3,3,16 101:12 102:5 104:2 106:16,17 107:2,11 112:11,15 119:12 122:2
scotlands (5) 8:9 9:14 10:25 13:22 64:24
scotlandspecific (2) 24:16 106:21
scott (81) 1:7,8,14,19,21,21,24 2:4,7,10,14 3:15 4:17 5:1 6:3,13 7:2,20 8:9 10:5

11:18 12:19 13:9,11,25 14:6 21:17 22:4 25:7 26:2,6,9 29:19 35:6,7,8 37:18 43:5,20,22 44:8 45:3,6 46:7,17,21 47:12,15 48:8,10,24 49:2,7,10 50:11,14 51:21 52:12 53:23 54:2 60:9,10 65:2,5 67:16,25 69:13 73:5,7 75:7,11 78:2,5 79:22 80:6,21 82:12 83:9 84:15 86:19 124:2
scottish (63) 1:12 2:6,13 7:24 9:19 10:23 11:4 12:4 13:9,11 14:3 15:22 21:20 22:8 26:10 27:18,24 34:14,19 43:9 45:6 46:23 67:3 70:18 71:8 76:22 77:5 79:23 80:7 81:14 82:5,8,15,18,25 83:15 85:16,17,19 90:21,24 95:11 96:1,8 97:8 98:9,20 100:1 101:25 103:17 104:15,16 105:2,10 106:11,24 107:2,21 112:7 113:12 121:24 122:8,17
screen (2) 45:13 87:21
screening (1) 31:23
se (1) 77:7
search (1) 110:11
second (6) 66:3 92:1 95:13,16 96:5 111:25
secondary (1) 110:7
seconded (1) 77:6
section (9) 16:24 50:12 80:20 107:24 109:11 111:8 119:4 120:8 121:15
sections (1) 119:25
sector (18) 13:11 39:12 40:7 55:8 58:2,3,8,18 62:23 68:17 74:4 75:13 76:19,24 77:3 80:7 83:23 85:7
sectors (3) 40:3 42:3 58:14
security (4) 17:22 27:15 57:1 62:15
see (13) 6:4 31:4 36:14 45:15 47:1 49:3 51:16 64:2 65:6 87:2 88:4 108:2 117:11
seeing (6) 20:9,11 30:2 66:23 88:9 113:4
seek (2) 18:17 44:6
seekers (1) 70:9
seeking (4) 52:15,17 69:11 82:1
seeks (1) 12:11
seem (2) 11:15 41:8
seemed (1) 33:19
seems (2) 10:13 108:18
seen (8) 11:2 28:8 53:12,12 57:25 59:8 64:1 115:8
segregation (3) 57:17 58:10,25
send (3) 10:6 31:6 116:2
senior (3) 73:8,20 82:19
sense (2) 26:13 118:4
sensitive (1) 82:20
sent (6) 63:1 85:4,8 102:24 103:3,6
sentence (1) 91:2
sentences (1) 46:5
separate (2) 7:12 17:2
september (5) 38:9 43:12,14 101:23 102:4
sequelae (3) 31:10 106:9 110:10
serious (6) 42:9 45:11 46:8 76:14 94:25 110:11
serve (1) 5:6
service (9) 10:24 13:24 19:15 21:15,25 34:11 38:15 66:4 80:1
services (51) 10:11 13:4,7,17,20 14:12,12 16:4,10,11 17:21,23,23 19:17 20:2,5 21:1 22:9 25:17 27:15 31:22
33:5,15,23 34:22,23,24 38:6 44:5,13 49:15 50:20 62:8 64:20 65:10,25 68:5,7,11,12 69:3 82:2 93:10 104:2,4,11,14 105:5 112:8,9 117:11
sessions (1) 65:22
set (5) 54:22,24 84:9 103:25 122:8
settings (2) 12:23 68:9
several (1) 96:12
severe (4) 40:25 58:24 94:22 117:14
severity (1) 118:20
sex (1) 37:25
sexdisaggregated (1) 82:21
sexual (13) 12:20,25 13:5 16:5 23:7 31:22 36:25 37:19 43:2,6 45:11,17 67:2
shakti (2) 14:14 47:16
shall (1) 105:17
share (1) 48:12
shared (4) 12:1 17:3 53:4 60:6
sharp (1) 36:9
sheriffs (2) 52:4 66:11
shetland (3) 68:5,6,12
shielding (3) 28:20 32:17 51:2
shifting (1) 32:18
short (3) 42:21 62:1 87:8
shortages (1) 39:22
shortly (1) 30:5
