

# OPUS2

Scottish Covid-19 Inquiry

Day 29

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1 Friday, 22 March 2024  
 2 (9.30 am)  
 3 THE CHAIR: Good morning, Mr Gale. Good morning,  
 4 Mr Macaskill.  
 5 MR GALE: Good morning, my Lord.  
 6 THE CHAIR: When you're ready, Mr Gale.  
 7 MR GALE: Thank you, my Lord. We have two witnesses today.  
 8 Both are representatives of the organisation  
 9 Scottish Care Limited. The first is  
 10 Dr Donald Macaskill. I will be leading Dr Macaskill.  
 11 The second is Ms Hedge and my colleague Mr Dunlop will  
 12 be leading her.  
 13 THE CHAIR: Thank you.  
 14 MR GALE: The reference of Dr Macaskill's statement is  
 15 SCI-WT0189-000001.  
 16 DR DONALD MACASKILL (called)  
 17 Questions by MR GALE  
 18 MR GALE: Dr Macaskill, your full name, please?  
 19 A. Donald Macaskill.  
 20 Q. Your details are known to the Inquiry, your contact  
 21 details, and you provided the Inquiry with a detailed  
 22 statement. You've also provided the Inquiry with other  
 23 documents which the Inquiry has regard to and, as  
 24 I understand it, you are happy that the statement that  
 25 you've provided, together with the evidence that you

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1 give today, will constitute at this stage your evidence  
 2 to the Inquiry in relation to impacts in the health and  
 3 social care sector, and you're particularly interested,  
 4 obviously, in the social care sector.  
 5 A. Yeah.  
 6 Q. For the avoidance of doubt, you have already given  
 7 evidence to the UK Inquiry, when it sat in Edinburgh on  
 8 18 January of this year, and the relevant transcript is,  
 9 for that date, from pages 106 to 172. Just for  
 10 completion, my Lord and Dr Macaskill, obviously we have  
 11 an agreement with the UKI to share information and not  
 12 to duplicate matters, so we have regard to what you said  
 13 both in your statement to the UKI and your oral evidence  
 14 to the UKI, so we will have regard to all of that.  
 15 Against that background, can I ask you a little bit  
 16 about your personal background? You are the chief  
 17 executive of Scottish Care?  
 18 A. I am.  
 19 Q. How long have you been in that position?  
 20 A. Seven years.  
 21 Q. Yes. In regard to your evidence in this section of the  
 22 Inquiry, you are dealing specifically with the care home  
 23 sector, if I can put it that way?  
 24 A. I shall.  
 25 Q. Yes, and your colleague, Ms Hedge, will be dealing with

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1 care in the community, if I can put it again in that  
 2 way?  
 3 A. She will.  
 4 Q. Now, could you just tell us a little bit about  
 5 Scottish Care, what it is, what it does, who it  
 6 represents?  
 7 A. Scottish Care is the national representative body for  
 8 social care providers, mainly for older people and  
 9 adults, and our membership constitutes the majority of  
 10 care home providers in — the term that we use is "the  
 11 independent sector". That means the charitable,  
 12 not-for-profit, employee-owned and private sector; in  
 13 other words, all care homes who are not run by the  
 14 state. And it also, in our membership, includes the  
 15 majority of providers of care at home, housing support  
 16 for individuals living in their own home, again, not  
 17 provided by local authorities or the state.  
 18 So as an organisation we have existed over a number  
 19 of years to engage in policy and seeking to influence.  
 20 Our basis is that we are concerned with the improvement  
 21 of the quality and the delivery of care and that the  
 22 social care sector is better understood and valued  
 23 within wider Scottish society. We do that through  
 24 various mechanisms, such as policy, influence,  
 25 contributing to Scottish Government and local authority

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1 and other partnerships' development.  
 2 Q. Something I think you will come on to later, but you  
 3 mention the care sector being properly regarded in  
 4 Scottish society. I can ask this at this stage and  
 5 I will ask you to develop it later: has the pandemic had  
 6 a negative effect on the way in which the care sector  
 7 has been regarded?  
 8 A. Before the pandemic, the social care sector in Scotland  
 9 was not sufficiently understood or regarded and the  
 10 pandemic has only served to worsen and deepen that  
 11 ignorance, lack of priority and understanding of the  
 12 value of social care in Scotland.  
 13 Q. From your perspective, as the head of Scottish Care,  
 14 what steps are you presently and have you been taking to  
 15 counteract that negative impression?  
 16 A. I think virtually every time I open my mouth, certainly  
 17 publicly, it is to underline the value that should be  
 18 given to the women and men who work in social care and,  
 19 even more importantly, the women and men who receive  
 20 social care support, regardless of their age, status or  
 21 any designation of any condition. So I think I and all  
 22 my colleagues are about enhancing the understanding of  
 23 social care as an intrinsic part of Scottish society.  
 24 The language that is often used about social care is  
 25 about how much it costs us, how much it's a drain on

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1 society and, as an organisation and as a membership  
 2 body, we are about emphasising how intrinsic to the  
 3 nature of Scotland as a community the delivery of social  
 4 care is and how we need to value the women and men who  
 5 work in the sector and how we importantly need to better  
 6 value the women and men who use social care support. So  
 7 it's a constant battle and it's probably sadly one which  
 8 was made worse by the pandemic.

9 Q. Yes. Can I put it bluntly? Is there and has there  
 10 been, in your view, an unfair criticism and an unfair  
 11 comparison of the Scottish Care sector as compared to  
 12 the NHS?

13 A. I think there's always been a lack of understanding  
 14 about the intimate relationship that exists between  
 15 health and social care provision. Historically it's  
 16 always been easier to understand the NHS as an entity in  
 17 itself. It's always been a challenge to convince — and  
 18 this includes clinicians and advisers who should know  
 19 better — about the value of social care.

20 The way in which I often communicate it is that, if  
 21 I break my leg and I end up in A&E and am admitted into  
 22 a hospital, then the nature of the support I get is  
 23 going to be very, very different to what I need should  
 24 I then have, as a result of that incident, to spend the  
 25 rest of my life receiving care and support in the

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1 community or in a residential setting. We're not  
 2 talking about the same entities or institutions or  
 3 organisations or skills but we are talking about  
 4 a deeply connected set of relationships between the NHS  
 5 and social care.

6 And I think all of us, whether working with  
 7 children, those living with the addiction or mental  
 8 health issues or, in my context, adults and older  
 9 people, bemoan the lack of understanding in the general  
 10 public and perhaps more concerningly amongst our  
 11 political leadership of all parties about the nature of  
 12 social care. We are not the NHS, we're not better or  
 13 worse than the NHS, but we are essential to the fabric  
 14 of health and well-being in Scotland.

15 Q. And something we'll come to, Dr Macaskill. But you  
 16 mention there that this perhaps lack of understanding is  
 17 something that permeates through to political figures.  
 18 In the course of the pandemic, did you encounter  
 19 difficulties in your dealings — and we'll come to  
 20 discuss your dealings with various ministers and  
 21 officials in due course — but did you encounter  
 22 instances where there was not a proper appreciation on  
 23 the part of politicians as to the significance of and  
 24 the difference from the NHS?

25 A. I think, with very few exceptions, the understanding of

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1 social care amongst parliamentarians, whether at  
 2 Westminster or in Holyrood, is not where it needs to be.

3 When one considers not only the contribution of social  
 4 care to our national economy, this is a sector that  
 5 contributes the fourth—largest economic contribution of  
 6 any sector in the country, but much more importantly,  
 7 given the fact that thousands — tens of thousands of  
 8 individuals today are using social care supports, which  
 9 massively dwarfs the 17,000, for instance, who are in  
 10 a hospital today, that lack of understanding of the  
 11 reality of social care delivery is very concerning.

12 What I found is that there were some who were open  
 13 to learning, to listening and to understanding about the  
 14 nature of social care, and we might want to talk about  
 15 some of those, but there were others who swallowed  
 16 assumptions, followed stereotypes and, to be truthful,  
 17 were not that interested in a perspective that didn't  
 18 have the NHS badge attached to it.

19 Q. Right. We'll come to some specifics in due course.  
 20 A little about your own personal background. You have  
 21 a doctorate. Can you tell us what that doctorate is in,  
 22 please?

23 A. So it's a multi-disciplinary doctorate in sociology,  
 24 theology and in psychology. I explored and examined the  
 25 nature of occupational burnout and the degree to which

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1 vocational roles impacted on your sense of identity and  
 2 what happened if those were diminished and burnout  
 3 resulted. And, sadly, it was an academic study which  
 4 became much more resonant in my professional life, not  
 5 least during the pandemic and since.

6 Q. Right. You also have, if I can put it in generality,  
 7 a human rights background and interest. Again, can you  
 8 tell us about that, please?

9 A. Yeah, when I was primarily working in academia, I was  
 10 very much involved in the whole field of equality,  
 11 diversity, inclusion and human rights, and when I left  
 12 that world, I established a human rights and equality  
 13 consultancy and led that for about 13 years, working  
 14 with public bodies predominantly across the  
 15 United Kingdom and internationally, and latterly focused  
 16 predominantly on the human rights of older people and  
 17 what that meant in practice. And I was privileged to  
 18 work with bodies such as the Scottish Human Rights  
 19 Commission in developing practice around the human  
 20 rights of older adults in different settings, including  
 21 in the care setting.

22 Q. Again, if I can put it bluntly, is it the case that very  
 23 frequently the human rights of the elderly are ignored?

24 A. I think it is almost to be taken for granted that the  
 25 community and a group of people who we describe as

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1 "older" are least protected in terms of our human rights  
 2 frameworks. There has been --- and I've been part of  
 3 it --- a growing clamour for the United Nations to  
 4 develop a convention on the rights of older people and  
 5 there has been a growing desire for communities and  
 6 nations to develop commissioners for older people.  
 7 I was privileged during the pandemic to work closely  
 8 with the Older People's Commissioner for  
 9 Northern Ireland and for Wales. Scotland does not have  
 10 that role and neither has England. I think the valuing  
 11 of older people and their distinctive human rights is  
 12 one which, whilst in rhetoric we talk a lot about in  
 13 Scotland, in practice --- and the pandemic certainly for  
 14 me personally underpinned the reality --- in practice we  
 15 pay lip service to the rights of older people.  
 16 Q. Right, thank you. Again, something we'll develop in  
 17 a little . I think you then go back to the nature of  
 18 Scottish Care. You set this out at paragraph 7 and  
 19 following of your statement, and I think we can see that  
 20 Scottish Care has 350 members which cover, as you put  
 21 it, approximately 900 services. It seems --- in terms of  
 22 services, it seems an awful lot. Can you explain how  
 23 that number was arrived at?  
 24 A. So one of our members may, for instance, have 60 care  
 25 homes or 50 care homes or 30 care homes and, obviously,

1 that's a distinct service per number, and so that's the  
 2 differential between the number of members and the  
 3 number of services delivered. I would have to say that  
 4 the 85% or 86% --- it changes --- of all care home  
 5 delivery in Scotland is undertaken by the independent,  
 6 charitable, private, not-for-profit sector, and the vast  
 7 majority of those are members of Scottish Care. So our  
 8 membership does constitute one of the largest social  
 9 care representative bodies in Europe.  
 10 Q. You give an indication in paragraph 10 of the nature of  
 11 the various varying types and sizes of the organisations  
 12 and, obviously, that ranges from a single individual  
 13 care home --- and I think you've emphasised on a number  
 14 of occasions, certainly in conversation with me, that  
 15 a lot of these are family-provided. They're family-run,  
 16 family-operated.  
 17 A. Yes, and when I first got involved in the sector,  
 18 I suppose I had the image that many others have, which  
 19 is that care homes are run by large groups and multiple  
 20 organisations within a group. Now, that is true to some  
 21 extent, but in Scotland we're very different or have  
 22 been historically different compared to the rest of the  
 23 United Kingdom in that the vast majority, historically,  
 24 of care homes are run by individuals or by families and  
 25 constitute either single care homes or units of no more

1 than two or three care homes in a group. And that's  
 2 always added a particular colour to the Scottish  
 3 context, but it's also added a particular challenge and,  
 4 sadly, both before and since the pandemic we are seeing  
 5 more of those family-run organisations not being able to  
 6 meet the challenges of sustainability .  
 7 There were huge pressures, particularly for these  
 8 small care homes, in dealing with a pandemic, not least  
 9 in the fiscal challenge of getting hold of PPE, which is  
 10 much easier if you're a group of 50 or 60 care homes  
 11 than if you're a care home --- a single care home in  
 12 a remote part of Scotland. So the nature of social care  
 13 provision in Scotland is changing and, sadly, from my  
 14 perspective, we are losing some of the colour and the  
 15 locality of businesses and organisations which were set  
 16 up by families. And in the same way, we are losing at  
 17 a really disturbing rate our charitable care homes,  
 18 which, when I started this role, constituted around  
 19 about 19% to 20% of our membership and now are closer  
 20 to 10.  
 21 Q. 10%, right. Again, a point that you will come to later  
 22 in your statement, in your evidence, I think one of the  
 23 difficulties that care homes experienced during and as  
 24 the pandemic progressed was the obtaining of necessary  
 25 insurance. I take it that would be more difficult for

1 the smaller ---  
 2 A. Yeah.  
 3 Q. --- independent care homes than the larger more corporate  
 4 care homes?  
 5 A. Yeah. Of necessity, if you are a larger corporate  
 6 group, you have an ability to negotiate and to identify  
 7 insurance cover which is much larger than a smaller  
 8 provider. And I can remember one instance in the middle  
 9 of the summer of 2020, this single care home operator in  
 10 the north of Scotland, who was absolutely at wits' end  
 11 on a Friday --- her insurance cover, despite months of  
 12 activity, was due to finish at 5.30 that evening --- and  
 13 she ended up, literally because of a lack of choice ---  
 14 ended up paying approximately four times the amount of  
 15 money that she had previously paid for insurance, and  
 16 that nearly put her out of business, in her own words,  
 17 though she is still in business. It was virtually the  
 18 straw that nearly broke the camel's back. So it's  
 19 extremely and was --- and to be frank, still is ---  
 20 a considerable challenge for smaller providers to  
 21 identify insurance who are prepared to insure single  
 22 entities .  
 23 Q. Right, thank you. One point --- I'm sorry, I'm slightly  
 24 going back --- one point I forgot to ask you about. You  
 25 have a particular interest in the care of those with

1 dementia.

2 A. Yeah.

3 Q. And I think you were --- you chaired the

4 Scottish Government's Care Home and Dementia Group and

5 also the Dementia Advisory Group. Can you tell me how

6 your interest in that particular area developed and what

7 your role was in those various groups?

8 A. I suspect, like many people in this room, my interest in

9 dementia is a very personal one in that my own mother

10 had dementia and died from and with dementia. My

11 grandmother had dementia and my great-grandmother had

12 what we would now define as dementia. From an early

13 age, my understanding of older age was very much

14 connected to neurological decline and disease, and that

15 did deeply influence, probably with retrospect, much

16 more of my professional life than I then understood.

17 I considered it a privilege to chair the

18 Scottish Government's dementia working group in care

19 homes, and I did that I think for six years before

20 I resigned from the post in the middle of the pandemic.

21 And the purpose of that role was to learn the lessons of

22 what good dementia care needed to look like within the

23 care sector because supporting an individual,

24 particularly with advanced dementia --- and the majority

25 of individuals in a care home are living with a degree

13

1 of neurological decline --- to support that individual is

2 I think the essence of good care and support and it

3 requires the skill, aptitude, compassion and ability of

4 a very dedicated staff.

5 I said earlier this week in a talk that working with

6 somebody [sic] like dementia was --- necessitates you in

7 relearning a language; learning how to communicate, for

8 instance; learning to be sensitive to what can sometimes

9 be the very challenging changes in behaviour and in

10 manner of somebody living with dementia. I am always

11 and remain in amazing admiration for the women and men

12 who support others living with dementia, and doing

13 a small part by chairing a group, by improving practice,

14 was the least I could do and it's something that remains

15 very important to me.

