

# OPUS2

Scottish Covid-19 Inquiry

Day 30

March 26, 2024

Opus 2 - Official Court Reporters

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1 Tuesday, 26 March 2024  
2 (9.45 am)  
3 (Proceedings delayed)  
4 (9.52 am)  
5 THE CHAIR: Good morning, everybody. Good morning to you  
6 all. Right, you're going to get asked some questions ---  
7 well, I should be careful here. I'm not entirely sure  
8 how Ms Bahrami is going to deal with this but I suspect  
9 there will be some questions asked to you, whether  
10 singularly or collectively, I am not so sure. Over to  
11 you, Ms Bahrami.  
12 MS BAHRAMI: Thank you, my Lord.  
13 MS MANDY RODGERS, MS CAROL ANN CURRIE, MS MADEANA LAING and  
14 MR PETER MCCORMICK (called)  
15 Questions by MS BAHRAMI  
16 MS BAHRAMI: Good morning. Thank you for joining us.  
17 Please could you start off by each just briefly telling  
18 us what your role is and a brief background of ICHS,  
19 starting with you, Ms Rodgers.  
20 MS RODGERS: Yes, my name is Mandy Rodgers and I'm the  
21 manager of Blenham House Nursing Home in Edinburgh,  
22 which is a City Centre 60-bed facility for frail /elderly  
23 clients.  
24 MS CURRIE: My name is Carol Ann Curry. I'm a principal  
25 carer in Randolph Hill, Dunblane.

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1 MS LAING: My name is Madeana Laing and I'm a care home  
2 manager and a registered nurse at Beech Manor Care Home  
3 in Blairgowrie. We're a 45-bedded nursing home.  
4 MR MCCORMICK: My name is Peter McCormick. I'm the managing  
5 director of Randolph Hill Nursing Homes. We've got  
6 seven care homes across East Central Scotland and ICHS  
7 is a group of care home providers who came together to  
8 give evidence to this Inquiry.  
9 MS BAHRAMI: Thank you.  
10 Now, I want to start off by looking at guidance.  
11 Guidance --- well, it's in the statement that guidance  
12 would be received from Government, from the NHS, local  
13 NHS branches and the local Health and Social Care  
14 Partnerships. Is that correct?  
15 MS LAING: Yes.  
16 MS BAHRAMI: Firstly, how simple did you find the guidance  
17 to interpret from those various sources?  
18 MS LAING: It was very --- it wasn't something that was  
19 particularly --- from my perspective, something that was  
20 straightforward or simple, purely because of the amount  
21 and the volume of guidance that was issued. It would  
22 change numerous times in a day. Often you would just  
23 have, you know, read and shared with staff one set of  
24 guidance and then, by lunchtime, there would be  
25 something else or it would be late on a Friday evening

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1 when you'd been working all week. So the content itself  
2 wasn't particularly complex in some ways, it was just  
3 the sheer volume of it, and implementing that into  
4 a care home environment, which is very different from  
5 a hospital environment as well, was quite challenging.  
6 MS BAHRAMI: Thank you. Following on that, the timing of  
7 it, in the statement it said that often it was a Friday  
8 evening, which meant that matters were left unaddressed  
9 until Monday, but also there was an issue in that  
10 sometimes definitions came up to two weeks --- up to  
11 a week later. What impact did the timing of guidance  
12 being issued have on staff at different levels within  
13 the care homes?  
14 MS RODGERS: For us particularly, it's the dissemination of  
15 the information. You're getting guidance at --- often  
16 when people were turning their computers off on a Friday  
17 to go home for the weekend and, because of the  
18 importance of following the guidance in our environment,  
19 we felt we had to implement it as quickly as possible  
20 because, if for any reason something appeared to go  
21 wrong and we hadn't adhered to the guidance as quickly  
22 as we possibly could, then it might fall on our  
23 shoulders.  
24 MR MCCORMICK: I think as well, as Mandy says, the guidance  
25 would quite often come out on a Friday but it would

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1 often be announced in advance on the Thursday or the  
2 Friday, so everyone would know it was coming, and that  
3 information had been passed out to the general public,  
4 you know, so all of the relatives would come with an  
5 expectation that guidance that was announced on the  
6 Friday night would be implemented immediately. And  
7 quite often the sheer volume of it just took a long time  
8 to go through, so it might be a couple of days even to  
9 implement some of the simplest things.  
10 But some of the things involved people like  
11 Public Health and the local authority, who were just  
12 as --- who had only received the guidance in the same  
13 timescale as we did. So we often had to send proposals  
14 to them for their approval before we could implement  
15 pieces of the guidance and they'd only received the  
16 guidance on the Friday night as well so they weren't  
17 ready. None of these processes were set up and running.  
18 So on some occasions --- not every one, but on some  
19 occasions we'd have the guidance on Friday but actually  
20 implementing it might be almost as long as two weeks  
21 later.  
22 MS BAHRAMI: Yes. I want to ask you about that. Well,  
23 firstly, it said in your statement that the guidance ---  
24 and we know this --- wasn't numbered and changes weren't  
25 highlighted. A suggestion that you've made is that

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1 guidance could be better numbered and more discrete  
 2 changes within guidance could be highlighted using track  
 3 changes. What kind of difference would that have made  
 4 to you if it was quite clear what had actually changed?  
 5 MR MCCORMICK: I think there were so many different bodies  
 6 issuing quite often the same guidance, so we would see  
 7 guidance apparently coming out from Scottish Government  
 8 or the NHS nationally and then other parties, like the  
 9 local council, like the local NHS trust, would issue  
 10 their own version of the guidance, sometimes with little  
 11 differences on it. And we were reading documents that  
 12 were 100-plus pages long to try and work out little tiny  
 13 differences between one council area and another or one  
 14 NHS area and another, and it just struck us that,  
 15 looking in retrospect at least, it would have been  
 16 really helpful if they could have just called something  
 17 like "Care home guidance 1.001", the same way that  
 18 computer software is numbered, so it would be very clear  
 19 which document was which, because sometimes we'd get  
 20 a document from the NHS nationally and then we'd get  
 21 a document from the local council and we were having to  
 22 compare them both to see whether they were the same  
 23 document or a different document. I think, as you said  
 24 there, it would have been helpful if the documents were  
 25 quite clear in terms of what had changed.

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1 They were often very large documents and you were  
 2 reading through with the old one and the new one, trying  
 3 to work out what the difference was. Again, you see  
 4 this in so many other cases where you get documents from  
 5 people and they highlight in one colour all the things  
 6 that have been added and they highlight with another  
 7 colour or with cross-throughs all the things that have  
 8 been taken out, and that would have been much easier to  
 9 work with.  
 10 MS RODGERS: Also the terminology — it was called  
 11 "guidance". It wasn't guidance. It was these were sets  
 12 of rules that we had to abide by but under the umbrella  
 13 of "Well, the guidance says ...". But the guidance  
 14 was — it was like, "If you don't follow the guidance,  
 15 what's going to happen? It's up to you what you do but  
 16 the guidance says ...". So we had to follow it strictly  
 17 so that we couldn't be accused of not — even if some of  
 18 it didn't make sense to us.  
 19 THE CHAIR: Can I press you on that, please, and  
 20 I appreciate you're not a lawyer so this is a little  
 21 unfair. Would I be fair to interpret your answer as  
 22 saying that you regarded yourself as obliged to follow  
 23 the guidance?  
 24 MS RODGERS: Yes.  
 25 MS CURRIE: Yes.

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1 THE CHAIR: Even though a lawyer might take a different view  
 2 of the obligation upon you, you felt as a matter of  
 3 practicality it was a binding obligation upon you?  
 4 MS RODGERS: Yes.  
 5 MR MCCORMICK: I think there were a number of inspecting  
 6 bodies, the Care Inspectorate most obviously in historic  
 7 terms, but also at times the NHS, et cetera, they would  
 8 come in and do inspections and they were inspecting  
 9 against that guidance and therefore you had to have an  
 10 absolutely compelling reason why you weren't following  
 11 it. I suppose, if you weren't following that guidance  
 12 and something negative happened, then you would  
 13 undoubtedly face criticism then.  
 14 THE CHAIR: Yes, and I suppose, taking it perhaps to an  
 15 absurd extreme but logically correct, you would have  
 16 been entitled, had the Care Inspectorate made a finding  
 17 against you — an adverse finding against you based on  
 18 guidance — to challenge that, of course, but I don't  
 19 imagine any commercial organisation like yours is  
 20 enthusiastic about requiring to get into challenges to  
 21 decisions made by bodies such as the Care Inspectorate.  
 22 MR MCCORMICK: Well, I think in a lot of cases a lot of the  
 23 decisions are made — this is not a very linear process.  
 24 You're making decisions against a wide range of  
 25 different moving pieces and therefore an awful lot of it

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1 can be based on people's opinions, so challenging it in  
 2 a very practical way is quite difficult.  
 3 THE CHAIR: It is, yes. I understand that. That's very  
 4 clear. Thank you.  
 5 MS BAHRAMI: Thank you.  
 6 I want to ask you about the implementation of plans  
 7 from Public Health as part of the guidance. You  
 8 mentioned that it could take up to two weeks for  
 9 Public Health to approve these plans and in your  
 10 statement you say that's simply because the  
 11 infrastructure wasn't there within Public Health to deal  
 12 with these more quickly and you've also said that they  
 13 didn't get the guidance themselves until you had it,  
 14 which made things more difficult. What was the impact  
 15 on the care of the residents and contact with their  
 16 loved ones of this delay because you also say —  
 17 sorry — that it seemed to you that certain guidance was  
 18 required by the Government to be implemented quickly,  
 19 immediately, but, in reality, despite your best efforts,  
 20 it was taking a couple of weeks. So what impact did  
 21 that have on patient care and contact?  
 22 MR MCCORMICK: I think very much — it was the way that  
 23 certain policies were announced in a sort of public  
 24 arena, typically on the television, and then the  
 25 guidance would come out some time after that. But the

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1 way it was announced — and I don't think anyone said  
 2 this specifically — but the impression given at the  
 3 announcement was that these things would happen  
 4 immediately whereas in the detail that wasn't really the  
 5 way it worked. So I think for families particularly  
 6 perhaps, more than residents, they had an expectation  
 7 that — what we're largely talking about is a lot of  
 8 time when the visiting rules were relaxed, and so  
 9 families would come with an expectation — you know,  
 10 almost immediately people would start to come to the  
 11 home and say, "Well, the guidance has changed and said  
 12 we can do this", and it was quite a difficult job,  
 13 wasn't it, explaining to people that, "That's what you  
 14 heard on the television, however ... and essentially  
 15 that's true but it's a more — it's more nuanced than  
 16 that and it's going to take a little bit longer". So  
 17 people who hadn't been able to visit face to face, for  
 18 example, for an extended period were obviously just  
 19 upset and disappointed, you know, that that wasn't able  
 20 to happen immediately.  
 21 MS LAING: I think as well with the visiting — because when  
 22 the visiting was re-introduced — and obviously it was  
 23 broadcast all over the news, essential visitors and  
 24 things like that — but the definitions were never  
 25 particularly clear. So the way that I would — you

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1 know, I've said, "This is classed as an essential  
 2 visitor", and maybe what you would have said could have  
 3 been totally different.  
 4 I certainly know from my experience because there  
 5 were several care homes — although my care home is  
 6 quite rural, there are several within a five-mile  
 7 radius — so one was doing one thing and then that word  
 8 might have spread to the other and so on, so if the  
 9 guidance, the definitions, had been more clear, it would  
 10 have been a lot more easy to implement in my opinion as  
 11 well.  
 12 MS RODGERS: With the visiting, obviously we'd an extended  
 13 period where people weren't allowed in at all and then  
 14 we could re-introduce it slowly. We had to have  
 15 a visiting co-ordinator, booked slots, we couldn't have  
 16 too many people in the building at the same time, and  
 17 the guidance clearly stated that they weren't allowed to  
 18 have physical contact with their own relatives, so  
 19 having not seen them for months and months and months,  
 20 had to stay 2 metres distanced from them. And how can  
 21 we — we can't police that. How can you stop a loved  
 22 one hugging their own mother, you know? But if we don't  
 23 try and enforce it and somebody brings the infection in  
 24 and gives it to their mother, then how did it get in?  
 25 It's my responsibility how that got in.

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1 MS BAHRAMI: Yes, and I will come back to the various  
 2 visitation issues. Firstly, what sort of plans did you  
 3 have to get approval from Public Health for?  
 4 MR MCCORMICK: I think we had to — it varied at different  
 5 times, but, as an example, once the visiting changed  
 6 that we could have socially distanced visiting — that  
 7 was one of the sort of earlier ones within the home —  
 8 you had to write out a plan of how you would meet people  
 9 at reception, how you would manoeuvre them — move them  
 10 through the home to the place where the visiting would  
 11 take place, how you would assist the resident to go  
 12 from, you know, their rooms or where they were down to  
 13 that area.  
 14 MS RODGERS: One instance, which was if someone was ill,  
 15 somebody's got a very high temperature and you need to  
 16 put a fan on them to reduce their temperature, we had to  
 17 put a risk assessment in place for every resident who  
 18 needed that. Another sort of bizarre example would be  
 19 we needed to have a risk assessment if we wanted to put  
 20 a Christmas tree up. We weren't allowed Christmas trees  
 21 for the residents, which might have been their last  
 22 Christmas. We had ridiculous posters of Christmas trees  
 23 on the walls to try and make it look festive, but we  
 24 weren't allowed a Christmas tree in case it spread  
 25 infection.