shortterm (1) 105:7
should (15) 6:20,24 7:7 14:20 20:15 63:24 72:20 75:18,20 76:16 81:1 84:19 94:9 105:15 112:20
shoulders (3) 59:21 65:25 115:23
shouldnt (2) 67:9 75:17
shows (2) 64:23 103:8
shrugged (1) 26:8
shrugging (1) 115:23
shut (4) 22:14 55:8 58:14 59:20
sick (3) 92:14 100:15 101:7
sickness (1) 40:25
side (5) 21:15 61:16 85:12 117:1 120:18
signed (1) 102:8
significance (3) 36:12 50:4 121:25
significant (10) 14:8 21:24 30:12 32:7 39:10 62:14 69:16 81:21 85:18 110:15
significantly (8) 21:8 45:23 52:24 55:8,21 58:9 62:5 69:19
similar (1) 21:16
similarly (1) 111:1
simple (2) 10:13 94:21
simplest (1) 18:7
since (5) 21:7,10 23:24 29:12 59:5
single (5) 23:19 60:15 93:19 112:10,15
sister (1) 5:6
sit (1) 75:23
sits (2) 63:25 85:12
sitting (3) 8:4 123:7,12
situation (14) 15:2 18:8 27:9 28:3 35:3 51:23 53:20 67:25 68:20 74:22,25 81:25 112:4 115:1
situations (8) 28:17 38:12 40:24 48:13 51:25 53:17 56:14 111:25
sized (2) 39:17 41:10
skills (1) 74:11
sleep (4) 29:3 118:9,11,12
slightly (2) 41:8 48:17
small (1) 43:16
snails (1) 14:24
social (26) 9:16 17:21 20:24 27:15 33:3 39:6,11,13,25
40:3,10,11 42:3,7,14 53:5 55:16 56:25 58:2,3 59:19 91:6 93:14 100:25 109:6 119:14
socialise (1) 92:13
socialising (1) 92:8
societies (1) 10:14
society (4) 7:15 41:17,20 71:1
socioeconomic (3) 19:2 36:17 81:3
soldier (1) 90:9
solicitor (3) 68:19,22 69:6
solicitors (4) 67:20 68:11,15,16
solutions (1) 78:9
solve (1) 113:8
somebody (5) 5:12 28:12 31:17 38:9 115:19
someone (1) 32:1
something (34) 6:3 9:25 13:25 15:15 24:9 34:17 35:6 36:12 41:11 46:17 54:1 55:24 60:9 62:18 64:1,2,10 65:1 70:16,19 72:10 76:20 77:11 84:16 85:11,13 91:3 99:8,19 111:13,24 112:13 114:2 123:10
sometimes (5) 32:20 69:22 86:9 93:16 117:24
somewhat (3) 72:12 83:7 84:6
somewhere (1) 23:8
sort (3) 14:9 30:15 105:13
source (1) 38:9
sources (3) 15:1 42:2 113:18
south (1) 30:9
space (3) 30:21 31:8 118:24
spaces (2) 44:12 53:6
speak (3) 5:8 10:15 120:18
speaking (3) 1:8 9:11 40:23
speaks (1) 18:4
specialist (4) 13:3,20 14:12 61:11
specialities (1) 105:9
specific (8) 9:4,11 61:24 69:25 74:3 76:8 80:7 82:25
specifically (2) 120:7,10
spent (3) 15:8 46:14 100:12
spike (1) 43:25
spoke (1) 41:1
spoken (1) 41:2
spread (1) 122:15
stability (1) 18:8
staff (11) 14:10 22:8 31:11 39:21,22,25 40:10 66:19 69:5,20 110:3
stage (4) 5:24 37:8 47:14 70:8
stages (4) 32:16 33:17,20,25
stairs (1) 101:13
stakeholders (2) 73:8 97:7
stalking (1) 52:20
start (10) 21:10 23:24 25:3 30:23 40:20 63:24 84:20 86:23 90:15 105:20
started (8) 34:1 35:22,22 97:24 98:1 100:24 103:2 104:3
statement (43) 1:8 3:14,22 4:7,16,18,18,21,23,25 7:5,11 8:21 9:1,25 10:3 26:1,3 28:6 43:1 50:8 53:24 54:20 84:7 87:14,18 88:3 89:11 90:16 92:15 93:22 95:9 96:23 98:7 99:19 109:10 111:20 119:25 120:9,16 121:15 122:6,23