16 Q. In the context of --- and we will, as an Inquiry, be

17 looking at preparations for the pandemic as a specific

18 subject --- but with your background and particularly

19 your background on these groups that you've mentioned,

20 presumably one would assume that, in preparing for

21 a pandemic of the sort that we encountered with COVID,

22 one would need to be aware of the impact on certainly

23 the most vulnerable in society, and including within

24 that category one would have regard to those with

25 dementia. Just from your perspective, did you feel that

14

1 there was planning put in place to cope with a pandemic

2 directed towards those with dementia?

3 A. My statement makes this quite clear, that I was

4 astonished and now am appalled about the fact that

5 preparation for a pandemic did not include social care

6 and, by "social care", I don't mean policymakers who

7 knew about social care or think they know about social

8 care, I don't mean those who necessarily commission and

9 contract social care delivery, I mean those who are

10 actually doing the job. And that's not people like me

11 but those at the front line with the knowledge and

12 awareness of what it means to manage a pandemic, not

13 least with individuals who might be most vulnerable and

14 not least with people living with dementia.

15 There was a complete and utter lack of inclusion of

16 social care providers and voice in the planning of the

17 pandemic, and sadly what I find all the more

18 inexcusable and astonishing is that the current

19 Scottish Government's pandemic preparatory body, looking

20 to the future, still does not include any

21 representatives from the agencies that I've just

22 described. So we are walking into the potential of

23 a future pandemic having completely failed to learn the

24 lesson that, unless you have those at the table who know

25 instinctively and at first hand what it means to manage

15

1 a pandemic response in different settings, then you are

2 destined to make the same errors again.

3 Q. Yes. Now, I listened carefully to your evidence to the

4 UKI, I listened to the evidence of other witnesses to

5 the UKI, and I think one of the points that was made by

6 you and by others was that, at the table when the

7 pandemic began, the early months of 2020 --- there was

8 nobody at that table who could represent the care

9 sector. Whether it be care homes or whether it be care

10 in the community, there was nobody approximating to the

11 role of the Chief Medical Officer or the Chief Nursing

12 Officer. There was nobody who could be, as it were, the

13 Chief Officer for Social Care. Is that something that

14 you see as a serious deficit in the way in which this

15 was carried out?

16 A. Yeah, I think it's fair --- and I was on record before

17 the pandemic as saying the lack of a social care voice

18 at the heart of Government was a misstep. I think now

19 it is a dangerous failure not to have a social care

20 voice. We have a professional advisor in terms of the

21 Chief Social Work Advisor, but we're not talking about

22 the same disciplines or professions or entities.

23 I think the fact that we had a chief medical officer,

24 a national clinical director, but that we did not have

25 in Government somebody with knowledge of the social care

16

1 sector was a real failure and it meant, I think  
 2 throughout the pandemic, a clinicalisation or  
 3 medicalisation of decisions and behaviours which failed  
 4 to understand the particularity of the care sector  
 5 because you do not know what you do not know and, sadly,  
 6 the social care sector has had experience of  
 7 presumption, which is the presumptive knowledge of those  
 8 who come from an overt clinical background that they  
 9 really understand social care. But, as I said at the  
 10 beginning, social care is not clinical care. It's  
 11 complementary to but distinct from.

12 Q. Yes, thank you. We're obviously looking, at this stage  
 13 in the Inquiry's investigations, at impacts, and it may  
 14 be perhaps a slightly unfair question to ask you, but  
 15 I'm going to anyway. Do you feel that the absence of  
 16 that level of preparedness had an impact on the cohort  
 17 of people within the social care sector, both staff and  
 18 residents and patients?

19 A. It had a profound impact and, on staff, for them, it  
 20 made it feel as if, "Nobody understands us, nobody is  
 21 listening to us, nobody is recognising us", and I think  
 22 for those who were receiving social care supports,  
 23 whether in the community or in care homes -- I think  
 24 somebody put it well to me, "If you've never been in  
 25 a care home, if you've never lived and worked amongst

17

1 people with dementia, then you could possibly have  
 2 developed the sort of guidance and the sort of systems  
 3 which we had to experience during the pandemic. But if  
 4 you had, you would at least have had the humility to  
 5 recognise that you do not know everything and that you  
 6 needed to ask, consult, engage and involve".

7 And I'm not saying this -- and I've thought very  
 8 carefully about what I'm about to say -- I'm absolutely  
 9 convinced that the lack of engagement and involvement in  
 10 planning at an early stage of the social care sector in  
 11 anything other than presence -- because it's different  
 12 simply being in the room; it's very different having  
 13 those who are making decisions listen to you, respect  
 14 you, trust you and act upon that -- that lack did and  
 15 sadly cost many people their lives, both staff and those  
 16 who were residents in care homes and citizens in our  
 17 community.

18 Q. Thank you. Can I go on to ask you a little bit about  
 19 your engagement with key stakeholders? Now, clearly you  
 20 are here as the chief executive of Scottish Care and you  
 21 have, of necessity, the interests of your organisation  
 22 and your members at the heart of what you say. Can  
 23 I ask you -- and again if I may be blunt -- has that in  
 24 any way disguised in your mind some of the deficiencies  
 25 that there may exist and the criticisms that there may

18

1 be about the care home sector?

2 A. I don't think it's disguised in any sense. I have  
 3 always been very honest with my colleagues and my  
 4 members in saying that the social care sector, whether  
 5 care home or home care, exists for the primary purpose  
 6 of supporting and caring for those who require care and  
 7 support and can only achieve that by the valuing and the  
 8 affirmation of those who work in the sector, and those  
 9 too have always been for me dominant. I took this job  
 10 and I said at my interviewing panel that it is very much  
 11 my intention that Scottish Care and the work that it did  
 12 should be a human--rights--based organisation. Now,  
 13 that's not always been possible to achieve and we're  
 14 still a distance from achieving the destination that  
 15 I would want the organisation to achieve, but I can  
 16 assure you -- and this did not always and has not always  
 17 made me popular -- for me the human rights of those who  
 18 receive support, who deliver support, are paramount in  
 19 the work that we do as an organisation.

20 Q. Well, you won't be surprised to know, I think,  
 21 Dr Macaskill, that this Inquiry has a similar  
 22 human--rights--based approach which we have expressed in  
 23 documents which are available online, so we are aware of  
 24 that sort of approach that is necessary. In terms, how  
 25 do you utilise the human--rights--based approach in the

19

1 way in which you run Scottish Care?

2 A. On a very basic level, when I came in, we sought funding  
 3 and were successful in establishing a distinctive human  
 4 rights project, which was working with care homes and  
 5 community organisations to embed human rights practice  
 6 in their delivery. I note in my statement that I was  
 7 part of the group that developed the Care about Rights  
 8 project, with the Scottish Human Rights Commission and  
 9 other partners, so we were very robust in encouraging  
 10 our members to think about what human rights really  
 11 meant. I would have to say there is a multiplicity of  
 12 commentary around what does human rights mean in the  
 13 care setting, and I don't think you'll find many  
 14 politician, policymaker or pundit, who would not be  
 15 comfortable talking about human rights.

16 But the reality of what it means in practice is  
 17 challenging. So in an environment where somebody living  
 18 with dementia wants to take a particular action which  
 19 may place them at a point of unsafety and the staff  
 20 member wants to, to a degree, prevent that person from  
 21 taking that action, where does human rights interplay in  
 22 that regard? So what we've been trying to do was to  
 23 give staff and managers and owners the confidence of  
 24 thinking, "How do you look at a situation through  
 25 a human rights lens?". And there are elements of that

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1 examination which alter your practice, which enable  
 2 a different understanding of risk, which encourage you  
 3 to include a diversity of those who contribute to  
 4 a decision and, ultimately, which alters your practice.  
 5 So I think --- and we're still not there and we've  
 6 some distance to go. I have very little interest in the  
 7 rhetoric about human rights. I think our pandemic  
 8 response is an example of a human rights failure and at  
 9 the same time I know that we have had loads of  
 10 commentary about how we are working in a human rights  
 11 basis.  
 12 Before the pandemic I spoke at the Irish Human  
 13 Rights Commission about the difference between rhetoric  
 14 and reality and the degree to which so many of us in  
 15 a broader human rights community were becoming  
 16 despondent about the way in which human rights language  
 17 just falls off the tongue but, when push comes to shove,  
 18 we don't implement human rights processes and practices.  
 19 And sadly --- and we may go on to talk about this ---  
 20 I think the pandemic and the Government's response to  
 21 the pandemic and to an extent the sector's response to  
 22 the pandemic underlined the difference between the  
 23 rhetoric and the reality of human rights.  
 24 Q. As an organisation, how do you or did you or do you get  
 25 across the human rights approach and basis to your

21

1 members, because I suppose it's a question of getting it  
 2 across to the care home providers but also assuming or  
 3 making provision whereby that also gets across to the  
 4 individual carers.  
 5 A. Yeah.  
 6 Q. So how does the organisation go about doing that?  
 7 A. I think probably the way in which I try to go about  
 8 doing it --- and with respect to you, Mr Gale, and other  
 9 distinguished members of the legal profession in this  
 10 room, for me, human rights and in the care setting human  
 11 rights is not about legality. It's not about knowing  
 12 which article might be engaged in a particular context,  
 13 though that is important. It is about, for me,  
 14 primarily relationship. And I ask and say to people,  
 15 "What do human rights mean to me? They mean how do  
 16 I relate to you; how do I relate to the person who might  
 17 not be able to communicate verbally, might not  
 18 understand because of capacity issues what's happening  
 19 to them; how do I relate to a circumstance where the  
 20 answer is not always black and white but is a very  
 21 challenging answer where we have to arrive at together".  
 22 So, for me, human rights is ultimately about the  
 23 treating of one another with and in the manner in which  
 24 dignity is upheld and that, for me, is what social care  
 25 should all be about and, sadly, often human rights are

22

1 left at the door in the delivery and in the  
 2 commissioning and the politicising of care.  
 3 Q. Thank you very much. Now, can I ask you a little about  
 4 guidance?  
 5 A. Yeah.  
 6 Q. And I should say, Dr Macaskill, that in the time that we  
 7 have available today, I will not be touching on all  
 8 aspects of your statement. Some of them I'm going to  
 9 just simply take as read, but there are certain matters  
 10 that I would like to explore with you in a little more  
 11 detail. I'd like to discuss the question of guidance  
 12 because I think it does cut across many other matters  
 13 that you touch upon, so visiting, PPE and others.  
 14 You, as an organisation, I think put out very early  
 15 in the pandemic --- I think it's dated  
 16 24 February 2020 --- guidance to your members, and  
 17 I think that was based on Public Health England advice,  
 18 wasn't it? What was the nature of that guidance? What  
 19 were you attempting to do at that very early stage?  
 20 A. It was essentially an information or briefing paper. It  
 21 didn't have the connotation of guidance, which later we  
 22 might want to talk about the understanding of guidance  
 23 as being, simply because we had members asking us, "Can  
 24 you give us some help?", because at that time, by the  
 25 time we published that document, there was no official

23

1 guidance from, at that stage, Health Protection  
 2 Scotland. The only guidance which existed was guidance  
 3 explicitly dealing with COVID which had been developed  
 4 by Public Health England and, in its early stages, it  
 5 talked about the importance of developing a resilience  
 6 plan, it talked about the importance of undertaking  
 7 a PPE audit, of understanding the nature of PPE that was  
 8 necessary, it talked about what you need to do to  
 9 support families and individuals to understand what may  
 10 be happening. This was in the context, you may  
 11 remember, that travel was being highlighted as  
 12 a particular issue and, at that time, Public Health  
 13 England had instigated a concern about people coming  
 14 from particular countries.  
 15 So it was very much a collation of material that was  
 16 available to try to support our members, who, from  
 17 probably the end of January/beginning of February, were  
 18 beginning to ask us, "What do you think this is going to  
 19 mean for us?", and, like everybody else, we were aware  
 20 of what we were seeing on our television screens from  
 21 Italy, Spain, France, and I, because of being a director  
 22 of the Global Ageing Network, tied into colleagues in  
 23 different parts of the world, was hearing from them the  
 24 early steps and measures that they were taking in aged  
 25 care facilities.

24

1 So we wanted, in the absence of anything, to say  
 2 something, and indeed I do believe it was used by other  
 3 organisations as an early tool until more formal  
 4 guidance came out from Scottish Government on 12 and  
 5 13 March.  
 6 Q. Thank you. You do mention --- it's at paragraph 58 of  
 7 your statement. You don't need to look at it --- but you  
 8 do mention that guidance, as one progressed to guidance,  
 9 was issued by a number of organisations, ranging from  
 10 the Scottish Government, Public Health Scotland, COSLA  
 11 and the Care Inspectorate. Now, in your experience, did  
 12 the fact that guidance came from a variety of sources  
 13 cause any difficulties ?  
 14 A. Yes, very much so.  
 15 Q. And what were they?  
 16 A. There was a difficulty of uncertainty over status, for  
 17 instance, of what status the guidance had because of who  
 18 was issuing it. There was an uncertainty particularly  
 19 in instances where there might be conflicting guidance  
 20 or statements which could be read in different ways. So  
 21 the --- you know, at one stage somebody said to me, "If  
 22 our pandemic response was based solely on the amount of  
 23 guidance and the changes to guidance and the amount of  
 24 paper and trees that were produced --- were wasted, then  
 25 our pandemic response would have been exemplary". But

25

1 actually the multiplicity of guidance, sometimes four  
 2 changes to guidance in a week, added real confusion  
 3 because, in the end of the day, the women and men at the  
 4 front line, their primary focus was keeping people  
 5 alive, and sometimes, I think with the benefit of  
 6 distance, we've lost a sense of the fear, the anxiety  
 7 and, in some parts, the terror. And I had people on the  
 8 phone not sure that they could go into work because they  
 9 were paralysed by the uncertainty and the fear of  
 10 working in an environment, particularly in care homes,  
 11 which they did not understand, because nobody knew about  
 12 this pandemic other than what we saw on the television  
 13 screens, and they tended to be scenes of ICU, with staff  
 14 dressed from head to foot in protection, and that's not  
 15 what was happening in the social care sector.  
 16 So in that context guidance added an extra burden  
 17 rather than what it should have done, which was to give  
 18 assurance, certainty and support. And, for me, the word  
 19 "guidance" has a counselling element to it, in which you  
 20 guide somebody to make them more confident and assured  
 21 in their practice, whereas, unfortunately, the way in  
 22 which guidance became understood was more restrictive  
 23 and limiting rather than something enabling.  
 24 THE CHAIR: You say "more restrictive". In what way more  
 25 restrictive ?