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1 MS BAHRAMI: Thank you. You said —  
 2 MR MCCORMICK: I was going to say, just to finish, as I say,  
 3 we put all those documents together to show all of that,  
 4 how you would move people round the building, how you  
 5 would clean afterwards, clean before, all of that type  
 6 of thing, and then that was sent off to — and it was  
 7 different people at different times — but Public Health  
 8 or the local Health and Care Partnership, and then they  
 9 would review that. And if you think about, you know —  
 10 excuse me — a council area, they would have 60 — in  
 11 some cases 20, in some cases 60 care homes, who would  
 12 all be doing that at exactly the same time. So even  
 13 their resources in order to approve that, you would be  
 14 desperate to get the answer back but you would be  
 15 hearing that they would be looking at your one next  
 16 Wednesday.  
 17 MS BAHRAMI: Yes, and in the meantime you would have family  
 18 members who were challenging you on the way you were  
 19 implementing the guidance?  
 20 MR MCCORMICK: Yes.  
 21 MS BAHRAMI: We heard before — we heard last year from  
 22 family members who were quite upset about this and said  
 23 that they found themselves having to challenge care  
 24 homes and some people — now, this may or not be the  
 25 case in this situation — but some people stated that

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1 they found they were having to inform care homes of the  
 2 correct position and, once they were doing that, they  
 3 were then getting access. Do you think that just that  
 4 process of having to have certain plans approved created  
 5 the impression perhaps that care homes weren't aware of  
 6 the guidance when in fact you were trying to implement  
 7 it and would do so as soon as your plans were approved?  
 8 MS RODGERS: Absolutely. We really wanted the relatives to  
 9 come in but we had to do it in such a structured way to  
 10 prove that we were heeding guidance and that we weren't  
 11 putting residents at risk.  
 12 MS LAING: I think as well, often, when the visiting was  
 13 back in place, there was the guidance that went  
 14 alongside that, which was fine, but also, if a resident  
 15 became unwell and was suspected to have COVID,  
 16 Public Health would very often, certainly for our care  
 17 home, say, "No, well, just shut your visiting off  
 18 again". So people were getting to come in and visit one  
 19 day and then, because one person who was isolating in  
 20 their room was potentially --- who had COVID, then no one  
 21 else got a visitor. And that didn't come from us, that  
 22 came from Public Health, but I think for families that  
 23 was really difficult to understand because they just  
 24 became so confused because one day they could come in,  
 25 the next day they couldn't. They didn't understand what

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1 was going on, which would be frustrating if you were one  
 2 of them.  
 3 MS BAHRAMI: Yes, thank you.  
 4 Now, you state that the care sector wasn't consulted  
 5 by those setting the policy and guidance. Presumably  
 6 you think that the care sector should have been  
 7 consulted. What do you think the impact of that  
 8 consultation could have been? How could it have ---  
 9 MS LAING: I think, if the care homes were consulted in  
 10 that, probably the guidance would have been a lot more  
 11 easier to follow, it would have been practical. Some of  
 12 it just wasn't practical for a care home environment,  
 13 and it was no disrespect to the people who were writing  
 14 it; it's just, if you haven't been in that environment,  
 15 how would you possibly know? It's not possible to  
 16 isolate people with dementia sometimes --- all these  
 17 different things that were just kind of overlooked and  
 18 very much focused on infection control and, "You must do  
 19 this and you must do that", but these are people's  
 20 homes. It's not a hospital setting, it's not a clinical  
 21 ward and things like that. So if care homes had been  
 22 consulted in it, there would have been a better  
 23 understanding of what it's actually like to live and  
 24 work in a care home.  
 25 MR MCCORMICK: I was going to say, I think earlier --- this

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1 probably changed across the time that the pandemic ran  
 2 and I think there was more consultation later, but  
 3 certainly in that first year it felt like the care  
 4 sector wasn't listened to. So I work with  
 5 Scottish Care, who I think you heard from last week, and  
 6 I think we very much felt in the first nine months of  
 7 the pandemic that the sector wasn't really listened to.  
 8 It's obvious in a public health emergency like we had  
 9 here that the Public Health Department would be leading,  
 10 but I think there is a very big difference between ---  
 11 all of us were faced with various restrictions in our  
 12 lives, and my daughter was in Aberdeen and I didn't see  
 13 her for a chunk of time, but we were always fairly safe  
 14 in the knowledge that I would see her at the end of this  
 15 pandemic.  
 16 I think for people in nursing homes, many of whom  
 17 are right at the end of their lives, that's not the  
 18 same. That's not the same dynamic for them. And  
 19 I think that wasn't --- it felt like it wasn't taken into  
 20 account and it felt like the sector wasn't being  
 21 listened to. And I think the impact on people in care  
 22 homes was --- and their relatives was --- underestimated  
 23 by being faced with quite the same restrictions.  
 24 And I also think, in the summer, after Easter 2020,  
 25 restrictions were lifted for many of us and it took

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1 a long, long time for the restrictions to be lifted on  
 2 care homes and I don't quite know why that is.  
 3 I mean, I --- on the one hand, they're vulnerable people  
 4 so it was a more risky thing to do, to lift the  
 5 restrictions, so that's understandable, but I think by  
 6 not lifting the restrictions as soon, there were other  
 7 negative effects that weren't really accounted for.  
 8 MS CURRIE: I think as well for the staff, the pressure of  
 9 the staff with the policies and procedures that were put  
 10 in place, especially working in a dementia setting, was  
 11 just --- it wasn't possible and the staff felt the  
 12 pressure of trying to navigate the policies and  
 13 procedures and into the dementia, but with dementia  
 14 patients it's very, very difficult. So people should  
 15 have come in and worked in these settings and realised  
 16 what worked in one doesn't work in the other, and  
 17 especially with dementia it was --- the staff felt the  
 18 pressure. They crumbled sometimes because they felt it  
 19 for the residents, they felt it from their family, but  
 20 also management and above us as well, that if we didn't  
 21 get it right, we would get in trouble or we would be  
 22 endangering the residents, and it was impossible some  
 23 days to go by these policies and procedures that were  
 24 put in place.  
 25 MS RODGERS: You really can't underestimate how it is for

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1 someone with really advanced dementia to be confronted  
 2 with all these people wearing masks and they can't see  
 3 your facial expressions, they don't know who you are.  
 4 We had some residents who didn't know what we looked  
 5 like. They couldn't remember our faces. And people who  
 6 walk with purpose — some people with dementia just walk  
 7 all day long. You can't keep them in one room and you  
 8 can't stop them from going out and touching things,  
 9 which was a potential spread of infection. And it was  
 10 really difficult on the staff to keep a handle on all of  
 11 that, particularly as we were very scared.

12 You know, everyone else — the vast majority of  
 13 people were working from home or furloughed. We were  
 14 working in the City. I was driving to work every day as  
 15 if it was Christmas Day. There was no traffic on the  
 16 roads whatsoever. And of course we have our own  
 17 families to think about. So we were going into a care  
 18 home that had active cases of COVID and then going home  
 19 to our own families and worrying that they were going to  
 20 get sick.

21 MS CURRIE: Yes.

22 MS RODGERS: So it was a very heavy burden for a lot of the  
 23 staff, especially if they had compromised people at  
 24 home.

25 MR MCCORMICK: I think as well — Mandy was just saying

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1 there — some of the guidance was just unrealistic.  
 2 Some of the earlier guidance said that residents should  
 3 be isolated in their rooms. As Mandy said, people who  
 4 were walking with purpose — many of the residents  
 5 simply can't understand that instruction. So there was  
 6 a huge pressure on everybody in the care home that we  
 7 were meant to be following this guidance; what would  
 8 happen to us if we didn't follow this guidance. And,  
 9 frankly, there was no way it was possible for it to be  
 10 followed in some — in many cases actually.

11 MS RODGERS: I had one lady in particular who was convinced  
 12 that her whole family had died of COVID and she was  
 13 extremely distressed, and we had to phone them to come  
 14 and stand outside in the street so that she could see  
 15 them through a window. But she could see them but she  
 16 couldn't speak to them or touch them or hold them, and  
 17 it was — for us, as care-givers, that's a really tough  
 18 situation to be in, very distressing.

19 THE CHAIR: Mr McCormick, I think you were envisaging there,  
 20 a moment ago, a patient — a person living in the care  
 21 home — who is ambulatory but very cognitively impaired  
 22 because of dementia. Such a person, how on earth do you  
 23 stop them moving? I mean, you would be actually  
 24 breaking the law if you locked them in their room.

25 MS LAING: There was just so little understanding to that.

18

1 When you had visits from Public Health and you would  
 2 have a resident, like Peter has described, walking  
 3 around the home, you would be told, "Oh, you'll have to  
 4 do something with that patient. You can't have them  
 5 walking about". Well, it's their home. They're  
 6 entitled to walk about in it. But also, in terms of the  
 7 cleaning and the guidance to do with residents touching  
 8 things, I was actually told at one point from  
 9 Public Health, for a resident who was very poorly in  
 10 their room, to pack up all their belongings so it didn't  
 11 spread infection. Not that I'd done that, but that was  
 12 the kind of things you would have been faced with on  
 13 a daily basis really.

14 MR MCCORMICK: I think, as Mandy said as well, for the first  
 15 Christmas there was things like — no Christmas  
 16 decorations were allowed, and we got these posters put  
 17 up on the wall, which were really a very second- or  
 18 third-best option, but we had to do all sorts of things,  
 19 like we were instructed to take down photos and things  
 20 like that in residents' rooms. Now, none of the rest of  
 21 us were faced with that in our lives.

22 THE CHAIR: Ms Bahrami.

23 MS BAHRAMI: Thank you, my Lord.

24 When you contacted the relevant Government  
 25 department or Public Health to seek clarity or to

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1 challenge certain guidance requirements, how supported  
 2 did you feel?

3 MS LAING: I think it varied, certainly from my perspective.  
 4 Sometimes there were two or three individuals at  
 5 Public Health that, when I spoke to, were very helpful  
 6 over the telephone, but it depends because a lot of the  
 7 contact that you had was over the phone. They were  
 8 obviously overwhelmed with their workload too. There  
 9 were times where you would get conflicting information  
 10 if you weren't speaking to the same person or you were  
 11 actually telling them, "Actually, no, this is the  
 12 guidance so why would you be telling me that?". It was  
 13 conflicting but it wasn't always negative from my own  
 14 view.

15 MS RODGERS: No, I would agree with that. Some of them were  
 16 very helpful, especially with getting like lab test  
 17 results back quickly and things. When that was  
 18 established at the beginning, it was taking up to — you  
 19 would do a PCR test on maybe a poorly resident and you  
 20 weren't getting the result back for seven to ten days,  
 21 by which time the whole home could have been infected,  
 22 but once that was up and running, it was much better.

23 MR MCCORMICK: I think when you're speaking to the various  
 24 different departments, I think people generally tried to  
 25 be helpful. I don't think any of us would deny that.

20

1 But it was quite clear that — you know, this happens in  
 2 all sorts of walks of life but it definitely developed  
 3 in the pandemic. You would know in Public Health who  
 4 you might phone to get an answer that you wanted as  
 5 opposed to who you might phone to get a very definite  
 6 "No" to something you wanted to do. So they were  
 7 producing — you know, just the same as all of us were  
 8 doing, they were looking at the same guidance and coming  
 9 up with different answers. But sometimes that went  
 10 against us in as much as, when people from the NHS came  
 11 in, they would quite often give us quite definitive  
 12 statements of what they expected and weren't that open  
 13 to some of the suggestions we had, and yet, you know, in  
 14 other parts of the public sector you've got two people  
 15 in the same role who wouldn't give you the same piece of  
 16 advice, so it didn't always feel like an even playing  
 17 field. But I don't think anyone was trying to be  
 18 unhelpful, but that is how it felt from our point of  
 19 view.  
 20 MS BAHRAMI: One of the lessons that you think should be  
 21 learned is that there should be a readily available  
 22 mechanism for challenging guidance and another lesson  
 23 that you believe should be learned is the enshrinement  
 24 in law of Anne's Law, which you state your group  
 25 supports. What do you think would be the impact of

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1 those two measures being in place?  
 2 MR MCCORMICK: I think it's quite difficult with the  
 3 challenging — it was difficult through the pandemic  
 4 that we had certain people stating things very much as  
 5 if they're — they made the decision and there wasn't  
 6 anything else you could do about it. It was also  
 7 busy — particularly in the early stages of the  
 8 pandemic, it was very much day to day and sort of mouth  
 9 to mouth — hand to mouth, rather — but it did feel  
 10 unfair at times that there were decisions made that we  
 11 felt were wrong and there was no real mechanism to —  
 12 MS RODGERS: Some of the decision-making was directly — it  
 13 was mandated directly to us and didn't apply to anybody  
 14 else, so there was an unfairness in how this guidance  
 15 was applied. My example would be we had to test  
 16 ourselves. If our staff wanted to work, they had to  
 17 take a lateral flow test. First it was daily and then,  
 18 later on down the line, we had to do two lateral flow  
 19 tests and one lab test a week. That didn't apply to  
 20 anybody else and it certainly didn't apply to NHS staff.  
 21 MS BAHRAMI: Okay.  
 22 MS RODGERS: So I have colleagues who worked in the NHS who  
 23 never had to test. So I had the NHS Care Home Support  
 24 Team come to my door in the middle of this and wanted to  
 25 come in. First of all, I didn't know who they were.

22

1 Secondly, I asked them, "Have you taken a test today?";  
 2 "No". I said, "Well, why not?"; "Well, we don't have  
 3 to. We're not mandated to do that". I said, "But we  
 4 are and anybody who comes in here has to, even  
 5 contractors, repair men, whatever", and I said, "But you  
 6 don't?"; "No". I said, "Where have you just come  
 7 from?"; "And they were standing there in their  
 8 uniforms — bearing in mind that we had to get undressed  
 9 at the door, they had just been in another care home and  
 10 come straight to my door, untested and wanted me to let  
 11 them in, but I didn't because that was against the  
 12 guidance, but I got a bit of a bad rep for that.  
 13 MS BAHRAMI: But essentially you were having to enforce  
 14 guidance which required you to take every possible  
 15 measure to prevent infection spread —  
 16 MS RODGERS: Absolutely.  
 17 MS BAHRAMI: — and you had the people who were coming to  
 18 make sure you were doing that —  
 19 MS RODGERS: Who weren't doing it themselves.  
 20 MS BAHRAMI: — and they were posing a risk to your care  
 21 home?  
 22 MS RODGERS: Yes.  
 23 MS BAHRAMI: So you had to stand up against that as well?  
 24 MS RODGERS: Hmm—hmm.  
 25 MR MCCORMICK: I think as well we said in — I think we said

23

1 in our evidence that there seemed to be — again, this  
 2 is probably just how it felt from our point of view.  
 3 I don't think anyone ever said this — but it felt as if  
 4 the NHS were considered the experts in every  
 5 circumstance and that all of the expertise that was  
 6 within the care sector was essentially ignored in the  
 7 early stages. And so some of the groups that you were  
 8 talking about, Mandy — we know that the NHS teams were  
 9 sent out — were people that they just reallocated, so  
 10 they'd never been in a care home before, they weren't  
 11 infection control nurses, they'd been doing an entirely  
 12 different job, and in a relatively short period they  
 13 were sent out to care homes to do infection control  
 14 audits.  
 15 MS RODGERS: They were staffed that had been redeployed from  
 16 departments that had been closed because of the  
 17 pandemic, like outpatients' clinics. I think one of the  
 18 ladies who came to me was a cardiology outpatient nurse  
 19 who was coming in to check our infection control  
 20 practices in a completely alien environment to herself.  
 21 MS BAHRAMI: I'd like to move on now to staff working and  
 22 the impacts there. There's mention of people's hands  
 23 starting to bleed from hand-washing so much and other  
 24 things. Can you tell us a bit about how the guidance  
 25 impacted your working practices?