statements (5) 5:3,18 28:9,13 53:12
states (1) 59:21
static (1) 119:9
statistics (1) 95:20
status (7) 26:24 53:9 57:20
70:5 81:3 88:24,25
stay (5) 15:2 26:1,4 27:1 81:19
staying (2) 21:6 83:18
stenographers (1) 42:19
step (2) 25:11 81:9
sterling (1) 27:20
sticking (1) 49:11
stigma (1) 115:3
still (22) 18:16 29:8 30:2 35:13 58:16,22 60:21 69:4,23 79:5 83:10 91:8 93:11 94:11 96:14 98:10 103:5 104:13 106:8 114:20,22 121:7
stirling (1) 46:10
stone (1) 6:21
stop (2) 49:11 94:13
stories (2) 35:17 50:19
storm (1) 14:16
story (1) 101:3
strain (1) 24:6
strategic (3) 7:23 103:15,24
strategy (3) 79:25 86:2,5
strathclyde (1) 12:6
strengthening (2) 112:7,9
stress (8) 8:21 18:25 23:1,20 24:8,22 33:11 39:23
stresses (1) 22:10
stressful (1) 28:16
stripped (1) 38:20
strong (4) 20:13 21:5 58:4 85:8
strongly (2) 24:4 98:9
structural (2) 6:7 10:17
structures (1) 41:17
struggle (4) 12:3 94:20 105:6 113:3
struggled (6) 32:19 42:4,8,14 100:21,22
struggling (5) 29:14 48:2 69:5 105:5 117:22
studies (1) 119:14
study (3) 64:11,11 107:14
studying (1) 112:16
stuff (1) 77:12
subheading (1) 107:10
subject (6) 4:14 44:9 53:9 75:9 84:15 89:23
submitted (1) 32:11
submitting (1) 8:19
subsequent (3) 36:18 91:25 108:19
subsequently (2) 20:3,15
subset (3) 117:13,16,18
suddenly (4) 5:14 7:6 22:17 44:20
suffer (2) 23:1 111:4
suffered (1) 58:9
suffering (10) 31:12 81:5 94:11,17,19 95:21 96:4 107:19 110:20 122:10
suggest (1) 36:16
suicide (1) 29:12
suit (1) 86:15
summarise (1) 69:7
summary (2) 54:22 79:18
supervision (1) 55:14
supply (1) 68:15
support (30) 11:7 13:3,4,18,21 19:23 22:11,19 28:20 31:24 32:7 33:18 34:14 38:14 44:12 53:3 62:10 63:22 90:20,23,25 93:10,20 99:25 103:17 104:17 109:24 116:5,11 117:11
supported (5) 69:17 92:18 96:25 100:18 115:22
supportive (1) 111:2
suppose (5) 37:8 52:8 69:9 112:6 119:5
supposed (5) 54:12 74:9 99:25 104:19 116:23
sure (21) 1:24 6:23 7:20 12:19 13:2 17:1 25:1 32:16
38:11 43:5 52:12 55:1 56:17,20 62:3 71:7 86:15 103:5 106:5 113:12 114:1
surmise (1) 96:18
surprised (1) 65:5
surprising (2) 65:3,8
survey (4) 21:4,24 74:22 107:11
surveys (1) 21:25
survival (1) 121:20
survivor (1) 65:15
survivors (6) 13:2,5,7 44:15 69:17,20
suspect (1) 96:19
suspended (1) 62:24
suspension (3) 31:23 62:25 69:8
suspicion (3) 77:8 113:18 114:4
suspicious (2) 113:15 115:6
swathes (1) 15:8
symptom (1) 118:7
symptomatic (1) 99:4
symptoms (19) 39:1,2 90:4 94:25 95:1 106:23 107:3,6,8 109:14,17 111:4 117:6,7,10,12,12,14,17
syndrome (2) 110:9 118:16
system (10) 37:2 43:11 49:16 50:21 51:4 52:3 59:12 72:9,11 120:4
systematically (1) 65:24
systemic (2) 9:20 70:24
systems (12) 12:12 50:14 67:1 72:22 73:3 76:12 79:22 92:20 93:2,5,13 110:8