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1 A. I think one of the challenges, your Lordship, is that  
 2 the status of the guidance was unknown. So care  
 3 providers have been used to dealing with statutory  
 4 guidance in which it's very clear, "You do that and, if  
 5 you don't do that, then trouble might ensue", but  
 6 they've also been used to dealing with guidance which  
 7 doesn't have that statutory association or connotation  
 8 and for that there has always been a flexibility in its  
 9 interpretation and in its application. I think that's  
 10 important because at times I heard from some of our  
 11 members saying, you know, if they would just mandate  
 12 this and say, "Right, you have to do this", that would  
 13 make matters much easier because we could then say to  
 14 people, "Listen, we have no alternative". But that  
 15 actually I think might have been a very real weakness  
 16 and challenge because, if guidance is properly  
 17 understood, it should have a flexibility in it to allow  
 18 for local interpretation and adoption because no, for  
 19 instance, care home is exactly the same. The  
 20 environment is different, the people who are being  
 21 supported are different, the needs and the acuity of  
 22 individuals are different.  
 23 So if guidance is --- and it had been before the  
 24 pandemic --- written in a way which is guiding,  
 25 permissive, but affirmatory at the same time, then

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1 people can work with that. I think the challenge of the  
 2 pandemic was that the more guidance began to be used as  
 3 a tool against which to scrutinise, inspect and hold to  
 4 account, that flexibility in interpretation at local  
 5 level, to be sensitive to local needs, went out the  
 6 window, and it was exacerbated by actions elsewhere  
 7 which gave to guidance a role and a status which I think  
 8 was unhelpful and which meant that those who  
 9 deliberately went against the guidance were a minority  
 10 and did so with a very real sense of fear about  
 11 consequence.  
 12 THE CHAIR: I happen to agree with virtually everything you  
 13 just said and indeed have been critical in the judicial  
 14 capacity of guidance. But looking at it --- this is  
 15 something the Inquiry has to do --- from the perspective  
 16 of those making decisions which are capable of being  
 17 enforceable, ie a government, what then --- and I'm  
 18 asking you the question --- are they to do in a very  
 19 difficult situation such as a pandemic? I agree with  
 20 you, the only way they can make something mandatory is  
 21 to make it either a statute or a regulation with no  
 22 doubt penalties for failure to comply. On the other  
 23 hand, as you quite eloquently explain, guidance can be  
 24 itself helpful, informative and of considerable utility.  
 25 But how does Government make that decision and, more

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1 importantly, how do they give an indication of how  
 2 guidance should be interpreted? I think you've hinted  
 3 at the answer by suggesting — and presumably they'd  
 4 have to build this into any guidance they issued — some  
 5 further guidance as to how it should be interpreted and  
 6 applied, for example, perhaps allowing for regional  
 7 differences. But do you first of all accept it's rather  
 8 a difficult position for Government and how do you think  
 9 they should approach it in the future?  
 10 A. So I absolutely accept that it's a difficult position,  
 11 particularly in emergency circumstances, but I think  
 12 there are both lessons that we can learn now, but, even  
 13 more importantly, knowledge that we had before about  
 14 what makes guidance easier to apply. The first element  
 15 of that is the formation and the development of that  
 16 guidance, who is involved and engaged, which gives that  
 17 guidance an authenticity and a sense that there is  
 18 verifiable truthfulness around the guidance. And if  
 19 I can use — so we're talking about different guidance,  
 20 I suppose, in the Inquiry. If I can use guidance which  
 21 relates to infection prevention and control as an  
 22 example, I think one of the reasons that the sector  
 23 really struggled with the application of infection  
 24 prevention control measures in guidance was that that  
 25 was developed by individuals who were completely

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1 ignorant — and I'm not using that word lightly — who  
 2 were ignorant and insensitive to the different contexts  
 3 in which that guidance was ultimately going to be used.  
 4 The guidance produced was exemplary and often  
 5 international standard for an acute hospital secondary  
 6 care setting, but the application of similar principles  
 7 and approaches to infection prevention and control  
 8 within a care setting, which is singularly different  
 9 because you're dealing with people who are living in  
 10 congregated environments, who — and you're dealing with  
 11 an environment which is not the same as the rather  
 12 sterile, cold existence, with respect to my colleagues,  
 13 in acute and secondary hospital settings, and when  
 14 you're working with people who have fluctuating capacity  
 15 and live with conditions such as dementia, that's a very  
 16 different context.  
 17 So had the guidance had an authorship and a sense of  
 18 veracity about it which spoke the story of that  
 19 environment, then its adoption and application would  
 20 have been much easier. So I think that's the first ask,  
 21 whenever you're developing guidance, is: make sure you  
 22 know what you're talking about, you have people who  
 23 understand the context of its application and you're  
 24 sufficiently responsive after its application to any  
 25 changes that need to be made to make it more

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1 appropriate.  
 2 We were, all of us, to some extent with COVID,  
 3 learning as we went. I think some — and I would equate  
 4 here the social care sector — was more open to  
 5 listening to others than some, not least those who  
 6 developed infection prevention and control guidance,  
 7 were open to listening to the insights of the sector.  
 8 So I think guidance succeeds if there is proper  
 9 ownership, a sense of application and a real sense of  
 10 being able to adjust to meet changing needs. All of  
 11 those did not get achieved in terms of those IPC  
 12 guidance.  
 13 THE CHAIR: Now, again I understand that, but formulating  
 14 guidance in the way you have just described it is  
 15 something which I would imagine is going to be taking  
 16 time and would be very difficult to do in the very short  
 17 periods of time that the Government was facing in March  
 18 of 2020. Do I take it, then, that you would favour an  
 19 approach that guidance, which incidentally would have to  
 20 cover all sorts of settings, as you already indicated,  
 21 but also all sorts of different viruses that might  
 22 create pandemics — that sort of guidance should be  
 23 developed in a plan in advance of any future pandemic —  
 24 A. Yeah.  
 25 THE CHAIR: — and indeed modified on a regular basis?

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1 A. Yeah, certainly. And I think one of the intrinsic  
 2 elements of planning for any event is that you've  
 3 already built an understanding of the context, which was  
 4 singularly missing because of the lack of inclusion, and  
 5 that you've already started to form trust-based  
 6 relationships, because you're right that it — guidance  
 7 will only work if there's a sense of trust that the  
 8 people who developed the guidance knew what they were  
 9 about. I think the singular lack of involvement in the  
 10 planning for the pandemic of the social care sector made  
 11 when the guidance first came out, especially the first  
 12 elements of the guidance, it gave a sense of despair.  
 13 We held a surgery two or three days after the first  
 14 set of guidance came out, at which I think there were  
 15 240 of our members present, and the sense of despondency  
 16 was absolutely — you know, you could cut it with  
 17 a knife because people said, "Do they know what they're  
 18 talking about?". So guidance which said to isolate  
 19 individuals in their own room, how do you do that when  
 20 you've got people living with dementia — to fail to  
 21 understand that communal, collective, shared environment  
 22 was intrinsic to the way in which people managed their  
 23 dementia, for whom contact and relationship and physical  
 24 touch was really important in terms of assurance and  
 25 neurological confidence.

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1 Now, had people who knew what it was like in a care  
 2 home been involved, and not just involved but listened  
 3 to, at an early stage in March, then it would have been  
 4 very different. Now, as things got on, it improved.  
 5 However, I would have to say that I still today have  
 6 fundamental concerns that ARHAI and our professional  
 7 infection prevention control experts are still  
 8 insensitive to a context which is not an acute secondary  
 9 hospital context, and I don't think we've learned those  
 10 lessons.

11 So, yes, you are absolutely, I think, right,  
 12 your Lordship, in saying that there needed to be urgent  
 13 guidance delivered, but into the future we need to be  
 14 more responsive to what we already know and we could  
 15 have been more responsive in March and into April to  
 16 what the sector and other stakeholders were saying to  
 17 quote the experts, who -- and I used the phrase in April  
 18 that we were witnessing an "IPC fundamentalism", and  
 19 I used that deliberately because it presumed that the  
 20 science was certain and set in stone, whereas, as we've  
 21 all become aware of, the science for COVID, as much as  
 22 the science for IPC, is not certain. There is  
 23 a diversity of approach and, importantly, should we  
 24 consider human rights, sometimes the desired outcome of  
 25 an IPC guidance may be at odds with the human rights and

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1 the individual rights of individuals in a setting to  
 2 make decisions and to exercise risk which may  
 3 contravene IPC but may be most appropriate for that  
 4 individual or person.

5 THE CHAIR: Thank you. I'm sorry, Mr Gale --  
 6 MR GALE: Not at all, my Lord.  
 7 THE CHAIR: -- I've taken you out of order, and jumped  
 8 ahead, but it was interesting.  
 9 MR GALE: Indeed.

10 Really just to take I suppose that point a little  
 11 further, we've heard in this Inquiry of various care  
 12 homes operating within the same -- within the structure  
 13 of the same guidance but taking different approaches,  
 14 some -- and I'm talking really about visiting -- talking  
 15 about certain care homes having a more liberal approach  
 16 to visiting; others simply saying that the guidance is  
 17 such that there is no visiting, there must be no  
 18 visiting. Was that a problem for Scottish Care when you  
 19 had different care home operators, possibly within the  
 20 same geographic area, operating different policies on  
 21 visiting?

22 A. It was, and, you know, I had conversations with the  
 23 founders of Care Home Relatives Scotland, some of whom  
 24 would email me and say "Care home X is allowing visiting  
 25 but care home Y is not. Can you intervene?". We tried

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1 in our seminars with members -- I was involved in the  
 2 group that developed the first stage guidance and  
 3 I think my statement makes clear my despair that it took  
 4 so long after myself and others had developed that  
 5 initial guidance for clinicians at Government level to  
 6 actually act upon what we asked. It took over five  
 7 weeks from what we considered to be the completion of  
 8 guidance to a decision to be taken about its potential  
 9 implementation and then a distance of time before it was  
 10 implemented.

11 So we were very aware that there was a diversity of  
 12 approaches to guidance around visiting. I think both  
 13 myself and Ms Hedge and our management -- a senior  
 14 manager around membership -- did all that we could to  
 15 try to influence organisations to be as flexible and as  
 16 liberal, to use your phrase. But I do remember phoning  
 17 one operator and saying, you know, "What can you do to  
 18 be more liberal in interpreting the guidance?", and  
 19 being told, "You're not going to be held culpable or  
 20 responsible. If I do this ..." -- not least this was  
 21 after Operation Koper started -- "If I do this, will you  
 22 stand in front of a judge and take culpability for the  
 23 fact that ten people might die?", and in a very direct  
 24 way saying, "Will you speak to my insurance provider and  
 25 say that you have invalidated the protection of other

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1 people?". And equally the person said, "Will you tell  
 2 the relatives who have told me that they will come",  
 3 quote, "and absolutely get me if I let somebody into the  
 4 care home?".

5 So I think we forget that at the time we were, all  
 6 of us, wanting to change and to open up care homes, but  
 7 there were strong voices who were arguing, "Open up  
 8 immediately", and there were other strong voices saying,  
 9 "We can't and don't you dare". As an organisation,  
 10 I hope Scottish Care tried to positively encourage  
 11 a more liberal approach but at the same time I'm not  
 12 going to be held responsible or culpable for particular  
 13 acts, and, Mr Gale, you might go on to talk about  
 14 Operation Koper. Operation Koper was a deadening of  
 15 flexibility and, from my experience, was the singular  
 16 event which caused harm during the summer months to the  
 17 care home sector.

18 Q. Well, we will go on to Operation Koper in a moment.  
 19 We've heard very eloquently from Care Home Relatives  
 20 Scotland their argument for a more liberal -- I'll just  
 21 use that word -- liberal approach to access to relatives  
 22 in care homes and we've heard, obviously, about the  
 23 campaign in favour of Anne's Law, and I'll ask you about  
 24 Anne's Law in a little, but I think interestingly you  
 25 have indicated that there was a contrary view being

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1 expressed to both members of your organisation and  
 2 through those members to you. Was that coming also from  
 3 people who had relatives in care homes?  
 4 A. Yeah, I think things changed over time. So at the  
 5 beginning of the pandemic and when care homes went into  
 6 lockdown, I personally believed that lockdown was an  
 7 entirely proportionate and reasonable action to take in  
 8 order to preserve life, given the knowledge that we had  
 9 about a virus which we knew little about at the time.  
 10 And I think, to be fair, the overwhelming majority of  
 11 family members understood that action, primarily because  
 12 they had been used to lockdowns before because of  
 13 norovirus, but they had only lasted, those lockdowns,  
 14 two or at a maximum three weeks, so there was always an  
 15 end in sight.  
 16 In April people like me began to question the  
 17 appropriateness of lockdown which we could see no end in  
 18 sight to and certainly into the early months of the  
 19 summer we were seeing that this is causing more harm to  
 20 individuals, both families and to individual residents,  
 21 and our members were saying people were deteriorating,  
 22 clinically deteriorating, because of the absence of  
 23 family and normal activity. So I think in that context  
 24 there was a desire to try to open up as quickly as  
 25 possible but, over and against that, there was a very

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1 real concern that there were risks in doing so. And  
 2 I heard of a number of incidences where care homes had  
 3 virtual meetings with residents and families' groups and  
 4 where there were very strong views on both sides,  
 5 saying, wholly understandably, "I really want and I need  
 6 to see my husband/my wife/my partner/my daughter", but  
 7 equally, on the other side, especially in the early  
 8 stage, "Please don't open up. This is going to run rife  
 9 through".  
 10 Now, I think, knowing what we know now, we  
 11 absolutely should have opened up care homes  
 12 significantly earlier and the process of that opening up  
 13 should have been more local, it should have been more  
 14 trust-based and it should have been more respectful of  
 15 the professionalism of the staff, who had been used to  
 16 dealing with infectious diseases in the past. But there  
 17 were singular distinctions. One was Operation Koper,  
 18 the second was an inspection and scrutiny regime, not  
 19 least by oversight teams, against which the managers and  
 20 the staff of care homes were being held to account. So  
 21 this wasn't norovirus. This was something which they  
 22 followed in some instances the letter of the guidance  
 23 very conservatively, but I know that was because of fear  
 24 and anxiety. It wasn't because of a desire to keep  
 25 people out. I really don't recognise that at that

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1 stage.  
 2 Q. You speak very quickly, Dr Macaskill.  
 3 A. Apologies.  
 4 Q. It's not a criticism. It's just that we have to be  
 5 mindful of the stenographers and we have to give them  
 6 a break, so I'm going to ask for a break in a few  
 7 moments. But I would like to just pick up one point  
 8 that you made in that last answer, and that was  
 9 "trust-based". You said that the opening up of care  
 10 homes to visiting had to, amongst other things, be  
 11 trust-based. The trust of whom? Who would you be  
 12 trusting?  
 13 A. I think the trust of all engaged. The care sector felt  
 14 as if it had been done to. The multiplicity of  
 15 guidance, the fact this guidance was frequently changed  
 16 on a Friday to be adopted as immediately as possible,  
 17 the continual negativity of media and political  
 18 leadership was all about holding the care home sector in  
 19 particular in a light of negativity. And in such an  
 20 environment, distrust and a lack of trust is seeded. So  
 21 people become more conservative and more risk-averse.  
 22 Had we been in a context where, instead of being  
 23 instructed, there had been a more collaborative,  
 24 consensual, collegiate approach to shaping guidance, to  
 25 developing flexibility around visiting, to listening to

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1 families and to staff at the front line, then, for  
 2 instance, in relation to visiting, we would have opened  
 3 up earlier. I have no doubt about that.  
 4 And, you know, I have heard as much from my members  
 5 in March and April and May the words, "This is against  
 6 the human rights of residents", as I did from any other  
 7 commentator, but nobody else was hearing that statement  
 8 from my members except ourselves. And so part of our  
 9 role in developing guidance was to encourage those  
 10 outside the sector, particularly clinical advisers and  
 11 CMOs and IPC experts, to actually listen and trust the  
 12 sector.  
 13 These are professional skilled nurses and staff at  
 14 the front line. You would not have treated ICU  
 15 consultants or specialists in the way in which we  
 16 negated, ignored and marginalised the voice and  
 17 contribution of our front-line staff. If we'd trusted  
 18 them to do the right thing, then this pandemic in our  
 19 care home sector could have been dealt with extremely  
 20 humanely rather than the way in which it was, which was  
 21 not.  
 22 MR GALE: My Lord, perhaps we can take just a few minutes  
 23 for the stenographers at this stage.  
 24 THE CHAIR: We'll take 15?  
 25 MR GALE: 15 would be fine, my Lord.