24

1 MS CURRIE: I think for the care staff we had to wash our  
 2 hands constantly. We had hand gel on us, we had to wash  
 3 our hands constantly, all our hands were broke out up to  
 4 our elbows. We then had to wear gloves that water got  
 5 into or chemicals got into sometimes and some of the  
 6 staff actually had to wear dressings on their arms. Our  
 7 home was quite lucky, we did have a couple of different  
 8 types of gloves, but still, with the constant  
 9 hand-washing, it was very hard on the staff. We had  
 10 rashes, cuts, things like that.  
 11 MS BAHRAMI: Were staff still able to gather in staff rooms  
 12 to speak to and support each other?  
 13 MS CURRIE: Not really.  
 14 MS RODGERS: We had to socially distance.  
 15 MS LAING: Yeah.  
 16 MS RODGERS: So four people could take a break at the same  
 17 time in our staff room if they all sat in the corner,  
 18 they would be 2 metres apart, so it was very difficult.  
 19 Our staff are cohorted anyway in teams — we were on  
 20 three floors so we work in teams, so very much it was  
 21 quite easy for us to keep our teams together, but of  
 22 course you do get overlaps. If you're testing your  
 23 staff three times a week, you're going to have people  
 24 going off with asymptomatic COVID, which I suppose might  
 25 be one of the reasons — one of the drivers why the NHS

25

1 staff didn't have to test because they could have ended  
 2 up with maybe a quarter or half their workforce off at  
 3 the same time, which at some points in time we did;  
 4 12/15 people at a time.  
 5 MS BAHRAMI: Were staff having to work more days or hours  
 6 than usual?  
 7 MS RODGERS: They had to cover for all their COVID  
 8 colleagues.  
 9 MS CURRIE: Yeah.  
 10 MS LAING: When you had an outbreak within the staff room  
 11 testing, if you had a staff group of 60, you could have  
 12 sent 30 home, which then leaves 30 staff, so you're  
 13 working with half your staff load and there's not — you  
 14 know, the local authority and things would say, "We'll  
 15 be able to send staff from the NHS to come and support  
 16 or from agency", but through no fault of their own they  
 17 just didn't have that to send. So your staff that you  
 18 did then have left worked additional hours and worked —  
 19 really worked themselves to the ground until that next  
 20 batch of staff then could come back.  
 21 MS CURRIE: I know personally I was working six to seven  
 22 days a week. We'd done sleepovers as well. It was just  
 23 for the benefit of the residents because, if we went  
 24 home, then who would then look after them? It would be  
 25 them that would suffer. So I think the staff really

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1 stood up — especially in our team, we really stood up.  
 2 We worked six/seven days a week, and it wasn't because  
 3 we necessarily wanted to, it was for the benefit of our  
 4 residents and our other colleagues. But we were  
 5 completely, completely worn out.  
 6 MS RODGERS: The one benefit that I felt that we got from  
 7 this pandemic was that, because we only had the  
 8 residents and they only had us — we were going home,  
 9 work, home, work — the sense of community really,  
 10 really increased because they — we were the only other  
 11 human beings they were seeing. They weren't seeing  
 12 their own families. And to the staff's credit, that has  
 13 remained. So that is — it's one plus point in that the  
 14 sense of community and sense of belonging — did you  
 15 find that in your homes?  
 16 MS LAING: Yeah.  
 17 MS CURRIE: Yeah.  
 18 MS BAHRAMI: I think in your statement you actually say we  
 19 were like soldiers marching forward together.  
 20 MS RODGERS: Hmm—hmm.  
 21 MR MCCORMICK: I think one of the other things worth  
 22 mentioning is — you know, as has already been  
 23 mentioned, when there have been COVID outbreaks, there  
 24 were times when you lost a group of staff, you know,  
 25 because they had to then isolate at home. There were

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1 certain other rules that probably came in with the best  
 2 of intentions but didn't necessarily help that much.  
 3 So earlier on we were told that we weren't allowed  
 4 to move staff between one home and another home and so,  
 5 in that sort of circumstance, we might have moved staff  
 6 from one home to another to sort of fill that gap but we  
 7 were told we weren't allowed to do that. We also used  
 8 to have groups of staff called our "bank staff", who  
 9 weren't contracted. They would come in and work  
 10 individual shifts. And again the same thing, we were  
 11 told we weren't allowed to move them around the group.  
 12 But at the same time, you know, the place of last resort  
 13 is then to go to agency to get agency workers, but we  
 14 had no control over where those agency workers would  
 15 come from. So that seemed a bit of an incongruous  
 16 decision that didn't make sense from looking at it from  
 17 that direction. You could see it made sense — if you  
 18 had a surplus of people, not allowing people to move  
 19 around would make perfectly good sense, but there wasn't  
 20 a surplus of people before the pandemic and it didn't  
 21 get better during it.  
 22 MS BAHRAMI: Thank you. I think there's mention of NHS bank  
 23 staff. Were you able to make use of those?  
 24 MS LAING: No. I think when you had — when we had a COVID  
 25 outbreak, you would have daily Teams calls with NHS

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1 staff and the local — the Health and Social Care  
 2 Partnership staff and you would discuss how many of your  
 3 staff team were absent and what you were trying to do to  
 4 find staff to cover for them. But they would all say,  
 5 "But you'll need to find someone, you'll need to find  
 6 someone", but they weren't able to give us anyone. But  
 7 there seemed to be a lack of understanding that, if they  
 8 can't — you know, as the supporting bodies to us, if  
 9 they can't help and we don't have anyone because they're  
 10 all at home, where do you then find that person.

11 So I know, myself, as a nurse, you then often ended  
 12 up staying because all my nurses were off sick with  
 13 COVID and I was the only one that didn't have it, so you  
 14 were the only nurse for several days to cover that  
 15 because there is literally no one else. But there  
 16 seemed to be a lack of understanding of "There aren't  
 17 just people", if you know what I mean.

18 MR MCCORMICK: I think these NHS banks were sort of  
 19 mentioned quite a few times during the pandemic. They  
 20 were set up and available to help. But I've got a role  
 21 as the branch chair of Scottish Care in the Lothians and  
 22 so I speak to a lot of care homes and I can only  
 23 recollect one person that actually used the NHS bank and  
 24 it wasn't particularly successful. They had a problem  
 25 weekend coming up, they were lacking a number of staff

1 and they phoned up. In the end they got one person for  
 2 one shift over that weekend. The reality was they were  
 3 down a significant portion. One person — not that one  
 4 person didn't help, but it was nowhere near the  
 5 resolution. And so I think most care homes took the  
 6 decision — or were of the opinion, particularly after  
 7 this had been going for a while, that it was an absolute  
 8 waste of time to call. If you had a need, they weren't  
 9 going to be able to help.

10 MS BAHRAMI: How did all of that affect staff's home life  
 11 and well-being at home?

12 MS LAING: It was really, really difficult. I know for  
 13 myself there was just me and my daughter at home, so she  
 14 was able to continue to go to like school hub whereas  
 15 a lot of everyone else's parents were furloughed, so  
 16 they were getting to stay home with their children and  
 17 do all these things that everybody else was doing. But  
 18 you felt so guilty — you felt terrible because you were  
 19 putting her away to the school hub, you were working all  
 20 these long hours and then, when you were coming home,  
 21 you were exhausted, you were worried about passing the  
 22 virus on to then her or to other people and not just  
 23 myself — I think I can speak for all my staff team —  
 24 they were so scared to go home because they were  
 25 petrified of giving that virus to other people that they

1 lived with just so they could go to their work. It was  
 2 really, really difficult.

3 MS CURRIE: I'm the same. It's only me and my son at home  
 4 and I was working six to seven days a week, 13-hour  
 5 shifts. Sometimes I was doing sleepovers and sometimes  
 6 I just came home, said "Hi" to him, went in the bath,  
 7 sat and cried, and then came back out and was trying to  
 8 be jolly and not let him see how upset and exhausted  
 9 I was so he didn't worry, but try and keep my home life  
 10 as normal as possible and not let him see the stress  
 11 with what I was going through so it didn't affect him.  
 12 But it did. He did see through it.

13 MS RODGERS: My husband and I didn't sleep in the same room  
 14 for three months. He was very frightened of getting  
 15 COVID, so, yeah, it affected our home life because he —  
 16 but he was very supportive. He could see the strain it  
 17 was putting on myself as the leader of the team because  
 18 everybody brings — not that they're bringing their  
 19 problems, but you have to try and support all your staff  
 20 and to be seen to be doing the right thing, following  
 21 the rules. One particular story is my long-term deputy  
 22 manager died just at the beginning of the pandemic, just  
 23 before the lockdown, but her funeral was on the day  
 24 where the new rules came out on funeral attendance and  
 25 I couldn't go because, as the leader of the team,

1 I couldn't be seen to not be doing what the Government  
 2 had mandated, which was really, really, really quite  
 3 upsetting.

4 MS BAHRAMI: Thank you. On the point of sleepovers and  
 5 having children, if a member of the team had young  
 6 children, did that mean they didn't take part in  
 7 sleepovers or did they have to find someone to stay with  
 8 their child overnight, if they were a single parent?

9 MS CURRIE: Sleepovers were voluntary, as a member of staff.  
 10 Nobody was asked to do a sleepover. It was staff  
 11 volunteering. If they had looked at the rota the next  
 12 day and seen that there was X amount of staff off, they  
 13 would just put their hand up and be like, "Listen, we'll  
 14 sleep over tonight, we'll crash in one of the spare  
 15 rooms". Nobody was ever asked. It was staff just  
 16 stepping up, wanting to do their bit, again for their  
 17 colleagues and for the residents. It wasn't mandatory  
 18 or anything like that. It was just staff wanting to  
 19 help and to do their bit.

20 MS LAING: I know for me I didn't often do sleepovers, but  
 21 obviously the school hub was only open until 6 o'clock  
 22 or 5 o'clock so you did then have to find someone else  
 23 because you weren't going to be back in time because the  
 24 nurse was off sick or somebody else was off sick. So it  
 25 was really stressful trying to sort that out. Then, of

1 course, your children are wondering what's going on.  
 2 They're not going to school like normal, they're not  
 3 seeing their friends and you're not there for them  
 4 because you're having to go to your work and deal with  
 5 all that. So, yeah, it was difficult to try and deal  
 6 with it too.  
 7 MS BAHRAMI: Thank you. I'd like to move on to anticipatory  
 8 care plans and DNACPR. With regard to putting in place  
 9 anticipatory care plans, I understand you had to contact  
 10 patients --- contact families and also have discussions  
 11 with residents. What was the reaction of families on  
 12 being contacted about that matter?  
 13 MS LAING: I think we've always had anticipatory care plans,  
 14 so getting in touch to update those, you know, on the  
 15 back of the GPs asking to kind of just as lockdown came  
 16 into play wasn't something that was out of the ordinary.  
 17 The difficulty you then had was, if the family member  
 18 had said, "Well, if my loved one becomes unwell, not  
 19 specifically COVID related, just with anything, and  
 20 hospital treatment is required, then yeah, I would still  
 21 like them to go". That was then the challenge because  
 22 you weren't able to put them anywhere because nobody  
 23 would take them.  
 24 So trying to have that conversation was really  
 25 difficult and it wasn't one that --- I personally would

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1 then put the families back to the GPs because that's not  
 2 on me. That wasn't my call not to escalate that. But  
 3 people were still wanting their care escalated but were  
 4 being told by medical professionals that they couldn't  
 5 get it.  
 6 MR MCCORMICK: I was going to say, DNACPRs are a normal part  
 7 of care home life, I guess. There's always a discussion  
 8 with people about whether --- you know, which route they  
 9 would like to go. But I guess there was an impression  
 10 that there was --- I'm not sure this is the right  
 11 phrase --- but a push-on by the NHS to get more of these  
 12 things in place.  
 13 In one of our homes, we received DNACPRs for all of  
 14 our residents that hadn't already got one in place, and  
 15 we had a bit of a discussion back and forward and we  
 16 actually sent them back to the NHS. But, again, it goes  
 17 back to what I was saying before, which is that's one of  
 18 our homes out of seven, so there's quite different  
 19 processes going on throughout the country. It wasn't  
 20 a sort of unified approach.  
 21 But I also think --- and again we mentioned this  
 22 before. I mean, the pandemic was very busy, there were  
 23 so many things going on --- but I think there was  
 24 a restriction in terms of access to care for people in  
 25 care homes. I think that was a decision that must have

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1 been made by the NHS, but that wasn't a discussion that  
 2 was held in the full public light, and I think, had it  
 3 been --- well, there would have been people with all  
 4 sorts of opinions, but, you know, it seemed to be  
 5 a decision that was made very low key, not very well  
 6 publicised but was a reality of the first couple of  
 7 years of the pandemic anyway, yeah.

8 MS RODGERS: Yeah.  
 9 MS BAHRAMI: On page 5 of the statement --- I think it's  
 10 a section that you've commented on, Ms Laing --- you  
 11 state that you were advised GPs had discussions with  
 12 families about DNACPR forms and then subsequently all  
 13 residents who didn't previously have such forms were  
 14 issued with them. But despite being told by the GPs  
 15 that these discussions had taken place, your impression  
 16 was that that wasn't actually the case?  
 17 MS LAING: Yeah. I think ---  
 18 MS BAHRAMI: Why did you --- what created that impression for  
 19 you?  
 20 MS LAING: I think it was because it was very much something  
 21 that was just rushed, so it was, "Update your ACPs, your  
 22 anticipatory care plans", which was fine, and then it  
 23 was, "You need to look at who doesn't have DNRs because  
 24 they will now then need to have one". So when that was  
 25 the discussion that was had with myself, I had said at

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1 the time, "I can't make that decision, you'll need to  
 2 speak to the families about that, but I can let you know  
 3 who doesn't have one", because standard practice would  
 4 be for the GP to have that discussion with the family  
 5 member if the resident wasn't able to have that  
 6 discussion themselves. And then, within a couple of  
 7 days, you then did then get these outstanding DNRs that  
 8 we didn't have previously. So you would question  
 9 whether that was something that was done in conjunction  
 10 with families because the initial conversation was,  
 11 "It's just they need to have them now because they won't  
 12 be able to go to hospital", because they didn't want to  
 13 take them.  
 14 MS BAHRAMI: So essentially there was no nuance? The  
 15 conversation you had was based on there being no nuance,  
 16 no individual consideration, just that everybody ---  
 17 MS LAING: Yeah.  
 18 MS BAHRAMI: --- in your care home who is resident there must  
 19 have one of these?  
 20 MS LAING: Yeah, because they wouldn't be going to hospital  
 21 if they were unwell.  
 22 MS BAHRAMI: I take it on that basis then you weren't asked  
 23 about your impression of a particular resident's health  
 24 and frailty as part of the consideration of whether it  
 25 was clinically appropriate to put a DNACPR notice?