T

table (3) 49:18,24 78:8
tachycardia (1) 118:16
tackle (1) 8:14
taken (13) 4:11,13 34:16 43:25 44:20 46:18 71:18 74:18 80:23 81:10 89:17 120:24 122:22
takeup (1) 63:14
taking (5) 6:14 68:14,25 83:17 122:20
talk (13) 8:1 10:17 14:6 31:15 43:1 51:21 78:6 91:21 93:25 103:15 105:17 109:5 114:18
talked (1) 83:17
talking (22) 6:8 10:23,24,24,25 20:18 22:12 23:5 25:14 29:20 35:24 36:5 48:18 52:9 60:13 65:20 68:23 69:14 73:10 100:22 114:6,16
tasks (1) 94:21
team (9) 29:1,14 40:22 77:5 78:22 88:23 89:17 99:16 120:7
technology (1) 88:5
telemedical (2) 34:11,14
telemedicine (1) 35:12
telling (3) 32:23 101:17 102:19
tells (1) 84:5
tempter (1) 28:19
ten (1) 61:13
tend (2) 57:18,22
tendency (1) 51:24
term (3) 18:7 71:15 119:16
terms (22) 14:15 15:16 23:5 25:14 31:11 32:13 33:14 34:3 38:5,5 51:8 55:3 57:14,15 58:1 60:6 61:1,15,24 77:2 78:21 89:23
terrible (1) 67:25
testing (3) 106:25 107:7 109:23
tests (1) 115:24
thank (48) 1:5,13,18,25 2:1 3:1 5:14 7:2,3 8:8 9:9 11:19 12:15 13:8 15:11 16:21 18:11 28:5 31:14 34:6 42:15,16,19,24 49:7 64:19 79:14 86:17,18 87:6,11 88:20 90:8,12 93:21 98:6,6 101:17 103:13 109:4 118:25 122:20,24,25,25 123:2,6,13
thats (3) 8:8 30:13 49:4
theirs (1) 123:11
themselves (5) 33:2 46:9 51:13 67:11 116:8
therapy (3) 97:2 110:21,24
therefore (3) 41:23,24 109:17
thereof (1) 86:6
theres (2) 75:14 118:11
theyre (2) 31:11 77:10
theyve (2) 105:13,13
thing (13) 22:4 37:15 50:11 60:15 63:18 71:16 73:5 76:2,18 85:15,15,25 96:22
thinking (5) 7:1 23:13 29:25 72:12 109:2
third (2) 13:11 92:2
though (6) 16:3 41:6 68:10 86:6 105:10 110:21
thought (3) 23:3 60:4 84:1
thoughts (2) 6:19,22
threat (1) 53:21
threatened (1) 51:11
threatening (1) 54:2
threats (1) 54:4
three (7) 45:22 54:11,12 104:21 106:23 112:6 121:16
threepart (1) 107:11
threeyear (1) 103:18
through (32) 3:18 8:19 14:4 15:4,5,22,25 20:10,14,16,20,23,24 21:14 27:11 30:11 31:9,9 33:2 35:22 37:1 43:4 50:19 52:10 54:24 64:22 67:3 89:5 109:11 110:16 113:22 116:4