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1 THE CHAIR: The clocks seem to be all over the place. Does  
 2 anyone actually know what the time is? Let me check my  
 3 computer. 10.38. So if we come back at about five to  
 4 the hour, something like that.  
 5 MR GALE: Thank you.  
 6 THE CHAIR: Very good. Thank you very much indeed.  
 7 (10.38 am)  
 8 (A short break)  
 9 (11.01 am)  
 10 THE CHAIR: Yes, when you're ready, Mr Gale.  
 11 MR GALE: Thank you, my Lord.  
 12 Before we do recommence with the evidence, I think  
 13 we are aware we have a time constraint today and we also  
 14 have Ms Hedge to hear. What I propose to do is to  
 15 continue with Dr Macaskill until 11.45 and then, at that  
 16 point — and hopefully it will be at an obvious break in  
 17 a certain part of the evidence — ask Dr Macaskill if he  
 18 will come back and assist us at a further date. He's  
 19 indicated generally that he would be willing to do that.  
 20 I'm very grateful to him.  
 21 THE CHAIR: I'm very grateful to Dr Macaskill. That's  
 22 sensible.  
 23 MR GALE: Dr Macaskill, I'd like to ask you about the  
 24 content of paragraph 60 of your statement, where you  
 25 make reference to a statement made by the then

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1 Cabinet Secretary, Jeane Freeman, on 5 May 2020, which  
 2 was following a number of outbreaks — and I'm sure we  
 3 all remember those outbreaks — in care homes, where she  
 4 was concerned that the guidance was not being followed  
 5 by care homes. And what she said in her statement was  
 6 that the guidance for care home providers was "really  
 7 clear" and that the "private care home providers have  
 8 not, in some instances, appeared to follow the guidance  
 9 that we require them to follow". Can I have your  
 10 comment on that, please?  
 11 A. The comment today would be the comment I made directly  
 12 to Ms Freeman after she made the comment in Parliament,  
 13 that I thought it was both inaccurate and unhelpful.  
 14 The provision of care homes across the country is not  
 15 just in the private sector. It includes the charitable,  
 16 it includes the not-for-profit and it includes the  
 17 public sector. And to that period of time, we had equal  
 18 challenges with infectious outbreaks and, sadly, deaths  
 19 in other elements of the sector, and I felt and said to  
 20 her that this was an unhelpful politicisation of  
 21 a reality which was very, very challenging.  
 22 I also said to her — and I said at the time and  
 23 subsequently — that the guidance was far from clear.  
 24 So, for instance, the guidance issued on the 12th and  
 25 the 13th gave the presumption that you should not

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1 transfer somebody who developed COVID in a care home to  
 2 hospital. Now, clinically, that's understandable. If  
 3 somebody is not going to benefit from an intervention  
 4 from ICU or otherwise, then they should be enabled and  
 5 supported on a palliative and end-of-life pathway to  
 6 make their last few days as comfortable as possible.  
 7 That was not always the case. And I was dismayed and  
 8 distressed at the time to hear from our members that  
 9 people had phoned ambulances and ambulances refused to  
 10 take people to hospital, that people had been taken to  
 11 hospital and consultants had refused to admit an  
 12 individual because they had come from a care home, and  
 13 numerous such examples, that people were being prevented  
 14 as citizens from exercising their right to receive  
 15 clinical care and support simply because they had come  
 16 from a hospital [sic]. Now that was one piece of the  
 17 guidance which we robustly hit back at and was changed  
 18 by the time the guidance was reissued on 26 April,  
 19 though sadly that practice of denying people their  
 20 clinical rights, should they require transfer to  
 21 hospital, continued. Indeed I had an incidence of such  
 22 later that year and, perversely and coincidentally,  
 23 yesterday had an incident in which a provider, who has  
 24 made this public, contacted me to say that somebody had  
 25 had an injury in the care home and then the ambulance

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1 refused to transfer them to hospital. So we had then  
 2 a real challenge where guidance was uncertain. That's  
 3 one issue.  
 4 The rest of the guidance, the stuff about isolating  
 5 individuals, of not having people use communal space,  
 6 the insensitivity of much of that was not clear and it  
 7 certainly wasn't easily transferable by our members. So  
 8 I disputed with Ms Freeman at the time and, as I think  
 9 I've said in the UK Inquiry, we had a very honest  
 10 relationship, which I respected, but it was not helpful  
 11 for the front-line staff of the sector to be the object  
 12 of speculation and pillorying in the manner in which  
 13 that statement and the subsequent debate in Parliament  
 14 ensued.  
 15 THE CHAIR: Might I also suggest, probably from a lawyer's  
 16 perspective, that the use of the word "require" at the  
 17 end of the sentence is actually wholly inappropriate.  
 18 The Cabinet Secretary — I beg your pardon — yes, the  
 19 Cabinet Secretary cannot require someone to do something  
 20 that is merely guidance.  
 21 Do you agree with that?  
 22 A. Sorry, my Lordship, I wasn't aware you were asking  
 23 a question. Yes, I do.  
 24 MR GALE: Just another point on that quotation, "some  
 25 instances", was that expanded beyond "some" to "many"?

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1 A. I think the sentiment was expanding from "some" to  
 2 "many". I think throughout the pandemic it didn't  
 3 really matter whether your care home was run by  
 4 a private individual family group or a large corporate  
 5 or a local authority or many of our charitable members.  
 6 The care, the concern, the fear, the anxiety, the desire  
 7 to do what was best for people, was consonant. Nobody  
 8 comes into care with other than the best resolve, and  
 9 certainly during the pandemic the front-line women and  
 10 men did everything they could, and it was singularly  
 11 unfortunate that this debate started a process of  
 12 victimisation of many care home staff.  
 13 I had one colleague share with me the fact that  
 14 their nurse in a rural part of Scotland had to change  
 15 her shopping habits because she couldn't go into the  
 16 village shop because people were saying, "Oh, you work  
 17 in that death home", and those sort of assaults,  
 18 verbally bullying on front-line care staff or nursing  
 19 staff who were trying their hardest, were sadly far too  
 20 commonplace to respect any accidental intervention.  
 21 Q. You go on to talk about the constantly changing guidance  
 22 in relation to care homes and the effect that that had  
 23 on managers of care homes. One of the things we've  
 24 heard in the evidence thus far in the Inquiry is that  
 25 there seemed to be an unfortunate habit of issuing

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1 a change of guidance late on a Friday afternoon or an  
 2 evening. Was that something you were aware of?  
 3 A. We were painfully aware of it because the implication of  
 4 that meant that staff, particularly management and  
 5 supervisory staff, had to look at that new guidance in  
 6 the early stages, and for some considerable time there  
 7 wasn't a direct reference to what had changed and then,  
 8 even when that happened, there were inconsistencies.  
 9 So, anyway, managers and supervisors just had to read  
 10 everything anyway and that meant that they had to spend  
 11 in some instances, if they could, the weekend to  
 12 interpret what that actually meant.  
 13 Now, most staff working at the front line probably  
 14 did not see the full guidance because their managers and  
 15 supervisors and seniors translated the full guidance  
 16 into something that was meaningful for a front-line  
 17 carer or a senior carer or a nurse. So that process of  
 18 translation of guidance to application in the context  
 19 took time and it was hugely annoying. And we made  
 20 representations to our colleagues in Public Health  
 21 Scotland and through CPAG. There was an understanding  
 22 that this needed to change, but it didn't.  
 23 Q. Right. Do you know why there was the habit of issuing  
 24 guidance at the end of a week?  
 25 A. I think you — from memory, I think you — in deference

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1 I think you would probably have to ask those who  
 2 developed the guidance, but my memory —  
 3 Q. Yes, but your impression.  
 4 A. My memory was that the process was required to be as  
 5 late as possible because it needed to go through  
 6 sign-off processes, with the Chief Medical Officer, with  
 7 ministers and then with Public Health and then with  
 8 ARHAI specialists, and then it had to get publication,  
 9 so I would imagine that's Governmental publication unit,  
 10 before it came out to the sector.  
 11 We pleaded — the care home managers who were on the  
 12 Clinical and Professional Advisory Group pleaded to ask,  
 13 "Can this stop? Please stop issuing guidance on the  
 14 Friday". And I do mean pleaded because these were women  
 15 and men who were working 70-hour weeks and, you know,  
 16 who weren't being able to spend time with their family,  
 17 who — you know, some of our colleagues were isolating  
 18 so they weren't in contact with their family. I know  
 19 one manager who, for nine months, lived in a caravan  
 20 outside their house so they didn't bring the virus into  
 21 the care home or indeed bring the virus into their own  
 22 family home. So these were people who were massively  
 23 stretched, who were at their literal wits' end, and then  
 24 you got dumped upon on a Friday afternoon or early  
 25 evening and it started all over again.

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1 Q. I think you've hinted at this, Dr Macaskill. One would  
 2 need to know what the pre-existing position was in the  
 3 guidance —  
 4 A. Yeah.  
 5 Q. — then note what the change was, if any, in the  
 6 guidance and be able to then translate that —  
 7 I suppose, trickle it down to the workers themselves  
 8 within the care homes?  
 9 A. Yeah. And, you know, we used the language, you know,  
 10 "The guidance changed". It wasn't a sentence here and  
 11 a paragraph there. 18 months into the pandemic,  
 12 a colleague — a social worker in Glasgow said to me,  
 13 "Do you realise we're up at 2,900?". I said, "What  
 14 do you mean?". She said, "This is 2,900 actual changes  
 15 in this guidance since the start".  
 16 Now, that's not 2,900 documents, that's 2,900  
 17 changes, and I hesitate to think of what the number is  
 18 by the time we came to the latest ARHAI guidance. It  
 19 required managers, supervisors and team leaders to make  
 20 that sensible for front-line staff.  
 21 Q. Yes. Operation Koper, you've mentioned this already and  
 22 I think you've been very clear in your opinion of it.  
 23 I'd like to ask you a little bit more about it. You  
 24 talk about it in paragraph 62 of your statement and,  
 25 just to give context, it was an announcement by the then

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1 Lord Advocate in May 2020 that the death of any care  
 2 home resident due to COVID or presumed COVID was to be  
 3 reported to the Procurator Fiscal. You go on to talk  
 4 about the investigations associated with these reports  
 5 came to be known as "Operation Koper". I don't know  
 6 whether that's the correct pronunciation. I think  
 7 probably some people pronounce it differently.  
 8 The effect on your members and staff, can you just  
 9 explain what that was at the time and continues to be?  
 10 A. I think the effect was devastating at the time and  
 11 remains traumatic for hundreds, thousands, of front-line  
 12 staff. I think we've got to put this into context. The  
 13 first context is that the Lord Advocate at the time had  
 14 previously decided, because we were in an emergency  
 15 situation, that the routine process of reporting deaths  
 16 which were unexplained or which happened as a result of  
 17 an infectious disease which was notifiable would be  
 18 suspended, and that, at the beginning of the pandemic,  
 19 was what occurred across the board, both in the NHS and  
 20 social care.  
 21 Now, care homes were perfectly used to working with  
 22 the Procurator Fiscal locally if there was a death which  
 23 was unexplained or needed further explanation and  
 24 examination, and that has always been the nature of  
 25 provision. What singularly changed with the

1 announcement was that all deaths would then be -- would  
 2 require to be reported. Now, had that been a technical  
 3 reality, that would have been wholly acceptable. What  
 4 then resulted was the process of investigation of all  
 5 deaths, and I think many of us at the time -- and  
 6 I spoke to the team and have had -- we have had regular  
 7 engagement with the team at the Crown Office since --  
 8 what would have been entirely appropriate would have  
 9 been a proportionate response; in other words, were  
 10 there information or additional complaints or evidence  
 11 which would have suggested that there is merit in  
 12 further investigation of this death or that care home,  
 13 then that is entirely appropriate, and Scottish Care's  
 14 position has always been that those who have lost loved  
 15 ones deserve to know if there were instances of  
 16 inappropriate practice, following of guidance or error,  
 17 and that is an understandable right and intrinsically  
 18 important to the grieving process.  
 19 However, what we now have is, four years on, we have  
 20 thousands of staff whose professionalism has been called  
 21 into question, over whom there is a weight of suspicion  
 22 and a cloud hanging over and, sadly, that has resulted  
 23 in individuals feeling they can't continue in their role  
 24 and making a decision to leave the sector and,  
 25 tragically, it has resulted in individuals -- and

1 whereas there is never one reason for somebody to take  
 2 measures to harm themselves, I know personally that  
 3 there have been a number of individuals for whom  
 4 investigation as part of Operation Koper, even having to  
 5 fill out the 27 questions per death for each resident  
 6 that you supported when you maybe lost ten residents in  
 7 the space of a week -- even that process has broken  
 8 them.  
 9 So there is a complete imbalance and I think, you  
 10 know, personally it is a real stain on the justice  
 11 system in Scotland that this disproportionate action  
 12 still remains against a workforce who, by vast majority,  
 13 all they did was to try to do their best.  
 14 Q. You mention later in your statement -- and I will come  
 15 to it either later today or when you return -- it is  
 16 about the impacts on health and well-being of staff and  
 17 also you have a separate section on staff morale.  
 18 Operation Koper, was that a particular aspect that you  
 19 have in mind when you're talking about that?  
 20 A. There was a huge amount, and I've said in my statement  
 21 that I had the privilege of being appointed one of the  
 22 UK Bereavement Commissioners and, as a result of that,  
 23 I took evidence in that commission and read evidence of  
 24 hundreds of care workers. And undoubtedly the major  
 25 reason for trauma for front-line staff was, in a care

1 home, witnessing the deaths of people who you knew, who  
 2 weren't just patients you got to know one week ago, but  
 3 residents whose story had become part of your story over  
 4 a long period of time. And to go -- as somebody said to  
 5 me a few weeks ago indeed, how she went on one shift  
 6 from one room to the next, to the next, to the next and  
 7 lose four people in a shift, that scars and traumatises  
 8 and results in technically what we could call "prolonged  
 9 grief syndrome", but, in reality, what we were left with  
 10 was a broken group of people.  
 11 And Operation Koper has added to the inability to  
 12 heal those wounds because it's not going to change the  
 13 reality that these are front-line staff who experienced,  
 14 in some instances, really traumatic experiences of  
 15 somebody dying, who tried to be there when family were  
 16 shut out and not able to be present, who tried to be the  
 17 person so that nobody died alone. And these individuals  
 18 have, in many instances, really struggled, as that nurse  
 19 who spoke to me a few weeks ago has struggled. Even  
 20 though she's away from a direct care role now, she still  
 21 struggles, and she said to me, "I wake up at least once  
 22 a week thinking about that week where I lost so many  
 23 people".  
 24 I think our response as a nation and as a society  
 25 and certainly as a judicial system should have been

1 primarily pastoral rather than what appears to be  
 2 a disproportionate seeking for blame and guilt. Yes, by  
 3 all means identify culpability, mistake, accident, but  
 4 let's do it in a manner which respects individuals.  
 5 Q. You've used the wording of "human rights" on a number of  
 6 occasions in what you've been saying to us and the word  
 7 "proportionate". Do I take it that you are of the view,  
 8 if one is applying that term, that what has happened  
 9 with Operation Koper, which we know is continuing ---  
 10 I don't think there's been any prosecutions as yet ---  
 11 was not proportionate?  
 12 A. I think it is wholly and utterly disproportionate.  
 13 Proportionality is --- and I'm not trying to teach  
 14 grannies to suck eggs ---  
 15 Q. You can teach me about it. I'm very happy to learn.  
 16 A. Yeah, but proportionality is such a key concept, not  
 17 just in human rights law but in the practice of human  
 18 rights in the community, and, for me, one of the  
 19 descriptions which was used by one of Scotland's ---  
 20 Scotland's first Human Rights Commissioner,  
 21 Professor Alan Miller, was, you know, "You don't use  
 22 a sledgehammer to crack a nut". And I cannot think of  
 23 any other description for Operation Koper, but, in  
 24 truth, I cannot think of any other description for an  
 25 awful lot of things that we failed to do during the

1 pandemic response. We certainly did not embed human  
 2 rights and we are not embedding human rights in an  
 3 ongoing Operation Koper exercise.  
 4 Q. I suppose also that, for many people who have been  
 5 questioned in the context of Operation Koper, both  
 6 personally and within their communities, there will be  
 7 the shadow of suspicion lying over them. Would that be  
 8 correct?  
 9 A. Yeah, that would be --- I was interviewed myself by the  
 10 officers of Police Scotland as part of Operation Koper  
 11 and that was the first time I have ever had a police  
 12 interview. You know, it might not be an unusual  
 13 experience to some in this room, but it is extremely ---  
 14 I'm not suggesting criminality on the part of those in  
 15 the room, I hasten to add, but professional.  
 16 Q. We've read about it!  
 17 A. Yeah. But it brings it back upon yourself, you know, it  
 18 is an uncomfortable experience, and that's what loads of  
 19 front-line staff who, when asked to be interviewed ---  
 20 and I'm not by any means criticising the officers  
 21 involved, who are merely carrying out their duty and who  
 22 are doing so, from everything I hear, with a real  
 23 sensitivity to the exercise --- but it really has  
 24 frightened front-line workers, nurses, managers, because  
 25 of the uncertainty and the unknowability.