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1 MS LAING: No, we weren't, and even when residents who did  
 2 have COVID or maybe didn't have COVID, just became  
 3 unwell, as people still continued to do throughout the  
 4 pandemic, it was very much a cut and dry -- you know,  
 5 you got advice over the telephone but you still -- you  
 6 would have to fight very, very hard and challenge a lot  
 7 to get someone admitted to hospital when you could  
 8 clearly see that, if they went to hospital, they had  
 9 a really good chance of improving, of getting over what  
 10 was making them unwell in the first place. But it was  
 11 almost like -- you were not playing God, but it was  
 12 just, "No, you can't go, so you just have to stay", when  
 13 you could have gotten better if you'd been given the  
 14 chance.  
 15 MS BHRAMI: And your understanding is the lack of ability  
 16 to access an ambulance, paramedics or hospital was the  
 17 reason for these DNACPR decisions being put in place?  
 18 MS LAING: Yeah.  
 19 MS BHRAMI: Thank you. Had you ever previously experienced  
 20 a time where every resident --  
 21 MS LAING: No.  
 22 MS BHRAMI: -- in your care home had to have this?  
 23 MS LAING: No.  
 24 MS BHRAMI: Did the others on the panel have similar  
 25 experiences or were any of you in a care home that

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1 didn't have to approach this issue at all?  
 2 MS RODGERS: We always have DNARs in -- that conversation  
 3 anyway, and I have a number of residents who don't have  
 4 one in place but that didn't alter.  
 5 MS BHRAMI: Okay. So in your care home you didn't have GPs  
 6 contacting you saying that all your residents --  
 7 MS RODGERS: We were told that there would be no hospital  
 8 admissions but they didn't put any extras -- it remained  
 9 a choice.  
 10 MS CURRIE: I can't comment on that, but I know that 99% of  
 11 our residents do have DNACPRs. Whether that was  
 12 contacted through -- I can't -- I'm not involved in that  
 13 side.  
 14 MS BHRAMI: Sure. Thank you.  
 15 MR MCCORMICK: I think, as I said, it would be the normal  
 16 process that everyone would be -- there would be  
 17 a discussion about the appropriateness of it.  
 18 MS RODGERS: Yes, everyone has that conversation.  
 19 MR MCCORMICK: But, as I say, in one case we were issued  
 20 with blanket DNACPRs for all of the residents and, just  
 21 as you said, that couldn't have been a nuanced  
 22 discussion. There would have been no discussion  
 23 involved in that.  
 24 MS BHRAMI: Was your impression also that the reason for  
 25 that blanket imposition was the lack of access to

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1 ambulances, paramedics and hospitals?  
 2 MR MCCORMICK: Yeah, I don't know about ambulances and  
 3 paramedics particularly, but I think it was the  
 4 pressures of the NHS and, you know, a decision or at  
 5 least a direction of travel which was to limit the  
 6 access to hospitals for nursing home residents.  
 7 MS RODGERS: I think at the very beginning, when we had it  
 8 tough, when we did have very sick people who did have  
 9 COVID, one conversation was that they couldn't be taken  
 10 to hospital because it would take too long to clean the  
 11 ambulance, to dis- -- you know, to disinfect it, so they  
 12 wouldn't be going.  
 13 MS BHRAMI: I'll come back to that again. In relation to  
 14 the DNACPR forms, Ms Laing and Mr McCormick, did you  
 15 ever have conversations with concerned family members  
 16 about these? Did anyone approach you challenging this?  
 17 MS LAING: We had family members, when their resident became  
 18 unwell, COVID or not COVID related, who were concerned  
 19 about why a GP wasn't necessarily coming to see them in  
 20 person. And don't get me wrong, they did come out in  
 21 person at times, but again overwhelmed themselves. So  
 22 it wasn't that they didn't want to come. I think  
 23 sometimes just their workload meant that they couldn't.  
 24 But the family members would become concerned about why  
 25 that -- after they'd been seen by a GP, but why are they

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1 not going to hospital, and that's where the challenges  
 2 would become, and because the family members couldn't  
 3 necessarily get in touch with the GP directly to have  
 4 that discussion, we were the ones who kind of took the  
 5 brunt of trying to explain. And how do you explain that  
 6 because it's not -- it wasn't our decision and you  
 7 didn't necessarily agree with it, but we took the  
 8 forefront of dealing with that really.  
 9 MS BHRAMI: So the challenge about hospitals and GP care in  
 10 general but not specifically about DNACPR decisions in  
 11 your experience?  
 12 MS LAING: Hmm.  
 13 MS BHRAMI: Okay. Thank you.  
 14 Do you recall how long the blanket ambulance ban was  
 15 in place? I think you mentioned and you say in your  
 16 statement that for a while there was a ban on ambulances  
 17 collecting patients -- residents from care homes.  
 18 MS LAING: I think, as the pandemic went on, so after sort  
 19 of the first lockdown and into maybe towards near the  
 20 end of the second, we did have a few residents who  
 21 did -- probably just before the vaccine roll-out, we did  
 22 have a few residents who did go to hospital, but that  
 23 was quite a long time after it started really.  
 24 MS RODGERS: Yeah, months.  
 25 MS BHRAMI: Months. And you mentioned that there were

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1 times where a particular resident --- your impression was  
 2 that a particular resident had a good chance of  
 3 improving if they received hospital care but that wasn't  
 4 allowed. Do you think that that led to otherwise  
 5 preventable deaths?  
 6 MS LAING: I don't think you could really answer that in all  
 7 honesty, but you know yourself from working in that  
 8 environment, when people are poorly, COVID or not COVID  
 9 related, if they've had courses of oral antibiotics or  
 10 treatments for things and are improving a little bit but  
 11 not quite improving the way you would want, if the  
 12 family --- that was their wishes for escalation of  
 13 care --- then in any other circumstance their care would  
 14 then be escalated to hospital to try IV therapies or,  
 15 you know, different kind of interventions that in a care  
 16 home setting we just aren't able to do that. You  
 17 couldn't really probably 100% say, but I would like to  
 18 think that, yeah, you probably would have been --- some  
 19 residents who would have gotten better if they had the  
 20 opportunity to go to hospital.  
 21 MR MCCORMICK: Yeah, I mean, over any one person you can't  
 22 really say but over a number of people it must have made  
 23 a difference.  
 24 MS BAHRAMI: Thank you.  
 25 Ms Laing, I think it was you who said that you were

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1 able to get GPs into your care home.  
 2 MS LAING: Yeah, they came in.  
 3 MS BAHRAMI: Did others have the same experience or ...  
 4 Ms Currie, in your experience the GPs didn't ---  
 5 MS CURRIE: No, we didn't get any GPs in. We consulted with  
 6 GPs over the phone and nine times out of ten, regardless  
 7 of what the resident's symptoms were, they were  
 8 prescribed just-in-case medication. We really, really  
 9 struggled. I think it was months and months before we  
 10 got a GP into our home.  
 11 MS RODGERS: We were fine. We have a very good GP service  
 12 and they supported --- without their support --- you know,  
 13 they were really on it from the very beginning in terms  
 14 of testing and trying to stop the spread.  
 15 MR MCCORMICK: I think again, as I said before, there's  
 16 quite a mixture of reactions, so with seven homes there  
 17 were seven different GP surgeries, some of whom didn't  
 18 come, some of whom did. They were all available ---  
 19 I think they were available on telephone, et cetera, so  
 20 it wasn't a complete cessation of service, but it was  
 21 delivered in quite different ways.  
 22 MS BAHRAMI: You mentioned that often all that would happen  
 23 was that just-in-case medication would be prescribed.  
 24 If it was something more mild, were you able to get  
 25 things like antibiotics and mild treatments?

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1 MS CURRIE: Yeah, we would be able to --- yeah, they  
 2 prescribed antibiotics, but nine times out of ten, if  
 3 a resident didn't get better from that, it was  
 4 just-in-case that was prescribed.  
 5 MS BAHRAMI: Thank you.  
 6 We also know that allied health professionals  
 7 weren't able to visit care homes and it's mentioned in  
 8 your statement that other external activities also had  
 9 to be diminished, and all of this would have impacted  
 10 the quality of life for residents and their mental  
 11 health. Were your respective care homes able to  
 12 mitigate this in any way?  
 13 MS RODGERS: Yes, I became a very good YouTube hairdresser.  
 14 I can do the YouTube bob, so all our old ladies had the  
 15 same hair---do for a while. But apart from that, things  
 16 like chiropodists and dieticians --- we could access  
 17 other people outside and we just had to make do and mend  
 18 really and do some --- most of it ourselves.  
 19 MS BAHRAMI: Yeah.  
 20 MS LAING: I think it was really difficult because,  
 21 certainly in our care home, we have musical entertainers  
 22 in every week, we have school children that --- primary  
 23 children that come in every week for the whole day on  
 24 a Friday. We have so many different things that there's  
 25 just no way that you can mirror that, especially if your

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1 own staff team is depleted because they're all ill. So  
 2 your residents did become --- through no fault of your  
 3 own and through want of trying, they did become isolated  
 4 and they became lonely because there was not as much  
 5 mental stimulation. If you're having to sit in your  
 6 room, how can you --- it's just --- it's not practical, so  
 7 it just became something that was a very fun and lively  
 8 environment to be in with a lot going on to just  
 9 nothing.  
 10 MS RODGERS: We were going round --- particularly when the  
 11 residents were sort of stuck in their rooms, we were  
 12 going round the home with a karaoke machine and standing  
 13 outside their room and saying, "Right, what song  
 14 would you like?", and that was the best that they got.  
 15 And, to be honest, because they were in their rooms for  
 16 so long, when they were allowed back out again, some of  
 17 them didn't want to come out. They'd become accustomed  
 18 to being by themselves and isolated and sort of we had  
 19 to shoehorn them back out of their rooms to be social  
 20 animals again.  
 21 MS LAING: Yeah, they'd forgotten how to socialise, I think.  
 22 MS BAHRAMI: And the lack of allied health professionals  
 23 attending, did that cause your workloads to be increased  
 24 as well?  
 25 MS RODGERS: Absolutely. Absolutely.

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1 MS BAHRAMI: Okay. Do you have any thoughts on alternative  
 2 measures that could be put in place in the event of  
 3 another pandemic to try to mitigate the impact of some  
 4 of this, the attendance of allied health professionals?  
 5 MS RODGERS: I think it was all very well intentioned. It  
 6 was to protect these very vulnerable elderly people,  
 7 but — it was well intentioned but heavy-handed. Of  
 8 course we saw what was happening in care homes in other  
 9 European countries, you know, what happened in Italy and  
 10 Spain, where they were really hit hard, you know, and  
 11 all these — and I think they were trying to prevent  
 12 that happening here. So I know where that was coming  
 13 from, but it was the lengths that we went to. It lasted  
 14 too long and it was very unrealistic and I — in some  
 15 respects we felt a bit got at because there were rules  
 16 applying to us that didn't apply to anybody else. And  
 17 it really impacted on our residents because some of  
 18 these residents, it's the final years of their lives to  
 19 spend with their families and new babies had arrived  
 20 that they'd never seen. So I think there will be a lot  
 21 to learn from what we went through as a nation and  
 22 hopefully not have to suffer it all again.  
 23 MS CURRIE: Yeah, I would just like to say that as well.  
 24 I mean, especially they should go into a place and learn  
 25 different policies and procedures don't work in every

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1 different care home, and I think, for me, the one that  
 2 struck me the most was at the end of life, families not  
 3 being allowed to come in and see their loved ones at the  
 4 end of life. You know, they were allowed in at the  
 5 very, very end, but they missed out on precious moments.  
 6 They missed out on telling their loved one that they  
 7 loved them when they were conscious enough to understand  
 8 it and to hear their loved one's voice back saying that.  
 9 So, to me, it would be revising — especially if  
 10 this was to ever happen again, it would be the  
 11 end-of-life contact and things like that because, for  
 12 me, that was the hardest part, refusing relatives that  
 13 were banging on the door, wanting to come in and see  
 14 their loved one at the end and refusing them entry. To  
 15 me, that will stay with me forever.  
 16 MS BAHRAMI: I will come back to those issues, but in  
 17 relation to allied health professionals, do you think,  
 18 for example, certain professionals having virtual  
 19 sessions could have made a difference if they were, you  
 20 know, examining by video and perhaps attempting to guide  
 21 you through processes such as — you know, podiatry  
 22 processes —  
 23 MS RODGERS: You couldn't do that virtually.  
 24 MS BAHRAMI: No, but if they were to try to guide you  
 25 through that, for example?

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1 MS LAING: I think in theory that would work well, but if  
 2 you were in a similar situation, again you would not  
 3 have — the likelihood of having the staff to take off  
 4 to go and watch these videos would be very, very  
 5 difficult, so it would have to be something that was all  
 6 done in pre-planning of something like this happening  
 7 again.  
 8 MS BAHRAMI: The situation I had in mind was more a video  
 9 consultation between, say, a podiatrist and a resident,  
 10 with a staff member there to facilitate the examination  
 11 and then perhaps to take practical steps guided by  
 12 a podiatrist or is this not something you would be  
 13 comfortable —  
 14 MS CURRIE: We are not allowed to undertake any podiatry  
 15 work due to, like, nerve endings and things like that in  
 16 people's feet, so we're not allowed to do that in our  
 17 home anyway.  
 18 MR MCCORMICK: I suppose to some degree as well it seemed  
 19 like a lot of these services stopped entirely from our  
 20 point of view, and I think, as everyone is saying, the  
 21 workload in care homes is already higher, so being able  
 22 to do these things by video — and some of those things  
 23 did happen to a degree — but it couldn't really replace  
 24 it entirely.  
 25 So I'm not sure that — it did seem to a degree that

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1 some NHS services were switched off for an overly long  
 2 time, almost like what were we saving them for if they  
 3 weren't operating anyway, so perhaps with —  
 4 particularly once the initial problem with PPE had been  
 5 overcome, perhaps they could have come out sooner rather  
 6 than taking so long before things were reverting back to  
 7 normal.  
 8 MS BAHRAMI: Yes, thank you.  
 9 Now, moving on to end-of-life situations, we've  
 10 heard that some care homes didn't have sufficient  
 11 supplies of oxygen and just-in-case medicine. Was that  
 12 your experience or did your care homes always have  
 13 sufficient supplies?  
 14 MS RODGERS: We didn't have oxygen.  
 15 MS BAHRAMI: Okay.  
 16 MS RODGERS: So that needs to be — we can't even access  
 17 oxygen therapy through the GP. That needs to come  
 18 through a consultant in respiratory medicine. But we  
 19 were getting our antibiotics and things no problem at  
 20 all. But I would say that we did have COVID deaths in  
 21 our nursing home but far more people got COVID and  
 22 survived it than succumbed to it. And just like the  
 23 rest of the general population, we had numerous  
 24 asymptomatic COVID-positive, like myself. The only time  
 25 I got COVID was through a mandatory PCR test and

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1 I wasn't unwell at all. So you get two or three cases  
 2 in the home and you had to test everybody and you  
 3 wouldn't have known that half of them were positive.  
 4 MR MCCORMICK: I think there was a lot of difficulty during  
 5 the pandemic, though, with established NHS procedures  
 6 and how to deal with them in a different scenario. So  
 7 things like -- you talk about oxygen. There was lots of  
 8 consideration of, "We've got all these various rules in  
 9 place. Can we throw them out or how do we go around  
 10 that?". And I think it took a long time for a lot of  
 11 those to work their way through the system as well,  
 12 yeah.  
 13 MS BAHRAMI: Thank you. Now, in a section of the statement  
 14 on page 13, it says that black bags were being used for  
 15 gathering people's belongings after they died. We heard  
 16 from relatives last year who were quite upset by this.  
 17 They weren't a fan of those bags being used. What had  
 18 been your practice before the pandemic and did the  
 19 guidance require you to use a single-use bag for  
 20 belongings?  
 21 MS LAING: So pre-pandemic families would normally come into  
 22 the home and they would pack up belongings and take what  
 23 they wanted to take and have time with their families to  
 24 do that. Certainly during the pandemic they weren't  
 25 allowed to come in to do that, so I think each home