throughout (3) 15:17 18:3 75:19
thursday (2) 1:1 46:25
ties (1) 115:12
time (49) 6:2,20 14:22 15:3,8,21 19:15,22 20:4,25 28:15,22 29:18 30:18,23 34:23,25 35:13 41:3 53:15 55:6 59:14 60:7 61:6 64:4 73:21 74:8 78:23 80:14 86:22 90:6 91:1 92:14 97:12,21 98:3 100:21,23 101:7 102:1 103:9 105:2,3 112:16,17,25 122:20,22,23
timely (1) 107:4
times (9) 32:18 33:17 54:11 68:2 71:24 77:4 96:12,12 114:8
tip (2) 29:19 43:7
tiredness (1) 94:19
today (11) 2:9 5:9 6:21 7:5 36:6 83:10 94:11 114:23 122:20,24 123:5
todays (1) 120:12
together (2) 53:15 122:23
toilet (1) 30:14
told (9) 3:24 33:3 68:21 69:20 73:20 77:1 91:17 92:11 105:2
tolerable (1) 35:4
tomorrow (2) 7:8 123:7
too (6) 5:15 9:2 26:18 73:24 92:10 101:13
took (5) 34:25 59:23 61:18 63:6 98:25
tool (1) 37:20
tools (3) 44:4 54:13 80:8
topic (1) 70:9
topped (1) 55:6
total (1) 95:21
touch (3) 7:9 14:2 50:12
touched (4) 67:13 70:15,19 119:3
touching (1) 64:21
towards (4) 11:25 48:23 102:1 116:22
track (1) 62:21
tracked (3) 97:11,20 110:7
tragedy (1) 80:17
train (1) 54:6
trained (1) 109:16
training (3) 11:7 12:12 115:22
transference (1) 59:20
translated (1) 104:18
transmission (1) 108:7
transmitted (1) 106:7
transmitting (1) 106:13
transport (2) 31:6 66:15
trauma (1) 116:4
traumatic (1) 32:4
travel (1) 35:14
travelled (1) 66:17
travelling (1) 35:21
treat (1) 74:11
treatment (7) 104:18 109:18,24 110:20 111:3,10,23
treatments (1) 100:19
trenchant (1) 99:6
trials (2) 45:10,22
tried (2) 15:20 54:3
trouble (2) 7:18 93:23
true (3) 91:19 94:7 118:2
trump (1) 26:15
trust (1) 38:23
truth (1) 96:3
try (6) 9:1 58:25 76:6 85:19 93:19 113:24
trying (17) 15:23 19:21 21:13 22:10 24:2 30:13 31:8 54:6,16 58:16,23 92:20 93:1,13,14,14 116:11
tuc (1) 42:6
tuesday (3) 123:12,13,15
turn (4) 4:15 39:6 116:19 122:15
twice (3) 18:19 21:9 29:12
twothirds (1) 21:5
type (2) 77:22 119:9