1 One of my --- I've written this week indeed to the  
 2 Crown Office to ask for yet another meeting. One of my  
 3 hopes would be that we can get to a stage at which these  
 4 investigations can end and the thousands of staff who  
 5 are out there today thinking, "I don't know what that  
 6 might mean to me tomorrow", can have a degree of  
 7 assurance. And what really upsets, apart from that, is  
 8 this similar exercise is not happening for our  
 9 colleagues --- and nor do I think it should happen --- for  
 10 our colleagues in the NHS, where sadly more people died  
 11 than did in care homes.  
 12 Q. Right. You conclude that section of your statement at  
 13 paragraph 64 by saying that care home managers feel that  
 14 they had been abandoned by the Scottish Government. Can  
 15 you explain why you've come to that view and say that to  
 16 the Inquiry?  
 17 A. I think this is a direct reference to how long it was  
 18 taking to get announcements from Government about  
 19 different stages of opening up to visiting, and I don't  
 20 think it was just managers. I know from speaking to  
 21 family members that there was a sense in which, every  
 22 time there was a lessening in restrictions or an opening  
 23 up, that care homes were never mentioned. So I and  
 24 others sat watching the daily briefings from the  
 25 First Minister and other clinical advisers, waiting to

1 hear when are we going to get mention of care homes, and  
 2 from my perspective it was even more frustrating in that  
 3 I know we had done the work, we had done what was  
 4 required to make opening up possible, and yet it was  
 5 delayed and it wasn't published.  
 6 And I'm not saying people were deliberate. I think  
 7 there was a fear that the real harm and the loss that we  
 8 all experienced in March and April, at the height of the  
 9 pandemic, would be revisited upon us after the summer.  
 10 But, you know, there was a perverse irony that, by the  
 11 time we really began to open up, we were shutting down  
 12 again with the arrival of Omicron in December 2020,  
 13 whereas we could have had a summer of much more flexible  
 14 engagement and, you know, garden visits should only have  
 15 lasted a week. We could have moved from garden visits  
 16 to a much more person-to-person response if appropriate  
 17 PPE had been allocated to family members and others.  
 18 But we were keeping people distant when all they wanted  
 19 and needed was to be in touch.  
 20 Q. Right. Thank you. One further matter I'd like to ask  
 21 you about, and this, again, concerns the early part of  
 22 the pandemic and your interaction with the  
 23 Scottish Government. The Inquiry heard earlier this  
 24 week from representatives of the Royal College of  
 25 Nursing, and I think you are aware of their evidence

1 either in specific or general terms. One area of  
2 controversy that they identified as between them and the  
3 Government in the early days of the pandemic was the  
4 Government's adherence to the view that COVID was  
5 a virus spread by droplet and not by aerosol or, put  
6 another way, airborne transmission. Were you aware of  
7 that controversy?

8 A. Yeah, very much aware because we were in complete  
9 agreement with the RCN, from the perspective of this is  
10 what we were hearing from our managers and members,  
11 so — I mentioned the surgeries or webinars — we  
12 changed the name interchangeably — that we held with  
13 members. So there were two things that really struck me  
14 and, you know, I've watched these again in the early  
15 months. One was that our members were seeing the  
16 classic signs at which people are presenting themselves  
17 as potentially COVID-positive were not being mirrored  
18 explicitly in a population in our care homes. There was  
19 additionality.

20 The second was — and I remember we had clinicians  
21 present from Government saying that, you know, you were  
22 safe outwith a 2-metre area and as long as you did not  
23 have contact within that period for 50 minutes, which,  
24 at the time, was the advice that this was a disease that  
25 was transmitted by droplets and by cough and that mask

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1 protection was, for instance, not necessary in that room  
2 beyond 2 metres or indeed was not necessary elsewhere.

3 We were very aware — and probably myself especially  
4 aware because of contact with international colleagues,  
5 and I participated in some of the World Health  
6 Organisation sessions — that there was a growing sense  
7 from our sector that, "Oh, come on, this is not the  
8 case. This is much more virulent. This is airborne",  
9 and that we needed to increase protection, which is why  
10 Scottish Care, in a media statement, called in April for  
11 the mandatory wearing of — sorry, slightly later — in  
12 the mandatory wearing of masks. And it took about  
13 six weeks before that became the recommended guidance  
14 because front-line staff were saying, "This is  
15 presenting in extremely different ways from what we're  
16 being told".

17 Q. We've heard from members of the RCN that they made this  
18 point in discussion with Scottish Government officials.

19 A. Yeah.

20 Q. Were you present when they were made? Did you agree  
21 with them?

22 A. I completely agreed with the RCN representations. We  
23 weren't present all the times that RCN directly met with  
24 Government, but Ms McKenna, who gave evidence on  
25 Wednesday afternoon, and I were both part of the

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1 Clinical and Professional Advisory Group —

2 Q. CPAG.

3 A. CPAG, sorry.

4 Q. No, not at all.

5 A. — and quite frequently we were with one voice, together  
6 with care home managers, saying, "You know, we need to  
7 look at beyond what we're being told".

8 And again, throughout the pandemic's early stages,  
9 there was a degree of balancing what you were hearing  
10 from the trusted experts, the scientists, with what you  
11 were being told by, from my perspective, the experts by  
12 experience, who were on the ground telling a different  
13 story and experiencing a different pandemic. And I'm  
14 afraid increasingly I was trusting one voice over and  
15 against another, which would certainly be what RCN staff  
16 experience was telling them in both hospital and care  
17 home.

18 Q. I think we also know that — well, you mention that you  
19 were aware of what considerations were being given by  
20 the World Health Organisation. I think eventually the  
21 World Health Organisation confirmed that the method of  
22 transmission was by aerosol, by airborne transmission.  
23 That was obviously on the basis of a level of scientific  
24 advice and scientific knowledge as well as being  
25 supplemented by the information that came from your own

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1 individual members. Now, in discussions with  
2 Scottish Government, there was clearly a push-back  
3 against that at an early stage at least. Was the  
4 push-back against that being explained to you or  
5 were you — I'll ask you directly — did you feel you  
6 were being dismissed on that matter?

7 A. So personally I'm not a clinician, I'm not an  
8 epidemiologist. I'm conveying the experience of  
9 people on the front line to those who are, and certainly  
10 one has to trust. And their argument was, "That's not  
11 what ..." — whether it be SAGE UK level — "That's not  
12 what our expert advisory group is saying. That's not  
13 what international experts are saying". And, to be  
14 frank, I think those of us in some degree of leadership  
15 in the care sector were avaricious about trying to get  
16 information online, linking in with groups everywhere we  
17 could in order to get as broad an understanding of what  
18 was happening as possible.

19 But we trusted that what we were told, and  
20 I remember hearing somebody say, of seniority —  
21 a clinician of seniority say, "This is what happens and  
22 you're okay in X situation". I had no reason not to  
23 listen and nor did most of us, to be honest. But as it  
24 became increasingly clear that there were different  
25 sides to the truth, I think we began to question, and

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1 when we did so, the response was, "This is the evidence  
 2 that we have". And I — you know, we, as an  
 3 organisation, don't have scientists enabled to do the  
 4 sort of robust research that's required in a very short  
 5 timeframe in order to counter those arguments, and the  
 6 RCN stated this work that they undertook internationally  
 7 which provided them with that evidence, and certainly  
 8 bodies like ourselves and others utilised that to argue  
 9 the point.

10 Q. Again, I asked this of Mrs McKenna of the RCN and I'll  
 11 ask it of you: did you get the impression that you were  
 12 a lone voice in adopting this position?

13 A. I think CPAG — it was an interesting group because  
 14 myself and one colleague, Ms Hedge, and three other  
 15 providers were present in probably a virtual room of  
 16 40 to 50 people — that was the social care presence —  
 17 together with colleagues from the Coalition of Care  
 18 Providers Scotland, who were very much focused on adults  
 19 and children and younger people.

20 The vast majority of — quote — "expertise" in that  
 21 room was clinical and governmental. You know, I'm  
 22 probably not backward in coming forward, but even in  
 23 that environment it is difficult to challenge,  
 24 particularly virtually. And I know I was a proverbial  
 25 pain in the derriere and probably made life

1 uncomfortable for both of the chairs because my role  
 2 there was to say what we were being told and to advocate  
 3 as robustly as possible, but I think the care sector was  
 4 tolerated on that group rather than respected. And I'm  
 5 not saying that's an individual position because I've  
 6 spoken to the other group members who came from the  
 7 social care perspective. I think, when push came to  
 8 shove, the view of the NHS and clinical guidance at  
 9 Government dominated over any experience or any  
 10 contribution that we might have made, even with regards  
 11 to visiting.

12 Q. Can I go back to guidance just briefly, Dr Macaskill?  
 13 A. Yeah.

14 Q. These questions emerge out of some questions I've been  
 15 asked to pose to you. Can we understand from you what  
 16 steps Scottish Care took to ensure that all your members  
 17 were aware of the guidance that was current at the time  
 18 and then to changes in guidance when they took place?

19 A. If we're talking specifically about guidance in relation  
 20 to visiting —

21 Q. Let's talk about visiting, yes. I'm sorry, I should  
 22 have phrased it in that way.

23 A. If we're talking about visiting guidance, we were  
 24 obviously — and particularly myself — very closely  
 25 involved in developing both the initial guidance and the

1 subsequent guidance. We held weekly surgeries at which  
 2 our members attended, at which I was able to, with  
 3 Ms Hedge, engage in a question and answer and to explain  
 4 the guidance and to encourage and to try to reassure  
 5 within some of the parameters that I spoke about  
 6 earlier. We also invited our clinical colleagues from  
 7 Government and senior civil servants who had been  
 8 involved in developing the guidance, so there was that  
 9 ongoing effort. We also engaged in meetings with  
 10 stakeholders, such as the Cabinet Secretary. We  
 11 attempted to work at local level through our local  
 12 staff, our independent sector leads, to give support to  
 13 providers who were trying to embed best practice.

14 I think one of the ongoing challenges that we had  
 15 around guidance and its implementation was the role of  
 16 sign-off by local incident management teams and  
 17 Public Health teams. So particularly in the early  
 18 stages, a risk assessment had to be carried out by the  
 19 care home which had to be particular to that care home  
 20 and then it had to be signed off by the local team, and  
 21 you could only then have people admitted as visitors  
 22 once it had been signed off. That was torturous. And  
 23 I remember probably losing it a bit where, 24 hours  
 24 before we were due to start another phase of admission  
 25 of visitors, half the Public Health teams in Scotland

1 had not even looked at, never mind signed off, the  
 2 guidance.

3 So that gate-keeping, that lack of trust in the  
 4 professional ability of local teams, that necessity to  
 5 have external experts tick the box, was an example of  
 6 the way in which, despite the desire at local level,  
 7 there were obstacles and where there was a fear that  
 8 only added to the mechanism and the barriers to prevent  
 9 opening up.

10 Q. Right. One thing that we are aware of from the  
 11 Care Home Relatives group is that they conducted  
 12 a survey after the change to guidance in October 2020,  
 13 which I think was to make it more liberal, using my  
 14 expression, and that 90% of those who responded within  
 15 the group to that survey had not noticed any change in  
 16 visiting. Now, were you aware of that survey?

17 A. I was aware of the survey. I had conversations with  
 18 Care Home Relatives or the senior group of people at the  
 19 time. We were aware that there were issues of timing.  
 20 I've just expressed what some of the concerns were at  
 21 local level. I shared with them then the sort of  
 22 concerns I've shared with you today, about  
 23 Operation Koper, about insurance, about fear and  
 24 anxiety, and I said to them then — and I hope I've been  
 25 true to this — that I would personally do everything

1 I could to make sure that would change as speedily as  
 2 possible. And thankfully, by the time we got to  
 3 December, things were beginning to change significantly,  
 4 sadly only for things to go backwards in terms of the  
 5 closing down of care homes. So, you know, I — we  
 6 worked, hopefully constructively, with Care Home  
 7 Relatives to try to persuade our members to be as  
 8 liberal as possible but at the same time, as I said  
 9 earlier, understanding why there was reserve and fear.  
 10 Q. And was the reserve and fear engendered by the  
 11 localisation, I suppose, of advice being given to care  
 12 home operators?  
 13 A. To some extent. So it's difficult if you're a national  
 14 care home group and you're doing something in one area  
 15 but it's not replicated in another and that sign-off  
 16 happens in one area and it's not replicated in another.  
 17 That's difficult. I do think it's really important  
 18 that, in the future, if we have a future pandemic, that  
 19 we bestow more trust to a local level, but intrinsic to  
 20 that is the necessity of prior relationship. So if you  
 21 were to ask me before the pandemic, "Where is there  
 22 likely to be constructive, mutual regard and  
 23 professional relationship between the social care  
 24 sector, Public Health or Health Protection Scotland and  
 25 indeed health and social care partners and the NHS?",

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1 I could have told you where those areas were, and they,  
 2 not surprisingly, were the areas where we had least  
 3 challenge or difficulty because they had been areas of  
 4 developed relationship and professional regard. That,  
 5 sadly, was not and is not the case across Scotland,  
 6 where there is still a fracture of relationship and  
 7 regard and respect between social care and our  
 8 colleagues in the NHS and Public Health.  
 9 Q. I'm mindful of the time, Dr Macaskill, and I'm very  
 10 grateful to you for agreeing to come back and I think we  
 11 can — I hesitate to use "compartmentalise" certain  
 12 parts of your evidence, but there is just one other  
 13 thing and I think we can deal with it probably  
 14 relatively briefly. It's something that we perhaps  
 15 haven't discussed a great deal in the Inquiry, though we  
 16 have had it referred to. It's what you say at  
 17 paragraphs 83 to 87 of your statement and it relates to  
 18 the restriction on medical care of care home residents.  
 19 Now, as I say, we have heard something about it.  
 20 Obviously you're looking at it from the point of view,  
 21 principally, I suppose, from your members' point of view  
 22 but also from the point of view of the residents within  
 23 care homes. What was your view about restrictions that  
 24 were imposed on the medical care into care homes during  
 25 the pandemic?