1 would have used -- I don't know about the bag comment --  
 2 but certainly I know from our home, if we had boxes or  
 3 things, we would just box it up -- or suitcases -- and  
 4 put it into that. But the guidance, if I remember  
 5 correctly, would have said that it had to be put in  
 6 a bag of some description for infection, I should  
 7 imagine.  
 8 MS RODGERS: Because it had to be single use so they could  
 9 take these things home and isolate them for 72 hours  
 10 before they did anything with them in case there was --  
 11 in case there was infection on them. There wasn't  
 12 really very much that we could do. We weren't allowed  
 13 to let the people in to come and clear the room.  
 14 MR MCCORMICK: I think that's the fundamental thing,  
 15 isn't it? In the past people would come in and collect  
 16 belongings, et cetera, and for a period of the pandemic  
 17 that was just entirely stopped.  
 18 MS RODGERS: And it was awful actually, you know, just  
 19 handing people's belongings over at the door. It's not  
 20 a very nice feeling at all.  
 21 MS BAHRAMI: But it's not something you were choosing to do.  
 22 MS RODGERS: Absolutely not.  
 23 MS BAHRAMI: You were obliged to do that.  
 24 Moving on to visitation, your care homes locked down  
 25 prior to the national lockdown. Were you --

1 MR MCCORMICK: I think there was a difference between the  
 2 different care homes.  
 3 MS BAHRAMI: Was there? Okay.  
 4 MR MCCORMICK: Yeah.  
 5 MS BAHRAMI: So which of your care homes locked down sooner  
 6 and which didn't and why was there that difference?  
 7 MR MCCORMICK: In Randolph Hill we didn't choose to lock  
 8 down sooner. I think Scottish Care had put a notice out  
 9 a couple of weeks ago suggesting -- a couple of weeks  
 10 before -- I don't think it was saying that you had to  
 11 lock down but it was suggesting that it might be an  
 12 idea. I think in our internal discussions we felt that  
 13 visiting was so important, we were frankly hoping that  
 14 it wouldn't actually come to this. So we locked down as  
 15 a company when we were mandated to -- you know, when the  
 16 UK Government and then the Scottish Government announced  
 17 that we had to do that, yeah.  
 18 MS LAING: And we didn't fully lock down prior to the  
 19 national lockdown but we did start to scale back some of  
 20 our entertainers. And the visiting, as in family  
 21 members and things, we didn't scale that down until it  
 22 was the national lockdown and we were told we had to.  
 23 But in terms of other people coming in, sort of your  
 24 hairdresser or musicians, we did start to try to scale  
 25 that back a little bit earlier along with the visiting

1 children, just to try and help really.  
 2 MS BAHRAMI: Thank you. Did your care homes lock down  
 3 sooner?  
 4 MS RODGERS: We were part of Peter's group so we did it when  
 5 we had to.  
 6 MS BAHRAMI: Okay. When things moved on and garden visits  
 7 started, how did you find managing those actually?  
 8 MS RODGERS: We just had to be very adaptable. We had to  
 9 redeploy staff to be guards, to make sure that the  
 10 people who were coming in were tested and that they  
 11 weren't getting too close because, if we got an  
 12 outbreak, it would be because we didn't manage it  
 13 properly, which was -- we were very fearful of that,  
 14 that if we got an outbreak it might be construed that we  
 15 weren't being vigilant enough whereas -- but the garden  
 16 visits, they worked really well actually to start with  
 17 because people were so happy to see each other.  
 18 MS CURRIE: I think as well, the garden visits, because they  
 19 were outside, I think it felt to the relatives a little  
 20 bit more relaxed rather than being stuck in a room face  
 21 to face. It was outside and -- yeah, I agree, the  
 22 garden visits worked well. The relatives were just so  
 23 happy to see their loved ones.  
 24 MS BAHRAMI: Was then moving on to indoor visits more  
 25 demanding of your time, resource?

1 MS RODGERS: Very much so. It was a bit like  
 2 a hairdresser's booking sheet. We couldn't have too  
 3 many visitors in at the same time, so people were  
 4 ringing up to book a half-hour slot and they had to test  
 5 before they came in and not --- and wear a mask, going to  
 6 the room, around the building. But, to be honest,  
 7 people were very, very kind to us and very compliant and  
 8 they just went with the flow. As long as they were kept  
 9 informed --- we did big group emails and --- like to tell  
 10 everybody what was going on. But, yes, so we had  
 11 visiting co-ordinators and people who --- and some of our  
 12 visitors weren't able to test themselves, so elderly  
 13 people, you know, coming to visit brothers and sisters,  
 14 so they would take them into a little room and make sure  
 15 that they weren't infectious before we let them in.  
 16 MR MCCORMICK: I suppose most people were happy to see  
 17 visiting opening up so that would be the general idea,  
 18 but, again, some of the things we talked about earlier  
 19 were definitely issues. People were taking their own  
 20 interpretation of what the rules were and not everyone  
 21 was --- not every visitor was happy.  
 22 MS RODGERS: No.  
 23 MR MCCORMICK: There were various times when people were  
 24 very unhappy and we had to in effect police the system,  
 25 which is not a role we'd have wanted to do.

1 MS RODGERS: A few visitors who were very anti-vax or  
 2 anti-mask and we were like, "This is what we've got to  
 3 do. You can't come in unless you do".  
 4 MS BAHRAMI: How did you interpret or deal with essential  
 5 visits and end-of-life visits and did you have a lot of  
 6 push-back from relatives?  
 7 MS RODGERS: We interpreted essential visiting when it was  
 8 allowed, something --- it's not always end of life  
 9 because, if someone is in a very distressed state and  
 10 very confused, very not well, I would interpret that as  
 11 an essential visit --- if it's for the benefit of the  
 12 resident who is distressed, not just dying.  
 13 MS LAING: Yeah, I would agree. The essential visiting, in  
 14 some ways, because it wasn't particularly well defined,  
 15 was an easy way around being able to let families come  
 16 in because you would say, "It's an essential visit and  
 17 people's mental health is just as important". So all  
 18 residents' mental health was impacted during the  
 19 pandemic, so when we were able to have essential visits,  
 20 we would say, "It's an essential visit for their mental  
 21 health because they're feeling down. They haven't seen  
 22 their family". But, again, I think everyone's  
 23 interpretation of it was different, but it did mean you  
 24 could have people coming in.  
 25 MS BAHRAMI: Thank you. How did you find balancing the

1 requests or demands of those who wanted more  
 2 restrictions put in place to safeguard their loved ones  
 3 with the requests or demands of those who wanted more  
 4 flexibility to spend time with their loved ones?  
 5 MS LAING: I don't really think we had anybody who wanted  
 6 more restrictions ---  
 7 MS RODGERS: Yeah, we didn't either.  
 8 MS LAING: --- for their loved ones. They just wanted to  
 9 come in to see them and for their lives to go back to  
 10 the way they were before, I would say.  
 11 MS CURRIE: Yeah, we were the same. We never had anybody  
 12 that wanted more restrictions. It was --- they were  
 13 begging us to ease the restrictions.  
 14 MR MCCORMICK: I was going to say, I think there were a few  
 15 people who we encountered who --- they weren't  
 16 particularly asking for more restrictions but you could  
 17 see in their actions that they were looking to be as ---  
 18 take as little risk as possible. So there were some  
 19 people throughout the group who continued to do window  
 20 visits after visits in the home were allowed. They were  
 21 probably a minority and they're generally quite a quiet  
 22 minority, but I think we just need to be a little bit  
 23 careful we don't forget about them entirely. But  
 24 I think by and large most of us in the public as well as  
 25 most people with relatives in care homes were looking,

1 you know, for restrictions to be lifted as soon as it  
 2 was practical.  
 3 But, as I say, I do think we were a bit slow in  
 4 lifting the restrictions within the care home sector.  
 5 I think we all had more freedom to act in our own sort  
 6 of personal lives, particularly in the summer of 2020,  
 7 than nursing home residents and their families did.  
 8 They were faced with restrictions that lasted longer,  
 9 more burdensome restrictions, and things that most of  
 10 the rest of us didn't encounter.  
 11 THE CHAIR: You've got ten minutes, Ms Bahrami.  
 12 MS BAHRAMI: Thank you, my Lord.  
 13 My Lord, I think we started ten minutes later than  
 14 scheduled. May I be permitted to ---  
 15 THE CHAIR: You may be right. I don't know. Do you know by  
 16 any chance? All right. I didn't pay any attention.  
 17 MS BAHRAMI: Thank you, my Lord.  
 18 I want to move on to testing. On page 8 it's stated  
 19 that it took three or four months for a testing regime  
 20 to be fully put into place. During that time, did the  
 21 lack of testing lead to any issues? Did it add to  
 22 anxiety and concerns for either residents, staff or  
 23 families?  
 24 MS RODGERS: The staff team, they were very reticent.  
 25 Nobody is used to testing themselves, even us as nurses,

1 so it became very onerous because we felt we were  
 2 required to prove that all the staff were testing when  
 3 they should be testing so it was --- and then recording  
 4 because the powers that be can go on to Turas and have  
 5 a look at --- well, not Turas. It was something else,  
 6 wasn't it? --- to look and see that people are being  
 7 regularly tested, so we did feel under scrutiny; "Have  
 8 you tested? Have you tested?", every day.  
 9 MR MCCORMICK: I think it's difficult to look back --- we're  
 10 looking back more than three years now, but I think in  
 11 the early stage, I think everyone was quite worried  
 12 about COVID and the risk of catching it. As you said  
 13 earlier, we're all going into work every day and meeting  
 14 far more people in that environment than most of the  
 15 rest of the population were. So I think it was a worry  
 16 in the early stage that there wasn't --- that there  
 17 wasn't testing available.  
 18 I think it's difficult to be critical because this  
 19 was a new --- it took time for all this to fall into  
 20 place. I think, if you look back, the fact it took  
 21 three-odd months was probably not --- was surprisingly  
 22 good actually. But nevertheless in that period of time  
 23 everyone I think felt very exposed.  
 24 I mean, we bought 50 tests as a company early on and  
 25 we hardly used any of them because it was quite clear

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1 that --- it cost £5,000, I'm not sure we could have got  
 2 more, but we brought them in as a precaution. But we  
 3 soon realised that actually the only effective way to  
 4 use them --- we'd have used all of them overnight frankly  
 5 and then it would have given us a momentary --- it was  
 6 600 employees, 50 tests --- it would have given  
 7 a momentary snapshot of something and then nothing  
 8 thereafter.  
 9 MS RODGERS: In our environment, if any of the staff were  
 10 unwell, we had to phone up and book an appointment to go  
 11 to an external --- the drive-through and get our nose  
 12 poked and then wait for the result, and if we weren't  
 13 positive then we could go to work and if we were,  
 14 obviously we couldn't. So once the test kits came  
 15 through, that made everything much more simple for us.  
 16 We could just test ourselves.  
 17 MS BAHRAMI: Yeah. And on page 9 in relation to transfers  
 18 from hospital, it stated that the NHS was not as  
 19 rigorous in testing patients as they should have been.  
 20 Could you expand on that?  
 21 MS RODGERS: People were being discharged without --- we had  
 22 to ensure that they were --- to say, "We will not accept  
 23 them unless they've had a negative COVID test". So it  
 24 wasn't so much that they weren't being rigorous. You  
 25 just had to remind them all the time.

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1 MS BAHRAMI: Okay, because there was a possibility that they  
 2 would discharge someone without a test?  
 3 MS RODGERS: Yes.  
 4 MR MCCORMICK: I think you have to remember that everyone  
 5 else has their own pressures. We see that all the time.  
 6 Even in the current environment hospitals are looking to  
 7 discharge patients because they need the space for other  
 8 people and the people in the social work departments are  
 9 under pressure to move these people from hospital into  
 10 care homes or into another environment, and I think that  
 11 continued throughout the pandemic. I think there were  
 12 multiple instances where a discharge was arranged and  
 13 you would speak to the hospital and say, "Have you done  
 14 the test?", and I think there were instances where you  
 15 were told they had and, when you asked for evidence,  
 16 they didn't have it and so we had to wait a couple of  
 17 days until the test came through. There were other  
 18 examples where they would say, "Oh, no, we haven't done  
 19 it", and they went and did it.  
 20 It's quite difficult to pin that down from this  
 21 point of view, what percentage that was, but it  
 22 undoubtedly happened. I mean, does anyone --- yeah, so  
 23 it undoubtedly happened, both from within our group and  
 24 from other care home operators I spoke to. I doubt you  
 25 could find many care homes that wouldn't have said they

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1 didn't find individual examples of this happening.  
 2 I think, apart from the risk of passing the virus,  
 3 we felt we were under a microscope with the various  
 4 people coming in and inspecting us. They would have  
 5 criticised us quite heavily if we'd knowingly brought  
 6 somebody in without a test regime being followed  
 7 through, and yet, just as we said there, it was not  
 8 followed as rigorously as it should have been.  
 9 MS BAHRAMI: And that added pressure to your work ---  
 10 MR MCCORMICK: It added pressure and it added a huge degree  
 11 of risk for all the residents and all the people working  
 12 in the care home.  
 13 THE CHAIR: You've actually got 11 minutes. I'm sorry to  
 14 steal three minutes from you, but at 11.22 the  
 15 stenographer's 90 minutes will run out. Sorry to hassle  
 16 you.  
 17 MS BAHRAMI: No, thank you. On page 23 you state that you  
 18 had to advise three organisations of a positive and  
 19 subsequent negative test. Which organisations were  
 20 these and why did you have to notify them separately?  
 21 Could they not create a system?  
 22 MS RODGERS: No, it wasn't all joined up. So for each  
 23 positive COVID test for each resident and each member of  
 24 staff, we had to inform the Care Inspectorate, the  
 25 Edinburgh Health and Social Care Partnership and

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1 Health Protection. Then, when they had completed their  
 2 isolation period and were no longer deemed positive, we  
 3 had to notify again to close that notification, so the  
 4 dates of a positive test and then the dates when the  
 5 isolation ended. It was very onerous.  
 6 MS LAING: And that was the same in Perth and Kinross.  
 7 Although we're two different areas, there was the same  
 8 process.  
 9 MR MCCORMICK: I think this is very much par for the course  
 10 for the sector. Prior to the pandemic, we already had  
 11 situations like that around adult support and  
 12 protection. From our point of view, you would have  
 13 thought, if we were informing the Care Inspectorate and  
 14 it needed to be notified to the local social work  
 15 department, the local health department, they would have  
 16 a system that allowed that to happen. But prior to the  
 17 pandemic, that wasn't the case and then, during the  
 18 pandemic, with COVID tests, equally that was the same  
 19 thing. We weren't able to inform one part of the public  
 20 sector that would share that information. It had to be  
 21 done — and often they would ask the same question but  
 22 slightly differently as well. It wouldn't be — it  
 23 wouldn't be a matter of just filling out one form and  
 24 sending it to three different people. You'd have to do  
 25 it in three different ways.