U

uk (15) 6:4 9:19 21:4 30:10 34:18,20,21 63:10,25 72:2,7,21 76:10 77:10 106:20
uki (1) 6:12
ukiwide (1) 6:15
ukraine (1) 77:6
ultimately (1) 59:22
umbrella (2) 8:1 13:16
un (1) 122:5
unable (2) 29:10 32:1
uncertainty (3) 18:21 65:16 66:25
unclear (2) 60:22 103:20
underestimate (1) 69:1
underfunded (1) 58:4
underlying (2) 111:1 119:18
underpaid (2) 39:15 55:20
underprotected (2) 39:16 55:20
underreached (1) 17:8
underreporting (1) 110:13
underresourced (1) 78:19
underscores (1) 73:25
underscoring (1) 54:17
understand (19) 2:5 8:5 10:1 25:21 26:11 43:16 53:25 58:23 70:20 72:17 73:14 74:24 92:23 100:17 104:12 112:3 115:5,7 119:18

SCI-TRNSPT-000018_0039

understanding (11) 9:8 10:9 25:3 78:24 80:10 93:17 106:1 111:15,18 115:11,15
understood (3) 9:21 44:15 92:4
undertake (1) 15:21
undervalued (3) 39:15 55:20 58:4
undoubtedly (2) 83:9 84:8
unequal (2) 18:22 80:2
unfair (1) 77:18
unfeasible (1) 112:12
unfettered (1) 52:5
unfolded (2) 97:13,22
unfortunately (5) 41:17 77:16 102:8 104:2 108:25
unintended (1) 80:12
unions (1) 8:12
unique (2) 84:21 97:11
unit (2) 78:18 85:20
united (1) 122:3
university (4) 12:6 45:9 64:5 97:10
unknown (2) 18:16 36:23
unless (1) 83:19
unpaid (11) 49:23 55:14 61:24 62:4,6,10,13 63:5 64:5,8,13
unplanned (1) 35:4
unpleasant (1) 103:3
unprecedented (2) 39:20,23
unsafe (1) 51:25
unsavoury (1) 96:22
unsuitable (1) 52:15
unsupported (1) 109:13
until (8) 65:6 73:24 94:13 96:12 107:9 118:11 123:12,15
untrained (1) 109:13
untreated (1) 111:1
unwanted (1) 35:4
unwell (2) 91:3 115:7
unwillingness (1) 114:5
update (2) 45:12 107:3
updates (3) 82:4 83:14,16
upheld (1) 116:25
upholds (1) 122:17
upon (4) 67:13 76:6 119:3 121:25
upsetting (1) 93:9
urge (1) 121:24
urgent (1) 84:24
urgh (1) 26:6
used (4) 33:3 43:23 74:23 83:11
useful (6) 10:1 14:2 48:19,25 84:5 114:3
uses (1) 11:23
usual (2) 51:7 67:9
usually (3) 15:1 44:19 47:25
utilised (1) 103:21
uturn (2) 34:18,21

V

vaccination (4) 32:21,24 33:6,10
varied (1) 33:16
variety (2) 15:1 19:19
various (9) 3:3 16:24,25 37:12 54:23 84:10 89:7 92:20 93:2
varying (1) 118:19
vascular (1) 108:8
vast (6) 22:6 24:22 27:14 56:11 63:20 75:24
vastly (1) 75:24
vein (1) 94:18
via (3) 9:22 42:2 92:19
victims (3) 43:17 44:14 47:22
victimsurvivors (3) 12:10 19:7 45:11
video (2) 68:13 87:20
views (2) 103:11 107:18
violated (1) 71:3
violence (16) 12:8,10,14,20 13:5 16:5 19:8 28:1 29:24 43:2,6,9 46:9 57:1,15 78:22
virology (1) 97:3
virus (6) 39:19,24 108:6 118:3,3 122:15
visible (1) 9:21
visitation (2) 50:17,20
visits (1) 41:6
vital (3) 16:11 70:23 122:16
vulnerability (1) 27:16
vulnerable (9) 17:8,8 18:1 22:16 48:15 66:1,24 70:25 72:16