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1 A. I thought it was deplorable and I would still have that  
 2 position now because, if you move into a care home, you  
 3 don't give up your rights as a citizen of the community  
 4 and the country in which you reside. It's a location  
 5 which is there to support and care for you and, if with  
 6 dementia, to enable you to live as fulfilling a life as  
 7 possible.  
 8 I understand fully at the start of the pandemic when  
 9 things were closing down that general practitioners in  
 10 particular were concerned about the risk of seeing  
 11 patients and bringing the virus into care homes, but  
 12 what I struggle to understand is those instances and  
 13 examples where people — managers were phoned up and  
 14 told, "We're not going to be back in", or where there  
 15 was a Jiffy bag of DNACPR forms put through the door or  
 16 another Jiffy bag in another care home in another  
 17 location where death certificates were put through the  
 18 door, and I could go on.  
 19 Q. To be completed, presumably?  
 20 A. To be completed. And I could go on and evidence, as  
 21 I think the Inquiry will no doubt hear from other  
 22 front-line practitioners, that all culminated to a real  
 23 sense of feeling alone, that actually we looked for  
 24 support and it's not there, except it is there  
 25 virtually, at a distance. And people were upset and

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1 they were frightened and, with the passage of time, that  
 2 turned to anger and hurt, that those who you looked to  
 3 care for you and support you at your time of need are  
 4 not there.  
 5 Now, by no means is that descriptive of all primary  
 6 care practitioners. There are glorious, honourable  
 7 examples of sacrificial dedicated professionalism, but  
 8 there are too many instances of a sense of abandonment.  
 9 And when I was invited to speak at a virtual conference  
 10 of the Royal College of GPs, I was honest a couple of  
 11 months later in saying, "This is what people are  
 12 feeling. They're feeling that where before there was  
 13 a relatively positive relationship, now they're on their  
 14 own, and they're on their own at a time with an unknown  
 15 disease which is causing terror and whose nature —  
 16 actually you being there just to listen, just to do  
 17 a ward round", which wasn't a virtual ward round, to use  
 18 the term used locally, "would have made a huge  
 19 difference", because front-line staff would not have  
 20 felt alone, families would not have felt that their  
 21 relative was somehow or other being considered as being  
 22 of lesser worth and it would have made a difference.  
 23 Q. You talk about a perception among the care home sector  
 24 that there was a presumption that had emerged amongst  
 25 medical professionals that no external clinical visits

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1 should take place.  
 2 A. Yeah.  
 3 Q. Was that a widespread perception?  
 4 A. It was very widespread. I've given instances of  
 5 transfer from care home to hospital. I think there  
 6 are --- it was --- you know, one nurse described to me  
 7 that it was impossible to get an allied health  
 8 practitioner to come into the care home. It was  
 9 impossible to get somebody who was a dentist or part of  
 10 a dentistry team to come in, an ophthalmologist.  
 11 Now, I accept that for the rest of society there was  
 12 a real drawing back of those services as well, but  
 13 in extremis it was possible to access all of those  
 14 services and to get the professional input that was  
 15 necessary. This is a population with multiple  
 16 comorbidities, this is a population who were at the  
 17 greatest risk of this disease in particular, and even if  
 18 they were unfortunate enough, as many, many thousands  
 19 were, to contract and to survive, the least we owed them  
 20 was the ability to have their other health conditions  
 21 maintained, whether that was cancer or COPD or any other  
 22 respiratory condition. It was really challenging and  
 23 that's why staff felt, "Gosh, we're alone here".  
 24 Q. You say at paragraph 86:  
 25 "This restriction of clinical care was hugely

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1 damaging to residents with ongoing and developing  
 2 clinical conditions and resulted in marked deterioration  
 3 in the health and wellbeing of residents. It also  
 4 increased the strain on care home staff who could not  
 5 obtain appropriate medical care for residents."  
 6 That tends to suggest that this was a very  
 7 considerable impact on residents and indeed on staff,  
 8 that such clinical visits were denied to them. Do you  
 9 agree?  
 10 A. Yeah. It pushed people back on their own resources and  
 11 actually it astonished me throughout the pandemic in its  
 12 early stages that hardly anybody left a care home by  
 13 resignation or by a desire to go somewhere else. Staff  
 14 stayed, they supported, they sacrificed time, they gave  
 15 of themselves to an astonishing degree, they were  
 16 exemplary, and I'm continually humbled by the humanity  
 17 of our front-line social care staff in the care home and  
 18 community. But it would have been inordinately  
 19 beneficial to the residents of our care homes had those  
 20 professional staff not had to rely as much as they did  
 21 rely on themselves and on their team and on their  
 22 knowledge because, expert though they are in older  
 23 people's care and support and clinically in the care and  
 24 support of dementia, they are insightful enough to know  
 25 that they don't have all the answers. But, sadly, when

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1 they asked the question, there was nobody there from  
 2 primary care and other colleagues all the time when they  
 3 were needed to answer that question.  
 4 MR GALE: Dr Macaskill, I'm going to pause there, if I may,  
 5 and we will invite you back to complete your evidence in  
 6 as short a period of time as we can, but with that,  
 7 my Lord, can we take a short break?  
 8 THE CHAIR: Yes, thank you. Thank you, Dr Macaskill. I'm  
 9 sorry your evidence isn't completed in one session, but  
 10 thank you for agreeing to come back.  
 11 A. Thank you.  
 12 THE CHAIR: Now, we were scheduled to start at 12.30, but  
 13 I suspect you'd like to start a little bit earlier.  
 14 MR GALE: Well, it's ---  
 15 THE CHAIR: In other words, allow you half an hour.  
 16 MR GALE: So vicariously I can say on behalf of Mr Dunlop,  
 17 if he's in the building, he will start ---  
 18 THE CHAIR: So we'll start --- I also notice that that clock  
 19 is wrong. I've checked my computer. I think it's five  
 20 or six minutes --- we'll try and get that sorted, but  
 21 I think that means that, if we go by my computer, which  
 22 says 11.52, we should be back at about 20 past or just  
 23 after 20 past 12, if that's okay. Very good. Thank you  
 24 all.  
 25 (11.53 am)

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1 (The short adjournment)  
 2 (12.20 pm)  
 3 THE CHAIR: Good afternoon, Mr Dunlop.  
 4 MR DUNLOP: Good afternoon, my Lord.  
 5 MS KAREN HEDGE (called)  
 6 THE CHAIR: Good afternoon, Ms Hedge.  
 7 MR DUNLOP: My Lord, we have one witness this afternoon,  
 8 Ms Hedge. For the benefit of your Lordship and the  
 9 transcript, the organisational statement provided by  
 10 Ms Hedge is referenced SCI-WT0159-000001.  
 11 THE CHAIR: Thank you.  
 12 MR DUNLOP: Thank you.  
 13 Questions by MR DUNLOP  
 14 MR DUNLOP: Good afternoon, Ms Hedge.  
 15 A. Good afternoon.  
 16 Q. I wonder if you could provide us with your full name.  
 17 A. It's Karen Louise Hedge.  
 18 Q. Thank you. You've provided us with a statement. That's  
 19 correct, isn't it?  
 20 A. That's correct.  
 21 Q. Before I move on to any of the substantive questions, is  
 22 there anything within the statement that you would like  
 23 to correct?  
 24 A. Yes, there is. I note, unfortunately, after submission,  
 25 that the organisation or the title of the organisation

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1 at which I previously worked at is wrong. It should be  
 2 the Prince of Wales Foundation, not the Prince's Trust.  
 3 Q. I think we find that --- do we find that in paragraph 2  
 4 in the last three lines? I think the statement should  
 5 be before you.  
 6 A. Yes.  
 7 Q. We see a sentence:  
 8 "Whilst based in Washington DC, I was the Director  
 9 of Finance, Governance, and Compliance at the  
 10 Prince's Trust ..."  
 11 And should we score out "Trust" and put in  
 12 "Foundation", is that it?  
 13 A. Prince of Wales Foundation.  
 14 Q. And having read through the statement, is that the only  
 15 error that you've identified?  
 16 A. Absolutely. I was forensic about the stuff pertaining  
 17 to the pandemic and missed my own background.  
 18 Q. Not at all, not at all. These things happen. We've  
 19 heard evidence this morning from your colleague,  
 20 Dr Macaskill, in relation to --- I didn't hear the  
 21 evidence but I understand it was in relation to care  
 22 homes. Am I correct that your evidence today before the  
 23 Inquiry considers care at home services and what you  
 24 refer to in your statement as "housing support  
 25 services"? Is that correct?

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1 A. That's correct, and some day care services as well, who  
 2 are also our members.  
 3 Q. Thank you. Just for our benefit, when we talk about  
 4 "care at home", it might seem self-explanatory, but  
 5 "housing support services" may not. Could you just  
 6 explain briefly what you mean by those terms?  
 7 A. Absolutely, and actually it's difficult to describe  
 8 because there's a myriad of different ways that it could  
 9 present, but effectively it's where you have housing  
 10 with additional support. So someone would come in to  
 11 where somebody lives, in their own home, to provide them  
 12 support. It could be personal care, it could be less  
 13 than that. It just depends on what individuals need at  
 14 that point in time.  
 15 Q. Is there any minimum or maximum number of hours or  
 16 services or can it just vary from person to person?  
 17 A. It varies from person to person, yes.  
 18 Q. If we can look forward to paragraphs 9 and 11 of your  
 19 statement, and at that point you're talking about ---  
 20 it's under the chapter "Scottish Care's engagement with  
 21 members during the pandemic", and you highlight that  
 22 there were regular meetings every fortnight for members  
 23 who were delivering care at home. You also state that  
 24 there were concerns about the guidance and changes in  
 25 the operating arrangements, such as banning agency staff

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1 working in care homes. Was that the particular concern  
 2 with the guidance or were there other concerns about the  
 3 guidance that members were expressing?  
 4 A. Many and several. The biggest challenge with the  
 5 guidance was the rate and the speed at which it was  
 6 changing, so the ability for providers to keep on top of  
 7 that was difficult. We heard some of that in  
 8 Dr Macaskill's statement this morning, about the impact  
 9 that had on the staff then trying to enact that, and  
 10 that was no different for care at home organisations as  
 11 it was for care homes.  
 12 Q. Were members expressing that to you directly or --- and  
 13 what did Scottish Care do in relation to that, when it  
 14 became aware that there was an issue with the speed at  
 15 which it was changing?  
 16 A. So one of the things that we do very well as  
 17 a membership organisation is engaging with our members  
 18 to find out, you know, how are they experiencing things  
 19 on the ground, trying to get as much evidence as we can  
 20 behind that to present that to the organisations that  
 21 were making the decisions. Principally that would have  
 22 been Scottish Government or ARHAI, but also  
 23 organisations such as the Care Inspectorate and local  
 24 health and social care partnerships.  
 25 Q. Sorry, immediately after "Scottish Government" you said

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1 a word which didn't immediately spring to my knowledge.  
 2 A. Yeah, it's part of Public Health.  
 3 Q. And what did you describe it as?  
 4 A. ARHAI, A-R-H-A-I, and please don't ask me to tell you  
 5 what they stand for.  
 6 Q. I won't then.  
 7 A. But it's where the infection prevention control guidance  
 8 came from.  
 9 Q. Okay. Thank you. You said there that the speed at  
 10 which guidance was changing was a concern to members.  
 11 What about the interpretation of the guidance? Was that  
 12 an issue or was it clear it was just an issue of speed  
 13 that was a problem?  
 14 A. So because the guidance was wide-ranging, sometimes it  
 15 was clear, sometimes it wasn't, sometimes it was  
 16 interpreted differently locally than it was nationally  
 17 and sometimes it was interpreted differently between  
 18 different organisations. And I don't mean our members  
 19 when I'm referencing that. I mean between, for  
 20 instance, the Care Inspectorate and individuals in  
 21 Public Health. And that caused challenge for our  
 22 members on the ground, knowing what was expected from  
 23 them in that instance.  
 24 Q. And if it wasn't clear and, as you say, caused  
 25 a challenge, was Scottish Care doing anything to address

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1 that or the members? What was being done?  
 2 A. So the surgeries that we set up were particularly useful  
 3 in that instance because it gave us a very quick ability  
 4 to respond to what was happening in real-time and then  
 5 feed that into Government meetings. So we specifically  
 6 timed the surgeries to be earlier in the week so that,  
 7 when we went to the Government meetings, which were  
 8 usually on a Wednesday and a Thursday, then we were  
 9 doing that in a timely manner.

10 We also have a branch structure, which comprises of  
 11 volunteer members, and it roughly matches health and  
 12 social care partnerships' area, but there are some which  
 13 duplicate, just for ease. We have some staff which are  
 14 funded by health and social care partnerships but hosted  
 15 by Scottish Care and employed by Scottish Care who were  
 16 also really integral in raising issues and concerns in  
 17 the local areas as well and enabling sort of  
 18 constructive collaboration where possible.

19 Q. Thank you. Just to go back and touch on it, you  
 20 mentioned that there were surgeries which were held  
 21 before the meetings, which were normally on a Wednesday  
 22 and Thursday. Can I take it from that, then, that there  
 23 was weekly surgeries?

24 A. Yes. So actually, in the very early days, there were  
 25 twice-weekly, and then, when things became more stable,

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1 we reduced the number.  
 2 Q. Can you tell us, when you say "surgeries", what did that  
 3 involve? Were they held remotely? Who was invited?  
 4 Can you tell us a little bit more about them?  
 5 A. Yeah, so the surgeries specifically were a Q&A session,  
 6 so members could come and talk about their experiences  
 7 and they could ask questions and ask to seek  
 8 clarifications on things like the interpretation of the  
 9 guidance and equally ask us to raise issues into, for  
 10 instance, Scottish Government.  
 11 Alongside that we also hosted webinars, and the  
 12 webinars were where we invited other experts to come and  
 13 speak to our members as well. It was mostly — we would  
 14 close the surgeries to our members only though to give  
 15 them a safe space where they could also experience some  
 16 peer support.  
 17 Q. And who was providing the answers at these surgeries?  
 18 Was that yourself or ...?  
 19 A. And Dr Macaskill, yes, and occasionally we would have  
 20 other members of the team who might have specific  
 21 expertise.  
 22 Q. And were they well attended?  
 23 A. Extremely well attended. We had to increase our  
 24 licensing to enable more people to attend, and I think  
 25 Dr Macaskill this morning referenced one meeting with

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1 240 of our members present. To clarify, we have about  
 2 350 members.

3 Q. In terms of — you mentioned other bodies earlier in  
 4 your evidence. If your members had any concerns about  
 5 your guidance or issues with other bodies, did you have  
 6 a mechanism of contacting those other bodies? You've  
 7 talked about the Wednesday and Thursday meetings. Were  
 8 those other bodies at those meetings?

9 A. Yes — in the main, yes, they were, though there was  
 10 some distance in the early days with Public Health,  
 11 which would have been Health Protection Scotland at that  
 12 point in time.

13 Other challenges that we had actually was that the  
 14 method for getting in contact with the individuals  
 15 responsible for different portfolios changed throughout  
 16 the pandemic, so not only was the guidance changing, not  
 17 only were the meetings that we went to changing, but  
 18 actually the persons responsible was changing frequently  
 19 as well. So sometimes it was a case of just finally  
 20 finding the person with responsibility for it and  
 21 holding on to their email address for dear life and  
 22 other times, you know, you were redirected through  
 23 a central mailbox system, which was then siphoned off.  
 24 So that made it particularly difficult in — when you  
 25 consider the pace at which things were changing,

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1 actually finding ways to navigate the system and to get  
 2 into the system and to find the relevant person to speak  
 3 to was difficult also.

4 Q. Okay. But let's — you've talked to us — obviously  
 5 there's a line of communication and you're feeding  
 6 back and you're at these meetings with the  
 7 Scottish Government. Were they listening to the  
 8 members' concerns and acting upon them or not?

9 A. Again I'm going to give you a varied response. So there  
 10 were experiences which were extremely supportive and  
 11 extremely helpful, so examples I would give there would  
 12 be around about PPE, which in the early days was  
 13 difficult, but then, very quickly, through NSS,  
 14 Scottish Government stepped up to support the sector  
 15 through the creation of hubs and access to the right  
 16 quality and standard of PPE.

17 And there were other areas where it felt as though  
 18 our presence was tokenistic and that rarely were changes  
 19 made to the guidance when we were raising the issues and  
 20 the concerns of providers, and in relation to — you  
 21 know, more examples in the space for care homes than  
 22 I have for care at home, but one of the big issues  
 23 I would raise would be about the oversight arrangements  
 24 that existed at the time.