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1 MS RODGERS: We still have to do a daily notification now  
 2 and declare any COVID cases, but that's just become  
 3 routine. It was something we didn't have before the  
 4 pandemic and it's been set up and we have to — we do  
 5 that routinely every day now.  
 6 MS BAHRAMI: I want to move on briefly to PPE. Three of you  
 7 give accounts that you experienced no issues in  
 8 obtaining sufficient PPE but one of you give an account  
 9 that you struggled at the outset.  
 10 MS RODGERS: Yes.  
 11 MS BAHRAMI: Can you tell us what factors contributed in you  
 12 being either able to source PPE readily or struggling  
 13 with that?  
 14 MS LAING: I think we were quite lucky that we were able to  
 15 source a lot of PPE. Our property manager for the group  
 16 had went and sourced all this before the lockdown had  
 17 actually come into force, so, yeah, we were really quite  
 18 fortunate that they were able to get all that. And  
 19 I guess maybe as well — you guys are Edinburgh City  
 20 Centre. We're quite rural so maybe there wasn't the  
 21 same demand where I was potentially as what there would  
 22 have been to here.  
 23 MS RODGERS: Yeah, we don't routinely — before the pandemic  
 24 we wouldn't have routinely kept lots of mask. Obviously  
 25 other PPE, gloves and aprons, we wear all the time, but

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1 masks were quite difficult to get at the very beginning,  
 2 but once we got them, then there was a good supply.  
 3 MR MCCORMICK: I think like a lot of the things that we're  
 4 talking about here, it was the first three months that  
 5 were really very, very difficult. Prior to the  
 6 pandemic, as Mandy said, we would use gloves and aprons  
 7 and other bits of PPE. We generally didn't use masks —  
 8 MS RODGERS: Not often.  
 9 MR MCCORMICK: — very frequently. When the pandemic came  
 10 in, suddenly there was changes in rules that we had to  
 11 use all of these items far more frequently than we did  
 12 before, and we all remember the television reports. You  
 13 know, there was — most of these things, for good or  
 14 ill — and it certainly caused a problem at this time —  
 15 most of these things are made in the Far East and they  
 16 were being swamped by demand from not just us, the whole  
 17 world frankly, and so it was very hard to mouth in the  
 18 first three months. We never actually ran out of PPE,  
 19 but we were often worried — you know, we'd often be  
 20 sitting here on a Monday thinking delivery was due on  
 21 a Thursday and nobody was quite sure whether it was  
 22 going to turn up, that type of thing.  
 23 You know, the production of all this stuff ramped up  
 24 quite quickly, so after three months it really fell away  
 25 as being a day-to-day problem, but at the beginning it

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1 felt like it was just a constant worry. I think earlier  
 2 on alcohol gel had never been used in such volumes  
 3 either, and earlier on in the pandemic the people who  
 4 made alcohol gel had all furloughed their staff and then  
 5 they started bringing them back once they were told,  
 6 "No, you need to be back", but actually the next thing  
 7 that happened is that the people who made the bottles  
 8 had also furloughed their staff and nobody got them to  
 9 come back, et cetera. So there was — so it just  
 10 took — it took a little bit of time to settle and in  
 11 that first three months I think it was very much — it  
 12 wasn't so much that we ran out but it was a huge worry  
 13 about where we would get things. And there were certain  
 14 things that we frankly never used before, like visors,  
 15 and we got them from — I think it was  
 16 Edinburgh University, one of their departments made  
 17 them, until they became — until they started —  
 18 MS RODGERS: Yes, and there was a company in  
 19 Northern Ireland that used to make blinds and they  
 20 started making visors instead and we got some cases sent  
 21 over from them. It was just getting them where you can  
 22 find them. Eventually there was a rolling programme and  
 23 actually the Health and Social Care Partnership had  
 24 a hub where you could just phone up and you could get  
 25 supplies really easily, but at the beginning it was sort

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1 of quite difficult .  
 2 MR MCCORMICK: I suppose one of the things as well --- and  
 3 I think this came from one of your comments in your  
 4 statement earlier, Mandy --- is, you know, the PPE we  
 5 used at the end of the pandemic was quite different to  
 6 the PPE we used at the beginning. So, I mean, guidance  
 7 changed across that period, but I think the level of  
 8 protection that was offered later on with the things  
 9 that people were using was more. So earlier on people  
 10 were probably more exposed to the risk of catching it.  
 11 THE CHAIR: Five minutes.  
 12 MS BAHRAMI: Thank you, my Lord.  
 13 And what challenges did you face when you had to  
 14 wear extensive PPE? At points I understand you had to  
 15 wear shoe coverings and gowns and masks, visors and ---  
 16 MS CURRIE: I think for the care staff, during, for  
 17 instance, personal care, where you're helping  
 18 a resident, for instance, shower, it would be quite  
 19 dangerous for staff because you had the shoe coverings,  
 20 you had a wet floor, you were slipping, steam from the  
 21 shower was in your visor so you couldn't really see that  
 22 well, which posed a risk to you and your resident. Also  
 23 putting on and off the PPE took a lot of time, and  
 24 I think especially, for instance, if you went into  
 25 somebody's room and they were maybe being sick and you

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1 were having to then rush and get all this PPE on and  
 2 things like that, it did take that little bit of time  
 3 and was quite a stress for the staff as well.  
 4 MR MCCORMICK: I think, as Mandy said earlier, imagine that  
 5 from the resident's point of view, particularly somebody  
 6 with dementia, where it's quite difficult to explain why  
 7 somebody is coming in almost looking like a spaceman at  
 8 times.  
 9 MS RODGERS: Yeah. Care homes are warm places. They have  
 10 to be nice and cosy for the residents. If you're  
 11 working a 12-hour shift and you're expected to wear  
 12 a mask the whole time --- so we were saying to staff, "Go  
 13 and take five minutes. Go outside, get some fresh air,  
 14 take your mask off", because it's unreasonable to expect  
 15 people to work in those circumstances without some  
 16 respite from it.  
 17 MS BAHRAMI: I'm very conscious of time and there are  
 18 certain things that I would have liked to cover more if  
 19 we had more time, so at this point really is there  
 20 anything that we haven't covered that you would like to  
 21 comment on?  
 22 MS RODGERS: There's one thing I would like to say and it's  
 23 that we found, where our nursing home is, that the  
 24 support of the local communities was invaluable to us.  
 25 We were very, very well treated, and people leaving

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1 presents on the doorstep for us, local bakery --- people  
 2 who couldn't work --- the local wagon who does the bacon  
 3 rolls in the morning were sending us round our  
 4 breakfast, children sending letters to the residents and  
 5 drawing pictures. And I don't think --- it was really  
 6 surprising. They would watch us going into work and  
 7 coming out and it was nice to know that they were  
 8 thinking about us.  
 9 MS CURRIE: I guess I would just like to say, for all  
 10 working through the pandemic was absolutely horrific and  
 11 will never ever leave me, I think the support of the  
 12 staff and the camaraderie and things like that, the  
 13 teamwork, it really shone through. As well for the  
 14 residents, what the staff done, outwith their working  
 15 time, stayed behind, sat with residents and supported  
 16 them, that was a highlight.  
 17 MS LAING: I think for me it would be that, if anything was  
 18 going to be learned, that people's mental health and  
 19 well-being is considered. I don't think initially that  
 20 it was, and people's relatives weren't treated as carers  
 21 and they are their carers. They should have been able  
 22 to come in right from the offset and I think that would  
 23 have helped a lot with the residents' mental health and  
 24 well-being throughout the pandemic as well because they  
 25 were just so lonely and so isolated, despite the staff's

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1 best efforts, and regardless of whether they had COVID  
 2 or became ill or not, they've never really regained the  
 3 same people that they were before that because they just  
 4 lost years of their life really.  
 5 MR MCCORMICK: I think, as everyone says, you know, there  
 6 was a lot of pulling together, there was a lot of  
 7 camaraderie and I think that was very positive in a very  
 8 difficult situation. I do think though it felt within  
 9 the sector it could be quite --- it flipped quite a lot.  
 10 At times you were praised for various things and then at  
 11 other times there was quite a lot of criticism, and  
 12 I think an awful lot of that wasn't with the full facts.  
 13 MS BAHRAMI: Thank you very much.  
 14 THE CHAIR: Yes, thank you all very much indeed. I'm very  
 15 grateful for your time and effort. Can I just say at  
 16 this stage, I'm very sorry that you can't have as long  
 17 as you might actually wish. I can only say that applies  
 18 to everybody. You will probably appreciate that we have  
 19 an enormous amount of material to listen to or hear and,  
 20 frankly, if we gave everyone as much time as they think  
 21 might be optimum, then we would never finish this  
 22 Inquiry, so we have to ration your time, but all you  
 23 have given to us in writing will all be considered as  
 24 well.  
 25 Thank you all very much.

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1 About 25 to 12.  
 2 MS BHRAMI: Thank you.  
 3 (11.22 am)  
 4 (A short break)  
 5 (11.37 am)  
 6 MS LISSA DI GIACOMO and MR SCOTT FINNIGAN (called)  
 7 Questions by MR STEPHEN  
 8 MR STEPHEN: Can I start by asking you to confirm your full  
 9 names, please?  
 10 MS DI GIACOMO: Lissa Di Giacomo. I'm a director with  
 11 Oakminster Healthcare.  
 12 MR FINNIGAN: Scott Finnigan, group general manager with  
 13 Thistle Healthcare.  
 14 MR STEPHEN: Thank you. Your age and contact details are  
 15 both known to the Inquiry so I won't ask you those.  
 16 Together you've helpfully provided a comprehensive  
 17 written witness statement already, and for the reference  
 18 the Inquiry reference number for that is  
 19 SCI-WT0423-000001. Are you both happy for that written  
 20 statement and the oral evidence you give today to  
 21 constitute your evidence to the Inquiry?  
 22 MR FINNIGAN: Yes.  
 23 MS DI GIACOMO: Yes.  
 24 MR STEPHEN: And you're happy for that evidence to be  
 25 recorded and published?

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1 MR FINNIGAN: Yes.  
 2 MR STEPHEN: I should say also that everything you say in  
 3 the statement and indeed today will be taken into  
 4 account, and even if we don't touch on something in your  
 5 oral evidence today, we will have it in writing, so  
 6 don't worry, the Inquiry will have in regard to that.  
 7 Finally, in terms of housekeeping, I would remind you  
 8 about the restriction order that is in place. Please  
 9 don't name other individuals when you are giving your  
 10 evidence today. If it's a staff member, just refer to  
 11 them as such, or a relative, without naming names. Is  
 12 that clear? Thank you very much.  
 13 Lissa, I think you just said a moment ago your  
 14 current position is managing director of Oakminster  
 15 Healthcare Limited; is that right?  
 16 MS DI GIACOMO: Yes.  
 17 MR STEPHEN: How long have you held that position for?  
 18 MS DI GIACOMO: About eight years.  
 19 MR STEPHEN: And how many care homes does Oakminster operate  
 20 in Scotland?  
 21 MS DI GIACOMO: Five.  
 22 MR STEPHEN: And how many residents roughly?  
 23 MS DI GIACOMO: About 330.  
 24 MR STEPHEN: And how many staff do you have operating?  
 25 MS DI GIACOMO: About 340.

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1 MR STEPHEN: In what part of Scotland, the geographical  
 2 area, roughly are these homes, the five homes you  
 3 mentioned?  
 4 MS DI GIACOMO: Glasgow. They are within about a ten-mile  
 5 radius of each other, of Glasgow City Centre.  
 6 MR STEPHEN: Similar questions for you, Scott. I understand  
 7 you're group general manager, operations and quality  
 8 improvement, for Thistle Healthcare Limited.  
 9 MR FINNIGAN: Yes.  
 10 MR STEPHEN: How long have you held that position for?  
 11 MR FINNIGAN: Seven years.  
 12 MR STEPHEN: How many care homes does Thistle operate?  
 13 MR FINNIGAN: Seven care homes under Thistle and three  
 14 associated care homes.  
 15 MR STEPHEN: Again, in what part or parts of Scotland are  
 16 those homes located?  
 17 MR FINNIGAN: The central belt, mostly Lanarkshire area, but  
 18 one in Glasgow and one in Dundee.  
 19 MR STEPHEN: How many residents fall under the care of those  
 20 homes?  
 21 MR FINNIGAN: 750 approximately.  
 22 MR STEPHEN: And how many staff?  
 23 MR FINNIGAN: Between 900 to 1,000.  
 24 MR STEPHEN: If I understand correctly, what would you say  
 25 is the make-up of your resident population in terms of

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1 age and their needs? How would you describe that, if  
 2 you can?  
 3 MR FINNIGAN: Mostly elderly. We have three services which  
 4 are alcohol-related brain damage services, so they're  
 5 usually younger adults in their 40s/50s, but the  
 6 majority of our population is elderly.  
 7 MR STEPHEN: Okay, and in your case?  
 8 MS DI GIACOMO: Mainly frail and elderly. We have a couple  
 9 of YPD units for young physically disabled and we have  
 10 two intermediate care units which are for discharges  
 11 from hospital and it's sort of an assessment  
 12 rehabilitation unit for 28 days while they go on their  
 13 onward journey either to another care home or back home  
 14 or to sheltered accommodation.  
 15 MR STEPHEN: Okay. Thank you. Now, if I understand  
 16 correctly, those two distinct care home operating  
 17 businesses, Oakminster and Thistle, plus another one,  
 18 Keane Premier Group Limited, together they form Central  
 19 Scotland Care Homes, the group that you represent today?  
 20 MR FINNIGAN: Yes.  
 21 MS DI GIACOMO: Yes.  
 22 MR STEPHEN: Thank you. I just want to ask you a question  
 23 now about pre-pandemic. In the witness statement at  
 24 paragraph 14, it talks about your members championing  
 25 a person-centred approach to care. I just wanted to ask

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1 you what that means, what that is.  
 2 MS DI GIACOMO: "Person-centred" is having the resident at  
 3 the heart of all the decision-making process to enable  
 4 them, empower them, include them to have their own voice  
 5 and be in control. So really, if any of us were about  
 6 to go into a care home, it's about what's important to  
 7 us, what matters.  
 8 MR STEPHEN: Okay. And before the pandemic what was your  
 9 members' policy on visiting those homes?  
 10 MS DI GIACOMO: We were open -- it was free access. The  
 11 only stipulation we'd put, we tried to protect the  
 12 mealtimes for residents, so we discouraged any  
 13 visitation at a mealtime, but other than that they could  
 14 come in freely.  
 15 MR STEPHEN: Okay. That takes us then to the initial  
 16 lockdown. Can I ask you to cast your minds back?  
 17 Lissa, I understand that Oakminster locked down its  
 18 homes on 12 March 2020; is that right?  
 19 MS DI GIACOMO: Yes.  
 20 MR STEPHEN: And Scott, for Thistle, I think that followed  
 21 one day later. Is it 13 March?  
 22 MR FINNIGAN: Yes.  
 23 MR STEPHEN: So that was around roughly ten days, I think,  
 24 prior to national lockdown, as you say in the witness  
 25 statement. Why was that decision taken to lock down