W

wages (1) 36:20
waiting (1) 69:21
wake (1) 29:2
wales (1) 79:2
walk (1) 117:22
wanes (1) 118:20
wanting (1) 111:22
wants (3) 11:21 84:16 105:8
wards (1) 32:3
wasnt (13) 16:14 28:3 42:11,11 58:4 63:19 65:3 72:9,20 74:12 77:14,14,15
wasted (1) 80:13
water (1) 38:21
wave (1) 98:4
way (21) 5:14 11:13 14:25 28:4 29:8 36:5 58:12,18,20 61:5 63:5,24 64:22 72:11 93:1,3 110:25 111:17 117:19,23 122:14
ways (5) 44:6 49:23 58:7 72:13 118:5
weaker (1) 58:7
weaknesses (2) 59:12,13
wearing (1) 20:17
webinar (5) 102:5,5,7,11,25
website (2) 20:24 116:2
websites (1) 107:3
week (1) 34:4
weekends (1) 29:4
weekly (1) 22:20
weeks (6) 20:10 30:7 61:13,19,19 65:6
welcome (2) 85:24 86:19
welfare (5) 98:16 99:12,17 120:4,11
wellbeing (3) 39:21 103:10 121:21
wenham (1) 6:5
went (9) 21:14 26:20 30:18 32:15 33:5,13 64:18 66:14 72:21
werent (8) 16:5,11,13 22:16 32:16 65:5 72:23 94:10
west (1) 38:15
weve (2) 76:20 96:11
whats (2) 116:14,15
wheelchair (1) 118:14
wheelchairs (1) 117:23
whenever (1) 64:7
whereas (1) 112:25
whilst (1) 28:14
whisked (1) 48:1
white (1) 41:19
whoever (3) 11:21 52:4 113:4
whole (3) 106:20 114:25 116:15
whom (1) 33:21
whomever (1) 16:23
whose (3) 4:18 98:3 117:17
wide (4) 18:10 20:22 21:14 32:14
widely (2) 118:22,23
wider (3) 91:13 117:6,7
willing (2) 113:9 116:19
wind (1) 22:21
wiped (1) 61:22
wish (4) 4:12 101:22 108:2 120:19
witness (7) 3:8 61:15 86:24 87:12,25 88:7 122:25
witnessed (1) 19:4
witnesses (5) 1:6 66:6,11,12 90:1
witnessing (1) 20:2
woman (5) 29:1 33:3 53:14 54:3,5
womans (1) 37:22
women (151) 3:11,20 4:1 5:5 6:6 7:14 9:4,16,20 10:19 11:5,14 12:8,13 13:14,18,21 14:25 15:10,13 16:4 17:4,14,22,25,25,25 18:13,16,18,24 19:1 20:23 21:5,8,11,21,25 22:7,7,9 23:9,19 24:10,20,22 25:4 27:17 28:2 29:22 30:13,23,24,24 31:4,24 32:1,7,16,23,24 33:2,9,18 34:3 35:5,13,17 36:9,19,21,22,24 37:23 38:2,19 39:7,10,13,18 41:24 42:11 43:7 44:5,8 45:18 49:21 50:22 52:15,15,16,22,25 53:1,8,9 54:14,18 55:4,11,12 56:2,5,7,13 57:1,5,5,6,6,15,20 58:8,13,21 59:12,19,21,23 62:4,6,9,12 63:21 65:9,21 66:14 67:5,9 68:3,8,15,19,21,21 70:1 72:15,16 76:4,5,9 78:22 80:3 81:6,6,7,7,11 82:1,12 85:23
womens (48) 1:12 2:6,13 3:16 8:10,14 10:9 12:4 13:9,11,19 14:3 16:18 18:8 20:20 21:3 22:8 27:9,13,16 28:2,3 37:19 47:16 49:17 52:25 56:22,23 57:2,3,8,16 58:8 59:18 60:13,14,16 61:3,3 62:12 67:3 71:8,14,15 77:25 78:7 82:6,19
womensic (1) 62:10
wonder (2) 3:4 90:16
wonderful (1) 78:16
wont (4) 26:22 50:5 73:21 117:23
work (35) 4:10,14 7:14 8:14 11:9 12:9,22 16:8 19:22 21:24 22:6 23:18,22 35:22 39:19 40:17 41:12 42:6 44:3 51:9 52:1 55:8,17,24 58:1,21,22 62:10,13,13 63:20 72:7 77:6 97:3 113:16
worked (2) 58:24 61:4
worker (3) 22:12 23:6 33:6
workers (16) 16:5,6 23:13 33:1,10 39:7,11,13 40:7,12 42:3,7 55:19 56:4 73:10,16
workforce (1) 40:1
working (17) 8:10,12 9:15 11:24 12:20 13:13 28:15,16 37:4 42:2 44:2 59:25 63:16 71:11,17 77:5 78:19
works (3) 12:24 13:2 14:25
world (3) 59:22 76:11 97:5
worried (2) 31:5 40:21
worry (2) 22:20 63:1
worrying (2) 67:10,10
worse (3) 21:10 69:19 121:3
worsened (2) 18:20 57:2
worth (1) 14:11
wouldnt (2) 33:8 89:9
writer (1) 4:17
written (1) 10:5
wrong (4) 49:6 77:7 115:24 116:17