25 Q. And by "oversight arrangements", is that

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1 Care Inspectorate are you talking about or what do you  
2 mean by ...?  
3 A. No, it's not. So during the pandemic oversight  
4 arrangements were stepped up, where they had individuals  
5 from Public Health who reported to the local director of  
6 nursing, who would go into care homes and effectively  
7 undertake what — which was a sort of inspection,  
8 looking at infection prevention control but also  
9 straying beyond that into areas which the  
10 Care Inspectorate were responsible for. That caused  
11 huge confusion in the front line —  
12 Q. Okay.  
13 A. — and did not recognise the pre-existing skill set of  
14 staff in the sector.  
15 Q. I won't go into care homes too much with you.  
16 I appreciate that Dr Macaskill's evidence has been  
17 part-heard and I hope continued at some point later in  
18 this Inquiry.  
19 A. There is — it may be helpful to talk about another  
20 piece of guidance where we did manage to get change. So  
21 initially there were recommendations made for staff not  
22 to car-share, but we managed to give feedback from the  
23 sector to relevant persons at Government to make change  
24 there, though it did take a couple of weeks.  
25 The reasons that that would not have been

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1 appropriate for this sector is because actually many  
2 people who work in care at home don't have a car. It  
3 is — although a highly skilled role, it is a lowly paid  
4 role, so we had to recognise that many of them don't  
5 have a car, many of them work part-time, so car-sharing  
6 was a significant part of how they would undertake their  
7 job. The alternative to not sharing a car would be to  
8 travel on a bus, which would potentially put them at  
9 greater risk because they would be travelling with more  
10 people in an enclosed space as opposed to their known  
11 colleagues, which is who they would be travelling with  
12 in a car, so the same people they would be going into  
13 people's homes with.  
14 Q. Am I correct in assuming that a lot of people who need  
15 care at home require two carers at one time?  
16 A. Yeah, that can be the case, particularly if people need  
17 support to use a hoist, maybe for showering purposes,  
18 things like that, yeah.  
19 Q. In your statement at paragraph 18, under the chapter  
20 "The key issues and impacts: care at home", you say at  
21 paragraph 18 that the way care could be provided to  
22 individuals at home was severely affected by the  
23 pandemic. I just wonder if you can give me some  
24 examples of how it was affected.  
25 A. So actually we know that there were significant staff

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1 shortages at the time and we know that some people had  
2 their care packages limited by local authorities to  
3 respond to some of that. We also know that some people  
4 chose to reduce the care packages that they had to be  
5 able to ease the impact on the social care workforce.  
6 Even a colleague of ours was written to by the local  
7 authority asking if they would reduce the care and  
8 support for their mother at that time. We also know  
9 there was significant backlog in social work assessments  
10 being undertaken which then resulted in significant  
11 delays to people in the community getting the care and  
12 support that they would otherwise have been able to  
13 access far more quickly.  
14 Q. Okay. Can I maybe just pick you up on a couple of those  
15 points? You said there were staff shortages. I wonder  
16 what the reason for those staff shortages were.  
17 A. Yeah, we were in a pandemic. You know, many staff also  
18 experienced, you know, catching COVID and had to take  
19 time off for that. There were also instances where some  
20 COVID tests, you know, would have given a false positive  
21 reading as well.  
22 Q. And were some of those carers shielding?  
23 A. Some of the social care workforce as in paid carers?  
24 Q. Yes.  
25 A. Sorry, I just wanted to distinguish.

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1 Q. Yes, of course.  
2 A. So, yes, some paid carers would be shielding. In those  
3 instances, it would — the first step would be to see if  
4 they could find some other work within the organisation.  
5 Maybe they could work remotely from home doing rostering  
6 or, you know, support to front-line carers over the  
7 phone. But actually, if you needed to shield, then you  
8 may have to take time out of work.  
9 Q. And you also said that care was — the local authorities  
10 sought to limit care, and you gave an example of one  
11 person, and please don't name any names —  
12 A. No, no.  
13 Q. — but one person being asked to reduce the care  
14 services that they were receiving. Why were local  
15 authorities doing that if there were people that were  
16 prepared to go out and provide that care?  
17 A. So just to clarify, it wasn't just one person. So we  
18 have letters from quite a few partnerships or local  
19 authorities who wrote blanket to everyone that was  
20 accessing care and support in that particular local  
21 authority area, so it was a fairly common practice in  
22 some areas at that point in time. And the reason was,  
23 you know, to reduce the burden upon the local authority.  
24 That's what they wrote in the letter. But we also know  
25 that that had a significant impact on some individuals,

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1 who reduced their care with the intent of helping the  
 2 system but putting the system before themselves as  
 3 a human being and their needs.  
 4 Q. It may be that we ask if these letters can be  
 5 produced —  
 6 A. Yeah.  
 7 Q. — but in terms of reducing the burden, was that  
 8 a financial burden, was it the burden of assessing what  
 9 care was required? Do you know what was meant by  
 10 "burden"?  
 11 A. So I don't have — you know, that would need to be  
 12 a question to those who made that, but I do know that  
 13 conversations that were had with local authority areas  
 14 at that point in time described the delays to  
 15 social work assessments and they described workforce  
 16 shortages. So it may have been a combination of those  
 17 things. There may well have been other things as well  
 18 contributing to that decision.  
 19 Q. Thank you. Moving on to paragraph 20, you discuss  
 20 guidance and we've had a chat about guidance already.  
 21 I just wonder if you can tell me, in terms of the  
 22 guidance, was the guidance sufficient in terms of  
 23 advising your members what should be worn in terms of  
 24 PPE?  
 25 A. So I think first of all it's important to note that it

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1 took a very long time to get guidance for care at home  
 2 in comparison to other parts of the health and social  
 3 care system, so that in itself was a worry and  
 4 a concern. And then, when it did come, there was  
 5 confusion or the requirement of a lesser amount of PPE  
 6 to be worn than in other parts of the system.  
 7 So what we saw was people living in their own homes  
 8 in the communities and care at home workers not having  
 9 to wear PPE unless they thought that individual had  
 10 COVID. So they were walking into a home — you know,  
 11 one person gave an example of walking into a home at  
 12 which point a community nurse was leaving that person's  
 13 home and the community nurse was wearing, you know, full  
 14 gown, mask, gloves, and yet the individual working in  
 15 care at home, provision to the social care worker was  
 16 not entitled to that same protection and nor was that  
 17 individual living in their own home. The assessment was  
 18 done based upon where you worked, not upon who was  
 19 coming into your home and who was at risk.  
 20 Q. There's a couple of points I wonder if I can ask you  
 21 about. You said it took some time for guidance to come  
 22 out. Am I correct that, before lockdown,  
 23 Scottish Care — and I think you deal with this in your  
 24 statement — Scottish Care produced its own guidance due  
 25 to a failure by the Scottish Government to provide

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1 guidance? Is that correct?  
 2 A. That's correct, yes.  
 3 Q. And I think you deal with that in your statement at  
 4 paragraph 14.  
 5 A. Yeah.  
 6 Q. Sorry, I was just going to ask, is there a reason that  
 7 you're aware of why the Scottish Government couldn't  
 8 have provided guidance, firstly just generally at an  
 9 earlier stage, and why it took — well, I'll ask you the  
 10 first question first. I'll ask you in two parts — why  
 11 the Scottish Government couldn't have produced guidance  
 12 at an earlier stage?  
 13 A. I don't know the reasoning why Scottish Government did  
 14 not provide anything sooner. However, having been  
 15 involved with the EU exit preparation planning of the  
 16 Scottish Government, I sat in a room and listened to  
 17 a 20-minute presentation by an NHS consultant on what  
 18 social care was, so I have a belief that there was  
 19 a misunderstanding and misrecognition of what social  
 20 care is and does and has the potential to do. So  
 21 I think that lack of understanding and recognition may  
 22 well have caused the delays.  
 23 Q. What led you to conclude that there was a lack of  
 24 understanding? Can you give me some examples?  
 25 A. So the failure to understand, for instance, the

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1 description that I gave earlier about who a front-line  
 2 care worker is in care at home, you know, the  
 3 constraints that they face; also the remarkable skill  
 4 set they already have existing in infection prevention  
 5 control because they're already managing things like  
 6 norovirus, flu, in the communities as well and  
 7 preventing that.  
 8 So it came through for me in the way that the  
 9 guidance was published and produced and it was done  
 10 particularly — and I will make particular reference  
 11 here to care homes — but I think there was a particular  
 12 failing in that space around about not recognising that  
 13 it's an individual's home, that they bring their  
 14 personal effects with them into a care home because it  
 15 is their home. It's where they live. And for care at  
 16 home, they didn't necessarily recognise that a care  
 17 worker is going into someone's home over which they have  
 18 no control over the environment. So the guidance didn't  
 19 recognise, for instance, that there could be other  
 20 family members present in that home and what to do in  
 21 that instance, should they wear PPE, should they not.  
 22 It didn't make reference to what the environment could  
 23 be, was there windows, was there ventilation, things  
 24 like that as well. So because these idiosyncrasies —  
 25 you know, this real detailed stuff was not there or not

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1 recognised, then that for me is that failure to  
 2 understand.  
 3 Q. Thank you. We saw that Scottish Care produced guidance  
 4 before the lockdown in relation to --- for the benefit of  
 5 your members. Can you remember --- you said it took  
 6 a long time for the Scottish Government to issue  
 7 guidance which was specifically directed at care at home  
 8 services. Do you remember when roughly that was  
 9 produced?  
 10 A. It was right in front of me on the screen. I think it  
 11 was 26 March. It was on the section that was up  
 12 earlier. So I know that only feels like a few weeks  
 13 after we published our guidance, but I think it was so  
 14 long ago now we forget how scared we were at that point  
 15 in time, you know, what the uncertainties were. We  
 16 didn't truly understand the nature of the virus, we  
 17 didn't truly understand the spread nor did we understand  
 18 in that context what we could do to protect people and  
 19 ourselves and our workforce. So although it was only  
 20 a matter of weeks, it felt, you know, like a matter of  
 21 years out there. People worrying, "Am I going into this  
 22 person's house? Will I infect them with the pandemic?  
 23 How do I carry that with me for the rest of my career?",  
 24 so basically crying out for guidance and support.  
 25 Q. In terms of --- we know that the Scottish Government is

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1 relatively well resourced. In terms of Scottish Care  
 2 producing guidance, what resources did you have to  
 3 produce that guidance? I don't know what size the  
 4 organisation is and my apologies if that came out  
 5 this morning in evidence, but were there a lot of staff  
 6 or ...?  
 7 A. We are a small charity. We have --- sort of circulate  
 8 around about 40, but over half of our team work  
 9 part-time, so, as with many other organisations during  
 10 the pandemic, it was very much an all hands on deck  
 11 situation and scenario. So many people in our team, as  
 12 in many other organisations, went above and beyond.  
 13 Q. Thank you. In your evidence there you gave an example  
 14 of a community nurse coming out who was obviously more  
 15 fully equipped with PPE than some of your members'  
 16 staff. Particularly at the beginning of the pandemic,  
 17 in late March and early April 2020, did your members  
 18 have difficulties sourcing (a) sufficient quantities and  
 19 (b) suitable PPE to go into homes?  
 20 A. Absolutely, yes. Particularly smaller organisations  
 21 found it difficult because they didn't necessarily have  
 22 the same purchasing power as the larger organisations or  
 23 possibly even the storage capabilities that larger  
 24 organisations might have had to just have that number of  
 25 masks or gloves stored somewhere in any eventuality.

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1 Scottish Care at that point in time worked closely  
 2 with suppliers and a colleague was enlisted in  
 3 contacting all the various suppliers and issuing every  
 4 week --- every Monday morning in fact --- a list of, "Here  
 5 is where you can get gloves, here is the prices. Here's  
 6 where you can get masks, here's the prices". So, you  
 7 know, we did as much as we possibly could to access  
 8 that. Another colleague supported a group of providers  
 9 to come together so that they could bulk-purchase  
 10 together, but, unfortunately, we still heard occurrences  
 11 when, you know, shipments of PPE came in to the UK but  
 12 they then didn't get to the provider who had purchased  
 13 them.  
 14 Q. Why was that?  
 15 A. So we heard stories that they were being commandeered  
 16 for the use of the NHS, though we have no evidence. But  
 17 that's what we were told.  
 18 Q. And in terms of the smaller organisations who were  
 19 having difficulties, as you identified, securing PPE, in  
 20 terms of the prices of PPE --- I think it's probably  
 21 within judicial knowledge that that had gone up --- did  
 22 that have an impact on the ability of your members to  
 23 purchase PPE?  
 24 A. Absolutely, and for all our members. So, you know, you  
 25 could add a couple of zeros on the end of what things

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1 had previously cost.  
 2 Q. You also discussed earlier that your members' staff from  
 3 your member organisations could be going into homes  
 4 where the community nurse had come out fully kitted.  
 5 Did that cause any concerns to your particular members,  
 6 that they didn't have the same level of kit, if you  
 7 like, as others and what type of concerns was it  
 8 causing?  
 9 A. Huge concern because it was such a time of uncertainty.  
 10 Nobody knew, you know, what the impact of the pandemic  
 11 was going to be at that point in time and how to  
 12 mitigate that risk. So they were seeing people coming  
 13 out looking as though they were very well protected and  
 14 they felt like they were second-class citizens. They  
 15 felt like they were --- you know, there was an acceptance  
 16 that they could be put at risk, whereas members of, for  
 17 instance, the NHS could not be put at risk. So they  
 18 felt like there was a hierarchy in their relevance as  
 19 persons and as individuals.  
 20 And I'll give an example of a front-line worker who  
 21 I spoke to at the time, who described coming in from  
 22 their shift, calling to the members of their household  
 23 not to come into the hall. They then stripped their  
 24 clothing off, ran from their front door to their washing  
 25 machine, put the washing on and then ran up to the

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1 shower because they were so scared and terrified that  
 2 they were going to pass anything on to their children in  
 3 particular .  
 4 Q. And some of those individuals, would they perhaps have  
 5 had people who were shielding in the property?  
 6 A. They may well have done, but I know that many staff made  
 7 arrangements to live elsewhere or to compartmentalise  
 8 their homes in those instances.  
 9 Q. Moving on to testing, which you deal with starting at  
 10 paragraph 33 of your statement, you tell us that testing  
 11 was extended to staff and residents working in care  
 12 homes but not staff or service—users providing care at  
 13 home. What impact did that have on your members who  
 14 were providing care at home services?  
 15 A. So, again, it made them feel as though the  
 16 decision—making was not done in the bounds of risk but  
 17 upon where you worked, the location of where you worked.  
 18 So it reinforced that feeling of being a second—class  
 19 citizen and reinforced the worry that, you know, they  
 20 could be passing on the pandemic unknowingly.  
 21 Q. Was that issue raised with the Scottish Government?  
 22 A. Yes, it was.  
 23 Q. Can you tell us when it was raised and with who?  
 24 A. I couldn't tell you a date at this point in time, but it  
 25 would have been raised through one of the weekly groups

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1 that we attended, most likely CPAG.  
 2 Q. And, as a result of raising it, was an explanation given  
 3 for the difference in treatment?  
 4 A. So at one point in time I was told there was difficulty  
 5 of access to a sufficient number of tests so decisions  
 6 had to be made about who got access when.  
 7 Q. And did anything change as a result of Scottish Care  
 8 having raised its concerns with Scottish Government?  
 9 A. So whether it was as a result of that or whether it was  
 10 as a result of access to more tests, I'm not sure.  
 11 I couldn't tell you that. But, you know, access was  
 12 made available to care at home staff eventually,  
 13 although, again, there was confusion about the type of  
 14 test because in some areas there was access to PCRs and  
 15 in some areas it was LFTs.  
 16 Q. At paragraphs 37 to 40 you describe the effect of  
 17 isolation on persons receiving care at home. Do you  
 18 know of any evidence, perhaps anecdotally from what  
 19 you've been told, whether that was affecting the mental  
 20 health of service—users?  
 21 A. Yes, because if you were shielding in your own home,  
 22 you're still not connecting with your local community.  
 23 You know, each of us in this room had to some extent an  
 24 experience of lockdown, but that would have been for  
 25 a prolonged period and we know that loneliness has