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1 earlier?  
 2 MS DI GIACOMO: For me, I remember watching the news and  
 3 seeing army trucks towing in Italy -- my family is  
 4 Italian -- and I saw them carrying bodies, deceased  
 5 bodies, from the villages, and I thought, "We are  
 6 looking after and protecting the most vulnerable of our  
 7 society". I didn't see it getting any better and  
 8 thought we should close our doors until we understand  
 9 more fully what we're dealing with and how we can best  
 10 protect them.  
 11 MR FINNIGAN: Yeah, I think a similar situation for us.  
 12 I think it was in the absence of any sort of guidance or  
 13 advice on what we should be doing at that time. We were  
 14 seeing numbers increasing of the virus and some  
 15 outbreaks in some of the care homes. We were having  
 16 relatives asking us, "What's the plans? What's youse  
 17 doing?", or we were being asked by Health and Social  
 18 Care Partnerships to provide contingency plans and how  
 19 we were going to maintain people's well-being and  
 20 safety. So I think, in the absence of any official  
 21 guidance at that time, we took the decision that we  
 22 thought it would be safer to lock down on the 13th.  
 23 MR STEPHEN: So those decisions were taken on 12 and  
 24 13 March. How quickly were those decisions implemented?  
 25 MR FINNIGAN: We tried to implement them as quickly as

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1 possible. Certainly on that day that we made the  
 2 decision, the 13th, we issued communications to  
 3 relatives and councils and the Care Inspectorate and  
 4 started phoning families to say that that's the decision  
 5 that we had made at that time.  
 6 MS DI GIACOMO: And we were the same. We put notices on the  
 7 door. We contacted families, our regulatory body and  
 8 let them know that we were closing the doors.  
 9 MR STEPHEN: Scott, you mentioned attempting to contact the  
 10 families.  
 11 MR FINNIGAN: Yes.  
 12 MR STEPHEN: By what means or methods was that done?  
 13 MR FINNIGAN: That was done by various methods, email  
 14 communication, telephone. We tried to telephone  
 15 everybody. That's not always possible for various  
 16 reasons, but we made that attempt to contact everybody  
 17 by telephone and we sent out written communication about  
 18 that as well.  
 19 MR STEPHEN: Did all families receive those communications?  
 20 MR FINNIGAN: They did all receive them. I think inevitably  
 21 there were some instances where some relatives didn't  
 22 get that communication straightaway, and that's for  
 23 various reasons. We have -- usually have one or two  
 24 relatives that's the main contact and they perhaps  
 25 didn't get through to passing the information on or that

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1 was a relative that we just hadn't managed to get on the  
 2 phone yet.  
 3 MR STEPHEN: What was the reaction of families that --  
 4 I appreciate it's a broad generalisation, you have a lot  
 5 of residents to look after, but what was the general  
 6 reaction of families to the decisions that you'd taken?  
 7 MR FINNIGAN: The general reaction at that time was okay.  
 8 People felt uncomfortable, I think, but I think they  
 9 felt that it was the safest option and it was the right  
 10 thing to do at that time and, as I say, we were getting  
 11 questions from lots of relatives about, "Is it safe?  
 12 Is it still safe for us to come in? What should we be  
 13 doing?". So I think there was -- at the beginning there  
 14 was a lot of understanding from relatives about wanting  
 15 to protect their relative in a care home.  
 16 MR STEPHEN: Was that the same for --  
 17 MS DI GIACOMO: Yeah, by far it was. Most of them were  
 18 understanding -- understanding the thinking process  
 19 behind it and we just wanted to protect the residents.  
 20 MR STEPHEN: Thank you. I'd like to move on now to the  
 21 effect that had on your residents. So during this  
 22 initial lockdown period, how did the care arrangements  
 23 for your residents change? We talked at the beginning  
 24 about the person-centred approach. How did that change  
 25 when lockdown kicked in?

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1 MR FINNIGAN: I think the change at that time was just the  
 2 visitation because normal care home life, apart from the  
 3 visitation, was resuming. People were still spending  
 4 time in communal areas and kind of going about daily  
 5 care home life. So I think the biggest impact for that  
 6 was about contact with families at the actual stages.  
 7 MS DI GIACOMO: Yeah, it was the same for us.  
 8 MR STEPHEN: Do I take from that, then — where were  
 9 residents located then when lockdown happened? Before  
 10 I think you mentioned about them sort of moving around.  
 11 MR FINNIGAN: Yeah.  
 12 MR STEPHEN: Did that change as a result of lockdown?  
 13 MR FINNIGAN: That changed — from our perspective that  
 14 changed when the guidance changed, when we had the  
 15 official guidance to say that people should — you  
 16 should try and keep people in their rooms 2 metres  
 17 apart, that sort of thing. But up until that point we  
 18 just took the decision to stop visiting. We didnae stop  
 19 anything else.  
 20 MR STEPHEN: And in terms of the activities or social events  
 21 that you would normally have run in your homes, one  
 22 assumes, did that alter at all when lockdown kicked in?  
 23 MR FINNIGAN: In lockdown ...? Sorry.  
 24 MR STEPHEN: When lockdown started, how did that impact?  
 25 MR FINNIGAN: What was different was outside. So, like,

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1 entertainment coming in, we obviously werenae going to  
 2 allow outside entertainment to come in if we weren't  
 3 allowing visitation, so — but in terms of the daily  
 4 things that the staff had already been doing, all of our  
 5 services have got activity co-ordinator staff so that  
 6 would have continued until the guidance to social  
 7 distance came in.  
 8 MS DI GIACOMO: Yeah, and it would have been the same for  
 9 us. We have well-being enablers and we brought actually  
 10 our "living our values" enabler in especially in terms  
 11 of supporting the staff through that period and helping  
 12 keeping the activities in the home and supporting the  
 13 staff — the care staff on the floor to keep that sort  
 14 of camaraderie there so it didn't impact them, because  
 15 we have supportive links with the community and the  
 16 entertainment and visitors that would normally come into  
 17 the home couldn't.  
 18 MR STEPHEN: Yes. I think you give specific examples of  
 19 this, for example, in daily care of the residents.  
 20 Things like hairdressers, for example, I assume that no  
 21 longer occurred?  
 22 MS DI GIACOMO: No.  
 23 MR FINNIGAN: No.  
 24 MS DI GIACOMO: The carers and managers at times —  
 25 MR FINNIGAN: Yeah, stepped in.

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1 MS DI GIACOMO: — stepped in to help.  
 2 MR STEPHEN: What was the position as regards external  
 3 medical visits from general practitioners, for example?  
 4 How did that change?  
 5 MR FINNIGAN: From our perspective that changed  
 6 dramatically — varying degrees to be fair. There was  
 7 some services where all visitation just stopped, so you  
 8 didnae see a medical professional. It was all telephone  
 9 assessments. There was some services where the GPs'  
 10 surgery was very proactive and was still in visiting  
 11 people. But I would say in the majority of cases it  
 12 kind of moved to telephone assessment.  
 13 MS DI GIACOMO: And it was the same for us. One of our  
 14 homes, the service continued. The GP was tremendously  
 15 supportive and came in and they formulated a system  
 16 between them so that the time the GP spent in the home  
 17 was more specific and more organised, if you like, and  
 18 then in other services they didn't come in at all. It  
 19 was telephone consultations.  
 20 MR STEPHEN: And with those telephone consultations, did you  
 21 find those to be an adequate or similar substitute for  
 22 the physical version?  
 23 MR FINNIGAN: I don't think there's any substitute for  
 24 physical assessment when we're phoning saying that  
 25 there's somebody that's unwell. I think, especially if

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1 we're using agency staff and it's agency staff who is  
 2 phoning the GP about a resident who disnae seem to be  
 3 well for various reasons, that can be quite difficult  
 4 when they don't know that resident and they're trying to  
 5 relay information to the GP. So I think that physical  
 6 assessment being missing had a huge impact.  
 7 MR STEPHEN: Were there any alternatives that your care home  
 8 explored? You mentioned mucking in, whether it was  
 9 hairdressing, daily care, anything else you tried to do  
 10 to engage the residents, socially or otherwise, within  
 11 the limits of what you were allowed to do.  
 12 MR FINNIGAN: I think the teams and the services tried  
 13 everything that they could. There was times where there  
 14 was — we had bingo going on, for example, but everybody  
 15 was at their bedroom doors. That works to varying  
 16 degrees and obviously that depends on the ability of  
 17 residents to be able to participate in that kind of  
 18 forum. Unfortunately a lot of the people we support are  
 19 living with cognitive impairment so that in itself  
 20 presents a lot of different challenges in terms of  
 21 trying to facilitate anything that would have been  
 22 normal life.  
 23 MR STEPHEN: Just to be clear, I think when testing became  
 24 possible, what was the procedure in your homes if one of  
 25 your residents was to be tested positive for COVID?

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1 What would be the procedure that would then follow?  
 2 MS DI GIACOMO: To try and isolate them, to keep them in  
 3 their room and barrier—nurse them in terms of looking  
 4 after them, which is extremely difficult, especially if  
 5 they're at the onset of the dementia journey or they  
 6 have slight confusion. You could possibly relate it to  
 7 if you have an elderly relative who comes to stay with  
 8 you after a period in hospital, an operation or  
 9 something, and they are slightly confused, they're on  
 10 their own set journey, and trying to keep them in  
 11 a bedroom within your house and asking them not to come  
 12 out for 14 days is quite a challenge for one, never  
 13 mind, when you have a care home or a unit full.  
 14 MR STEPHEN: Yes, you mentioned dementia. I was going to  
 15 ask you about it so I'm glad you brought it up because  
 16 you say in the organisational statement, I think, about  
 17 the increase in attention I think that those with  
 18 dementia required. Are you able to elaborate a bit more  
 19 on what you mean by that? I think you have to an extent  
 20 already, but if there's anything else that you would  
 21 add?  
 22 MS DI GIACOMO: Well, not really. Just that they don't  
 23 understand, and when you have what was a familiar face,  
 24 even if they can't, you know, remember your name, when  
 25 that person is going in with a mask on and gloves on and

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1 an apron on, they can't really work out who they are, so  
 2 it increases their anxiety, it increases their fear, if  
 3 you like, of what's happening.  
 4 MR STEPHEN: Which leads me to ask this question, I suppose:  
 5 do you think that those with dementia were taken into  
 6 account or sufficiently taken into account when these  
 7 restrictions, this guidance, was put in place?  
 8 MS DI GIACOMO: No.  
 9 MR FINNIGAN: No.  
 10 MR STEPHEN: Should they have been?  
 11 MR FINNIGAN: Absolutely.  
 12 MS DI GIACOMO: Absolutely, yes, because I think they were  
 13 affected mostly by this.  
 14 MR STEPHEN: I want to ask you more generally just about the  
 15 impact on your residents. We've talked about lockdown,  
 16 self-isolation and of course visiting restrictions, not  
 17 being allowed. What would you say were the primary  
 18 impacts that you saw or your members saw upon your  
 19 residents as a result of these restrictions being  
 20 imposed?  
 21 MS DI GIACOMO: I think fear and anxiety because for  
 22 reassurance you would automatically hold their hand or  
 23 touch them to talk to them, to reassure, and we couldn't  
 24 do that. And when visiting was — when the restrictions  
 25 were uplifted and families came in, it's natural that

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1 they just want to embrace for that reassurance, for that  
 2 comfort and peace of mind. And we created cuddle  
 3 curtains which were really — it was just polythene but  
 4 allowed them to have that embrace. Both the resident  
 5 and family, they just broke down through, you know,  
 6 happiness and sadness that they were eventually able to  
 7 embrace each other. But you can't — you just can't put  
 8 a price to that. It is invaluable. And I think not  
 9 having that, not being with their family, was almost as  
 10 detrimental as the virus itself to their well-being.  
 11 MR FINNIGAN: Yeah, I'd agree with everything Lissa just  
 12 said. I think emotional and mental well-being is not to  
 13 be underestimated and how it impacts people's physical  
 14 well-being as well. So I think residents deteriorated  
 15 as a result of the restrictions that were placed upon  
 16 them. Visiting had an impact on that because they  
 17 couldn't see their families, but I think also the  
 18 restriction of — limited movement had a massive impact  
 19 on people's well-being.  
 20 MR STEPHEN: Thank you. Given that lack of physical visits  
 21 at that time, I wanted to ask you about alternatives.  
 22 Did you attempt alternatives and, if you did, what were  
 23 they?  
 24 MS DI GIACOMO: There were video conference over — we had  
 25 tablets. We purchased more tablets and brought them in.

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1 We set them up. We tried to arrange appointments, if  
 2 you like, with families, where they could see their  
 3 family, their children, their grandchildren, and  
 4 although it brought a sense of joy at the time, it was  
 5 followed by, you know, "Why can't I see them and why  
 6 can't they come in and see me?", so in some cases it was  
 7 more upsetting seeing them and not being able to be with  
 8 them.  
 9 MR FINNIGAN: Yes, so we had video calls as well with  
 10 families and towards the summer, when we had nicer  
 11 weather, there was some window visits being carried out  
 12 as well, which was official guidance at that point  
 13 but it was just something that naturally materialised,  
 14 and I think that's — we had a lot of care home  
 15 providers doing that.  
 16 MR STEPHEN: I'll come on to visits in a second so I'm glad  
 17 you mentioned it. How successful would you have said  
 18 that those alternatives, the use of video calls and  
 19 things, were in your view?  
 20 MR FINNIGAN: I think it was probably more beneficial for  
 21 relatives than it was residents in most cases. I think  
 22 some residents struggled to understand what they were  
 23 looking at, what they were seeing, what was happening.  
 24 We had an example that sticks out. There was a resident  
 25 who was end of life due to COVID and the manager had

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1 facilitated a call with the family, just — and the  
 2 family were on that video call as the resident passed,  
 3 and that was for the family's benefit. The resident, as  
 4 far as we're aware, couldn't — didn't participate in  
 5 that, in that call. So I think there's varying degrees  
 6 of how successful that was across the resident group.  
 7 MR STEPHEN: Thank you. Turning then to visits, your  
 8 statement talks about how, after the first national  
 9 lockdown is relaxed — I think you remarked that  
 10 visiting in care homes still remained heavily  
 11 restricted. There were subsequently window visits and  
 12 then garden visits and then eventually indoor visits.  
 13 I want to start by asking about window visits. Were  
 14 window visits something that were available as an option  
 15 in all of your care homes?  
 16 MS DI GIACOMO: Not in ours. They were homes or school  
 17 conversions so the windows are quite high so we wouldn't  
 18 be able to facilitate window visits or garden visits.  
 19 MR STEPHEN: I think, Lissa, you might have one example  
 20 that's mentioned in the statement about perhaps the  
 21 lengths that —  
 22 MS DI GIACOMO: Yeah, I was driving into one of our care  
 23 homes and I saw a family — a lady and a gentleman — up  
 24 a ladder at one of our windows and they were both — but  
 25 they were both on the ladder at the same time, on either

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1 side, but one was standing on the platform of the ladder  
 2 and the other was on the steps. Initially I was in  
 3 shock and then concerned for their safety because they  
 4 were about, you know, five/six feet off the ground and  
 5 I just — my heart was in my mouth until I went round.  
 6 And I understood why they were doing it. I couldn't say  
 7 that under the same circumstances I wouldn't have done  
 8 something like that myself, but it was their safety that  
 9 I was concerned about.  
 10 MR STEPHEN: And, Scott, what was the experience ...  
 11 MR FINNIGAN: I think — similar to Lissa saying there,  
 12 I think most of — all of our care homes are over two  
 13 floors. We have one old school conversion as well. So  
 14 I think for the majority of people who were living on  
 15 the ground floor and that window was accessible, that  
 16 that happened, but, unfortunately, if you weren't living  
 17 on the ground floor, a window visit wasn't something  
 18 that was possible due to the restrictions of moving  
 19 people around the home.  
 20 MR STEPHEN: So overall, then, would you describe these  
 21 window visits as beneficial or not?  
 22 MR FINNIGAN: I think the people who had the opportunity to  
 23 have a window visit found them beneficial — again  
 24 varying degrees on whether residents found them  
 25 beneficial or not. I think the relatives who had the