Y

year (7) 45:21 64:8,14,25 104:6,8,22
years (15) 8:11 10:15 34:10 37:3 39:2 58:25 61:5,12,18 68:6 69:22 92:14 104:21 112:5,6
yesterday (2) 3:8 9:6
yet (6) 4:3 44:15 56:6 106:24 111:5 122:9
young (31) 7:15 12:22 13:15,18,22 17:5 36:9,24 41:2 44:16 47:20 73:9 90:21,24 94:2,23 98:12,14 99:10,21 106:10,16 107:1,13,19 109:22 111:3 116:3 121:22 122:2,10
younger (2) 55:11 57:6
youre (1) 91:16
yourself (1) 89:1
yourselves (1) 105:12

Z

zero (1) 57:22

0

02 (1) 90:15
03 (1) 92:15
04 (1) 93:22
06 (1) 96:24
07 (1) 98:8
08 (3) 101:18 103:14 105:19
09 (1) 105:20

1

1 (10) 4:20 23:8,8,9 47:1 64:9 105:21 124:2,3,5
10 (6) 11:20 61:5,18 103:16 104:21 123:13
1000 (2) 1:2 123:15
10000 (2) 94:16 95:7
100000 (2) 40:11,12
103 (1) 40:12
11 (5) 42:16 64:13 105:21 106:4 122:9
1102 (1) 42:20
1117 (1) 42:22
12 (1) 61:19
1226 (1) 87:7
14 (2) 103:25 104:23
144 (1) 40:11
14year (1) 36:11
15 (2) 61:5,18
16 (2) 28:6 36:10
17 (2) 13:3 31:15
170000 (1) 95:21
18 (1) 34:7
19 (3) 36:3,3,10
1950s (1) 60:4
1990s (1) 72:5

2

2 (8) 1:1 4:20 40:15,20 41:2 45:14,14 86:20
20 (4) 8:11 39:9 41:10 74:1
200 (1) 87:9
2001 (1) 21:4
2008 (1) 27:7
2014 (1) 122:3
2015 (1) 46:11
2019 (2) 43:13,14
2020 (14) 28:9,10 29:7 38:9 43:11,14 45:23 46:25 64:23 85:7 93:12 98:2 107:21 122:5
2021 (11) 28:11,23 40:14 45:12 88:22,23 93:12 101:1,23 102:4 114:21
2022 (9) 36:4 88:25 93:12 94:16 98:24 99:2 101:21,21 103:16
2023 (4) 1:1 88:25 93:10 123:16
21 (2) 40:5 109:8
22 (1) 43:2
24 (2) 119:1,2
24hour (2) 13:24 66:4
25 (2) 36:9 119:5
250 (1) 90:25
26 (3) 50:9 52:10 61:19
28 (5) 46:25 47:6,7,8,10
29 (1) 52:11

3

3 (5) 4:19,21 23:8 104:22,23
30 (2) 54:22,25
302 (1) 123:14
31 (4) 48:22 49:6,8 56:18
32 (2) 49:9 61:25
33 (1) 64:23
34 (1) 13:16
34106 (1) 43:14
36 (2) 21:8 67:13
365day (1) 13:24
37 (1) 67:19
39 (2) 69:7 88:15

4

4 (4) 4:22 23:8 40:19 98:24
40 (1) 69:25
400000 (1) 64:14
41 (1) 70:14
42 (3) 70:17,21,22
44 (1) 2:19
46 (2) 79:17,20

5

5 (4) 23:9 46:1,2 99:2
50 (2) 69:5 83:1
52 (1) 29:22

6

6 (2) 121:15 122:5

7

7 (4) 7:11 43:12 66:14 123:16
70 (3) 1:25 30:4 64:25
71 (1) 63:16
72 (1) 23:23
750000 (1) 64:9

8

8 (2) 7:18 43:13
80 (2) 39:12 55:19
87 (1) 124:6
88 (1) 124:7

9

92 (1) 23:19