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1 a significant effect on people's mental health. That  
 2 also had a significant effect on the workers going in to  
 3 those people's homes because they wanted to be able to  
 4 spend more time with them because they saw the impact  
 5 that it was having.  
 6 Q. You say they wanted to spend more time and I think you  
 7 deal with that at paragraph 40 of your statement. You  
 8 say that a local authority has the power to increase the  
 9 length of visits . Were there applications being made to  
 10 extend the length of visits ?  
 11 A. So one of the things which front—line care workers are  
 12 skilled at doing is completing care notes and within  
 13 that they will assess how that individuals is at that  
 14 point in time, and those notes will show changes over  
 15 time in a person's well—being, behaviour, health, and  
 16 that would be used as evidence to argue for changes to  
 17 the package that the provider is commissioned to  
 18 deliver .  
 19 Q. Were there administrative difficulties in increasing the  
 20 hours?  
 21 A. Because there were also staffing shortages within local  
 22 authorities , because, like our members, there were staff  
 23 absences during the pandemic, there were backlogs in  
 24 having these assessments seen to, yes.  
 25 Q. Okay. With the benefit of hindsight, are you or can you

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1 offer an opinion on whether there would have been a way  
 2 round that essentially ?  
 3 A. Yes, and in some areas this happened, and particularly  
 4 where the Self—directed Support Act is implemented  
 5 effectively , then there is the ability to change the  
 6 care and support that's delivered in real—time much more  
 7 fluidly . So if the Self—directed Support Act had truly  
 8 been implemented in Scotland before the pandemic, then  
 9 there would have been much more flexibility in the  
 10 moment.  
 11 Q. Would that have relaxed the assessment criteria or —  
 12 what would that have done?  
 13 A. It gives tolerances to respond to. So an individual can  
 14 request changes to their care packages, to increase, to  
 15 decrease, to do something different with it , to use  
 16 a different service in their community, not just a care  
 17 worker. And the same with care workers themselves, you  
 18 know, they can make — they can make the decisions and  
 19 make changes to that in those times day to day as well  
 20 and say, "Well, actually, I can spend a bit longer with  
 21 you here but what we'll do is reduce time over here" or  
 22 instead of — "What I'll do is I'll come in and we can  
 23 spend time maybe reading or doing something more social,  
 24 but instead of coming in and cooking you dinner, we  
 25 could get you a takeaway or something like that". So

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1 you can be much more flexible to the needs of the  
 2 individual at that point in time, upping care at some  
 3 points, reducing care at other points, just depending  
 4 what the individual needs there and then. But if you  
 5 don't have that relationship with your local authority  
 6 and you don't have self-directed support really  
 7 implemented in the correct person-led way, then you're  
 8 back to, you know, 15-minute commissioned visits.  
 9 Q. Okay. Did the local authorities have discretion to do  
 10 that?  
 11 A. Yes, they do. They do.  
 12 Q. Did some local authorities exercise that discretion and  
 13 others not or did any of them?  
 14 A. Some — not in response to the pandemic — some did  
 15 already have those arrangements in place.  
 16 Q. Most or a few?  
 17 A. A few.  
 18 Q. Okay, thank you. At paragraph 45 of your statement you  
 19 raise the issue of care staff not being recognised as  
 20 key workers and you give the example of the police  
 21 essentially I think stopping them when they're in cars  
 22 and Scottish Care having to get involved. Was that due  
 23 to poorly drafted guidance or is that due to another  
 24 reason?  
 25 A. Actually it's partly about identification. So if you're

1 wearing a NHS uniform, you're visible and people know  
 2 and see that you're a key worker. You know, it's  
 3 clearly understood. But there's such a richness and  
 4 variety of care providers, and that's a really good  
 5 thing because what it does is it offers choice and  
 6 control to individuals so they can choose who they want  
 7 to deliver their care and support — but because there's  
 8 such a variety in that, they were not always visible to  
 9 the police if they were a care worker because, you know,  
 10 it could look similar to a hairdresser's uniform or  
 11 other service professionals and individuals. So we had  
 12 to work with providers on, you know, what would be  
 13 a suitable identification and to educate the police that  
 14 that would be the case and that they should be accepting  
 15 that care workers were key workers.  
 16 Q. I want to just ask you a couple of questions about Long  
 17 COVID now. You talked about a worker coming back and  
 18 stripping off and jumping into the shower to ensure that  
 19 no members of the family contracted COVID. As far as  
 20 you're aware, were your members — if somebody did  
 21 contract COVID occupationally, was that being recorded  
 22 in the member's personnel files?  
 23 A. Yes, and they had to report to Government and to the  
 24 local authority on staff who were absent with COVID at  
 25 any point in time. Some were required to do that daily,

1 some were required to do it weekly, some were  
 2 required to do it to the local authority and the  
 3 Care Inspectorate and the Government, some were required  
 4 just to do it to one of those organisations, so there  
 5 was a lot of duplication on demand of data provision at  
 6 that point in time as well.  
 7 Q. Can I ask — obviously we don't have crystal balls so if  
 8 someone catches COVID, we don't know if it's going to  
 9 develop into Long COVID, but if it did develop into Long  
 10 COVID, would that be recognised in the employer's  
 11 records? You might not know the answer to that, but ...  
 12 A. I don't know the answer to that, that's correct.  
 13 Q. Moving on to paragraph 48, you identify that social care  
 14 workers experienced trauma and that there was inadequate  
 15 support in place. Can you maybe just tell us what you  
 16 mean by "trauma" and what support you expected to be in  
 17 place or hoped would be in place?  
 18 A. Yeah. So Dr Macaskill spoke eloquently on this for care  
 19 home workers this morning and it would be no different  
 20 for people providing care at home in the community. You  
 21 build a relationship up with those individuals — you  
 22 know, it's a job which I used to do many, many years ago  
 23 and I have — I couldn't tell you the dates, the times,  
 24 this, that and the next thing, but I could tell you, you  
 25 know, that one of the people I worked with, when they

1 were stressed, the noise of the Hoover calmed them down.  
 2 I can tell you that another individual liked me to sit  
 3 beside them and they would hold my hand while we watched  
 4 old movies. That's the sort of relationships that  
 5 people had with these individuals. And it wasn't just  
 6 last week, it's when I was at uni, so I still remember  
 7 that. I remember how that felt at that point in time.  
 8 So it's part of your life, a hugely significant part  
 9 of your life. So when you see the experience that they  
 10 have when they have COVID and when there's loss and when  
 11 people die as a result of COVID, you know, you're losing  
 12 that relationship too. You are a part — a de facto  
 13 part of their family, and through that they experience  
 14 trauma. You know, they've experienced significant loss  
 15 over a prolonged period of time. We know that some NHS  
 16 boards were offering psychological support to NHS staff  
 17 whereas that wasn't available to the same extent for  
 18 social care workers. There was well-being support but  
 19 not psychological.  
 20 Q. And is that — when you say "support", is that what  
 21 you're suggesting should have been available?  
 22 A. Yeah.  
 23 Q. Okay. At paragraph 51 you tell us that day care  
 24 services were advised not to fully re-open until  
 25 October 2022. Just a few questions about that.

1 I suppose firstly : who advised them, are you aware?  
 2 A. So that would have been guidance that came from the  
 3 Government.  
 4 Q. Okay. Do you know --- if you don't know the answer,  
 5 please just tell me --- but do you know why they were  
 6 advised not to fully re-open until October 2022?  
 7 A. I don't know, but I assume it would be connected to  
 8 infection prevention control.  
 9 Q. And I may be reading too much into it, but are you  
 10 criticising --- are you being critical of that decision  
 11 and, if so, why?  
 12 A. So, yes, I'm being critical of that decision because  
 13 this was a significant time after everyone else in the  
 14 community had gone back to --- you know, closer to our  
 15 normal pre-pandemic behaviour. So people living in  
 16 their own homes who would have previously had access to  
 17 the social support that day care services provided, the  
 18 stimulation that they had there was not available to  
 19 them for a very long period of time and that exacerbated  
 20 their feelings of loneliness, which had other  
 21 consequences on their mental health and well-being.  
 22 Q. In your opinion, perhaps with appropriate measures put  
 23 in place, wearing masks, social distancing, whatever  
 24 that might be, could they have re-opened at an earlier  
 25 stage?

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1 A. Yes.  
 2 Q. And not to pin you down to a date, but do you have  
 3 a view on how much earlier they could have re-opened?  
 4 A. I don't. I would need to go back through what was  
 5 happening at that point in time to do that ---  
 6 Q. I appreciate that.  
 7 A. --- I suppose specifically the science around about what  
 8 we knew about the virus at that point in time to give  
 9 that advice.  
 10 Q. I suppose just so that we appreciate the impact, how  
 11 important were those services to the people that used  
 12 them?  
 13 A. Yeah, so they performed a variety of tasks. It wasn't  
 14 just a social aspect. They would also provide personal  
 15 care, provide a warm meal for individuals as well, so if  
 16 that was something that you were used to accessing day  
 17 to day and then suddenly you didn't get that for, you  
 18 know, a couple of years really, then it certainly  
 19 exacerbated feelings of loneliness and put additional  
 20 pressure on potentially family members, who were having  
 21 to step in to deliver that care and support instead.  
 22 Q. I was going to say that. I appreciate you're not  
 23 speaking --- we will hear evidence in relation to unpaid  
 24 carers during the Inquiry. But in terms of respite,  
 25 from your experience, do these types of service offer

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1 a respite?  
 2 A. Yeah. Yeah, they did.  
 3 Q. Moving on to paragraphs 69 and 70, you discuss the issue  
 4 of data requests and you indicate that the sector was  
 5 under pressure from the Scottish Government, local  
 6 authorities and the Care Inspectorate in relation to  
 7 data requests. I suppose I'm just not clear, what kind  
 8 of data was being requested by those bodies?  
 9 A. Yeah. I think it's important that I say that data  
 10 collection was an important part of pandemic response,  
 11 so I'm not saying that it shouldn't have happened, I'm  
 12 saying that data collection was important, but it was  
 13 the manner in which it was requested and the duplication  
 14 was the biggest issue here. So at a time when we really  
 15 needed our social care workforce supporting individuals,  
 16 many of them were pulled away to do administrative  
 17 duties around about data request. So it was more  
 18 prevalent for care homes than it was for care at home,  
 19 although in some local authority areas they asked for  
 20 the same data in care at home as they did for care  
 21 homes. So the sorts of things that were requested were  
 22 number of people accessing care home support, number of  
 23 residents, number of those who had COVID, workforce,  
 24 workforce vacancies and things like that. But it  
 25 was the requirement to do that on different forms for

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1 each agency that was requesting it and the requirement  
 2 to do that on a daily basis in some instances, so at  
 3 a time when we really needed people concentrating on  
 4 delivering the care and reducing the risk, they were  
 5 spent having to fill in forms.  
 6 Q. Is your evidence essentially that there could have been  
 7 a more joined-up approach where there was one form  
 8 filled that could have been sent to all the various  
 9 agencies? Is that essentially ---  
 10 A. Yes. And now, you know, one of the things that's  
 11 happened as a result of the pandemic is it's accelerated  
 12 the uptake in use of technology and digital, so there  
 13 are other ways that we can consider going forward to do  
 14 that on an automated basis that would completely remove  
 15 the burden altogether if we were coherent in that.  
 16 Q. Thank you. I have some questions but you seem to have  
 17 answered them.  
 18 Before I ask you if there's anything further you  
 19 want to add, there's some questions that have been  
 20 provided to the Inquiry by core participants, so  
 21 I wonder if you can help us with these. So I'll be  
 22 moving back to the beginning of your statement. At  
 23 paragraph 4, you say that you sat on the Ministerial  
 24 Advisory Group for Health and Social Care. Do you know  
 25 if that involved any planning for a pandemic?

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1 A. Not at the time when I attended that group, no.  
 2 Q. And what time was it that you attended?  
 3 A. So most often it would have been Dr Macaskill and our  
 4 chair that attended, but I would step in for either of  
 5 those when one of them couldn't make it, and it was  
 6 certainly not discussed at any of the meetings that  
 7 I went to.  
 8 Q. And moving forward to paragraphs 49 to 52, at these  
 9 paragraphs you discuss the impact on day care services.  
 10 Do you know if the issue of closure and re-opening of  
 11 day care services was discussed at the  
 12 Scottish Government groups that the Scottish Care  
 13 attended?  
 14 A. It was because we raised it, as did some representatives  
 15 there from unpaid carers' organisations.  
 16 Q. And what was discussed?  
 17 A. The impact that it was having on the individuals not  
 18 being able to access it and also, from Scottish Care's  
 19 perspective, there were significant fiscal implications  
 20 for those organisations which might have prevented them  
 21 from being able to open again at all.  
 22 Q. And in relation to any potential future pandemic, did  
 23 the Scottish Government indicate what should happen in  
 24 relation to day care services?  
 25 A. No.

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1 Q. Moving forward to paragraphs 73.2 and 74, you mention  
 2 the Clinical Practice Advisory Group for Care Homes —  
 3 CPAG — meetings. Do you know if minutes were taken of  
 4 those meetings?  
 5 A. Yes, there are, yes.  
 6 Q. And to the best of your knowledge, at any of those  
 7 meetings, did any attendee call for a human rights  
 8 impact assessment in relation to restrictions of visits  
 9 to care homes?  
 10 A. Yes, my colleague Dr Macaskill did.  
 11 Q. And what was — my apologies if this was dealt with this  
 12 morning — what was the outcome of that?  
 13 A. So the response given at that time was there wasn't  
 14 capacity to do that.  
 15 Q. And finally at paragraph 80 you discuss  
 16 Health Protection Scotland guidance. Did Scottish Care  
 17 provide its members with advice on how guidance would  
 18 operate in practice?  
 19 A. Actually it was in many respects the other way around.  
 20 So what we are very good at is bringing our members  
 21 together to find a way through this, to navigate the  
 22 guidance together and to make sense of that. So one of  
 23 the things that had to be done was to translate the  
 24 guidance into a way that would be accessible to  
 25 front-line care workers, so we found that some of our

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1 managers were working together to do that. I don't mean  
 2 Scottish Care managers; I mean the managers within our  
 3 membership organisations.  
 4 Q. And just in relation to the final question, I appreciate  
 5 there may be a degree of separation between  
 6 Scottish Care and the family members, but did  
 7 Scottish Care provide any advice in relation to family  
 8 members who were providing care at home?  
 9 A. No.  
 10 Q. Simply before I thank you for your time, is there  
 11 anything that you wish to say that hasn't cropped up in  
 12 our discussions today or that is omitted from your  
 13 statement?  
 14 A. So I guess I want to recognise those that I had the  
 15 privilege to walk alongside during this experience in  
 16 the pandemic and thank them for their support in  
 17 supporting the sector through what has been a very  
 18 challenging experience. I also know that many of them  
 19 and many others experienced loss and trauma, so I would  
 20 wish to express my condolences.  
 21 MR DUNLOP: Thank you. I just take this opportunity to  
 22 thank you for your time today and also the considerable  
 23 time and effort that you've put into providing an  
 24 organisational statement for the Inquiry. It's much  
 25 appreciated.

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1 A. Thank you.  
 2 THE CHAIR: Yes, thank you. Thank you, Ms Hedge. I'm very  
 3 grateful.  
 4 A. Thank you, my Lord.  
 5 THE CHAIR: Good.  
 6 MR DUNLOP: There are no further witnesses for this  
 7 afternoon.  
 8 THE CHAIR: I knew that. 9.45 on Tuesday morning.  
 9 MR DUNLOP: Yes.  
 10 THE CHAIR: Very good, thank you.  
 11 (1.10 pm)  
 12 (The hearing adjourned until  
 13 Tuesday, 26 March 2024 at 9.45 am)

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