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1 opportunity found them beneficial, but not every  
 2 relative had that opportunity, so that presented  
 3 a different set of challenges as well about, "Well, how  
 4 can that relative get to see and I can't get to see my  
 5 relative?". So I think that was — it was one of the  
 6 situations where it was making do with the situation  
 7 that we had and the best option.  
 8 MR STEPHEN: Your point being there that perhaps some  
 9 families would feel, what, hard done by if —  
 10 MR FINNIGAN: Yes, absolutely. Absolutely.  
 11 MR STEPHEN: Understood.  
 12 MS DI GIACOMO: Yeah, I would agree that it was more  
 13 beneficial for the families and more reassuring for them  
 14 to see their loved one than it was particularly for the  
 15 resident.  
 16 MR STEPHEN: I'll move then to garden visits. I think you  
 17 say in the statement — this is at paragraph 68. This  
 18 was around winter 2020 — and at the outset of your  
 19 evidence today I think you said the make-up of a lot of  
 20 your witness population are the elderly. Did you think  
 21 garden visits were suitable for your resident  
 22 population?  
 23 MS DI GIACOMO: It depends on the time of year. Certainly  
 24 the families, yeah, it was — if it was a nice day and  
 25 they were out in the garden, it was fine. I think what

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1 sort of tarnished it a little bit was they couldn't  
 2 touch, and that was the hardest part and we had to sort  
 3 of supervise that, monitor it. And that was just  
 4 horrible for the staff and for the families, to be so  
 5 close and not to have that — especially for the  
 6 resident because it's what they needed. They needed,  
 7 you know, to see that gesture from their families to  
 8 know that they are okay and that they are going to be  
 9 okay. So I think it was sort of a double-edged sword in  
 10 a way.  
 11 MR STEPHEN: Because in your statement — I think it's  
 12 paragraph 69 — I think there's a description that's  
 13 made that these visits were almost akin to sort of  
 14 a prison visit, if you like, with no contact allowed and  
 15 a guard supervising them, quite strident language  
 16 I suppose. I was going to ask, because you've answered  
 17 it to an extent, Scott, what was the experience of your  
 18 staff in having to facilitate these visits?  
 19 MR FINNIGAN: I think staff on the whole felt uncomfortable.  
 20 I think there was that expectation about, "Here's what  
 21 the guidance is", and the guidance, although it was  
 22 called "guidance", was, like you've already heard, a set  
 23 of rules that was expected to be followed. So I think  
 24 there was lots of apprehension around if we don't follow  
 25 the rules what will be the consequence for us. So

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1 I think people felt uncomfortable with that.  
 2 And completely I can understand why people would  
 3 feel — relatives would feel that way about being  
 4 supervised visiting their relative. Personal  
 5 circumstances, I had a relative in a care home who my  
 6 dad was visiting and he made some comments about, "Well,  
 7 you're sitting 2 metres apart and wearing a mask.  
 8 I cannae hear what you're saying". But also you're  
 9 being watched, so you feel that that conversation you're  
 10 having can be uncomfortable.  
 11 MR STEPHEN: What would you say, then, to those relatives  
 12 who perhaps didn't feel like they were being trusted  
 13 with their loved ones? What would be your response to  
 14 that?  
 15 MR FINNIGAN: I think it was all coming from a good place  
 16 about trying to keep people safe. I think there was  
 17 certainly no intention that I'm aware of of trying to be  
 18 obstructive or difficult. In fact it actually made the  
 19 job that the staff are carrying out extremely difficult.  
 20 So actually it would have been easier for the staff not  
 21 to have these things in place, but there was a real fear  
 22 factor around doing something that's not in the  
 23 guidance.  
 24 MR STEPHEN: Is there anything you would add to that?  
 25 MS DI GIACOMO: Yeah, and it is about following the

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1 guidance. Even though we may not necessarily agree with  
 2 it, then we would follow it to the letter. And even  
 3 staff perhaps didn't agree with it when they were out,  
 4 and with the pressures that were on us at the time, you  
 5 know, to have staff sort of in that supervisory role was  
 6 the last thing that we wanted to have, but found it  
 7 necessary because, if a positive case was then detected  
 8 after one of these visits, the consequences of that for  
 9 us would be serious.  
 10 MR STEPHEN: Yes, because I think the words that are used in  
 11 paragraph 69 are "professional duty", and I think that  
 12 perhaps speaks to what you're saying there.  
 13 MS DI GIACOMO: Yeah.  
 14 MR STEPHEN: At paragraph 64 of your statement, when talking  
 15 about following that guidance, I think you state that:  
 16 "Our members wonder with hindsight whether they  
 17 should have made concessions ..."  
 18 I wanted to ask you about that. Looking back,  
 19 do you consider that care homes could have handled these  
 20 visits differently or not?  
 21 MS DI GIACOMO: In relation to the guidance, no. Unless we  
 22 ignored the guidance and sort of did what we felt was  
 23 the right thing to do, I don't feel that we had a choice  
 24 to do it any differently.  
 25 MR FINNIGAN: Yeah, and that would be my view as well.

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1 I think there was — most have got views on how it could  
 2 have been done better, but I think — in terms of  
 3 following the guidance, I think that's what you do  
 4 because that's the guidance that's set for you.  
 5 MR STEPHEN: Since we're talking about guidance, I think you  
 6 say in your statement that care home managers were  
 7 struggling to keep track of the guidance on the  
 8 visitation. Could you elaborate on why that was?  
 9 MR FINNIGAN: I think there was so many different views,  
 10 I think it was quite — a lot open to interpretation.  
 11 And as things moved forward, there was local  
 12 restrictions that had to be taken into account as well  
 13 as the care home guidance visitation, so that presented  
 14 some challenges. I think it was just the sheer volume  
 15 and probably feeling the same as the care home managers  
 16 did when you were speaking to Public Health, the  
 17 Care Inspectorate and the care home assurance team.  
 18 That was three different people and quite often you  
 19 would get three different answers to the same question.  
 20 And then the problem comes, "Well, whose advice do we  
 21 follow?". The Care Inspectorate was the regulator but  
 22 these other bodies are advising.  
 23 So that's, I think, the challenge. There was no  
 24 sort of consistency in that and I think that's just  
 25 pure — down to the pure volume of guidance that was

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1 being shared and how quickly and often it was changing  
 2 and — because it was quite often open to your own  
 3 interpretation.  
 4 MR STEPHEN: Was that your experience or ...?  
 5 MS DI GIACOMO: Yeah, we had a similar experience in terms  
 6 of the guidance was very much, we felt, open to  
 7 interpretation.  
 8 MR STEPHEN: On essential visits, a similar theme. I think  
 9 you say at paragraph 72 of your statement that there was  
 10 no such concept before the pandemic and then this new  
 11 concept is then introduced. Did you find the guidance  
 12 on what constituted an essential visit to be clear when  
 13 running these care homes?  
 14 MR FINNIGAN: No, I think it wasnae clear to begin with.  
 15 I think there was lots of again varying views on what  
 16 that should be. And I personally — after having spoke  
 17 with some relatives about what their view of essential  
 18 visits would be and information they were getting after  
 19 phoning Public Health themselves, Care Inspectorate  
 20 themselves, I was taking that information, phoning the  
 21 same bodies back, having the same discussion and I was  
 22 getting different answers.  
 23 So initially the information I was provided, which  
 24 was why we implemented it in our group, was that  
 25 essential visits were for end of life. That changed as

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1 the pandemic moved on and guidance did --- round about  
 2 that became a bit more robust and a bit more clearer.  
 3 But initially it wasn't clear and I think there was an  
 4 inference, "Well, there is a facility for that but care  
 5 homes aren't using it", but it wasn't clear that that's  
 6 what it could be used for. So things like residents  
 7 were distressed or even relatives were distressed about  
 8 not seeing their relative, so that became a --- that  
 9 became something that was used more openly towards the  
 10 end of the lockdowns, but initially it was a brand new  
 11 term that had just been brought in in this guidance  
 12 without any sort of definitive explanation of what it  
 13 was.  
 14 MS DI GIACOMO: Yeah, we had a similar experience and, when  
 15 you often sought clarification of what it exactly meant,  
 16 very often you would get different answers through so  
 17 you were left --- bearing in mind that we had to ---  
 18 sometimes, when information was released through the  
 19 media, through the television, then families would  
 20 arrive and say, well, you know, "I'm an essential  
 21 visitor, I must see my relative", and how do you say,  
 22 "Well, no, sorry, we can't let you in because your  
 23 relative isn't at end-of-life care" or --- it was  
 24 extremely challenging, especially for the staff because  
 25 they were at the front line of this with families who

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1 were visibly distressed, angry, frustrated. So it was  
 2 a difficult time.  
 3 MR STEPHEN: So what would you say was the impact upon your  
 4 staff of having to --- as you say, you're on the front  
 5 line --- having to deal with that angst, distress from  
 6 families? What would you say the impact was on the  
 7 staff that you had?  
 8 MS DI GIACOMO: Oh, they were --- I think they were just  
 9 burnt out. They were working long days. It's a 12-hour  
 10 shift. Routinely they were working four and five days  
 11 consecutively to cover and to prevent the use of agency  
 12 staff because it was challenging enough for them going  
 13 in with masks and gloves and aprons, but when you have  
 14 agency staff, which were in effect strangers to the  
 15 residents --- because the staff really became their  
 16 family during that period. They were the familiar face,  
 17 the familiar voice, the voice of reassurance, so they  
 18 were --- yeah, I think they were burnt out and then they  
 19 had to deal with facing their own fears, facing death,  
 20 working tirelessly and then having to speak to and try  
 21 and console and try and defuse a really upset relative.  
 22 It was extremely hard on them.  
 23 MR STEPHEN: And you say the staff became their family,  
 24 which leads me on, I suppose, to Anne's Law, which this  
 25 Inquiry has heard about already. I just want to touch

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1 on it briefly. I understand that Central Scotland Care  
 2 Homes support that ---  
 3 MS DI GIACOMO: Absolutely, yeah.  
 4 MR STEPHEN: --- especially with that individual concerned  
 5 having been a resident, I understand, in one of  
 6 Thistle's care homes.  
 7 MR FINNIGAN: Yeah.  
 8 MR STEPHEN: I just wanted to ask, in your view, what is the  
 9 impact then of removal of relatives from that care home  
 10 setting, both for the residents themselves but also for  
 11 your staff, because I think there's a football analogy  
 12 you used in one of the paragraphs I think about family  
 13 being the 12th player, if you like, so when you take  
 14 them out of the equation, what is the effect of that in  
 15 your view?  
 16 MR FINNIGAN: I think it's distressing for everybody.  
 17 I think it's impacting in daily life. I think that's  
 18 reality. We've got lots --- lots of our resident groups  
 19 are already frail and, prior to the pandemic and now,  
 20 a lot of these relatives visit daily, and that would  
 21 have been a lot of people's daily routine, that they  
 22 would see their relative every day. We've got some  
 23 relatives that spend all day in the care home with their  
 24 relative and go home, and then that daily life just  
 25 changed.

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1 I think the difficulty for the residents that have  
 2 cognitive impairment was understanding, "What's  
 3 happened? What's changed? Why can I not see ..." ---  
 4 and I think the window visits, that could be distressing  
 5 as well because they could see the person but couldn't  
 6 understand why they couldn't hear or touch the person.  
 7 So I think it's had a massive impact on everything, and  
 8 just the wee bits of information that family hold about  
 9 residents that staff might not always know, especially  
 10 if a resident was fairly new to the care home.  
 11 MR STEPHEN: You mention staff being burnt out. Again, if  
 12 relatives are removed --- and you've just highlighted the  
 13 importance of them --- what effect does that have on  
 14 staff?  
 15 MS DI GIACOMO: Absolutely because families would come in  
 16 and they would spend time with their loved one and they  
 17 would assist with different aspects for the resident or  
 18 they would talk to them. They would take time with the  
 19 resident that released the staff to then go and attend  
 20 to other residents that maybe didn't have family coming  
 21 in because many residents don't have family around.  
 22 MR STEPHEN: So that safety valve, if you like, was ---  
 23 MR FINNIGAN: --- removed.  
 24 MS DI GIACOMO: It was removed.  
 25 MR FINNIGAN: I think --- sorry, I would just like to add,

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1 I think there was a view that it was easier for care  
 2 homes not to have relatives visiting , and that's  
 3 actually the complete opposite. It was more challenging  
 4 in all the aspects we spoke about there for the staff  
 5 workload, for the resident well-being, for the relative  
 6 well-being. So actually we were --- it's not something  
 7 that was easier for us to not have relatives visiting .  
 8 Actually it 's the opposite.  
 9 MR STEPHEN: I want to circle back to guidance just before  
 10 we moved on. I think, Scott, you mentioned about the  
 11 sheer volume of it.  
 12 MR FINNIGAN: Yes.  
 13 MR STEPHEN: I think they were the words that you used. I'm  
 14 interested in the process for implementing that guidance  
 15 in the home. For example, was it possible for every  
 16 member of your staff to be familiar with that guidance,  
 17 given the volume that you've spoken about?  
 18 MR FINNIGAN: No, I think what we'd done as a senior  
 19 management team was digested that guidance, had  
 20 conversations with the leaders and the services , who  
 21 then disseminated that to their teams in a way that was  
 22 meaningful to them and impacted all different job roles  
 23 differently . So, for example, the housekeeping team,  
 24 one of the products that we would be used to cleaning;  
 25 on the care staff about how the direct care would be

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1 delivered , so we were kind of breaking that down for  
 2 each individual group of staff. It would have been  
 3 completely overwhelming to share the huge documents with  
 4 every member of staff and say, "Read that and get  
 5 familiar with it". That's just not how it could be  
 6 done.  
 7 MR STEPHEN: Was it a similar process for Oakminster?  
 8 MS DI GIACOMO: Yeah, we did the same. We took the  
 9 guidance, digested it , discussed it and then decided how  
 10 we would disseminate it out among the staff teams, get  
 11 it on to the floors .  
 12 MR STEPHEN: I think you mentioned earlier, Scott, about the  
 13 challenges of interpretation ---  
 14 MR FINNIGAN: Yes.  
 15 MR STEPHEN: --- and perhaps getting various sources telling  
 16 you different things ---  
 17 MR FINNIGAN: Yes.  
 18 MR STEPHEN: --- I think was the way you put it. Did that  
 19 cascade down then to the way it was to be implemented?  
 20 Was it easy to decipher what to do in light of that?  
 21 MR FINNIGAN: No. I think getting the guidance initially  
 22 was a challenge as well , so --- still to this day I'm not  
 23 on the mailing list for guidance, so I was relying on  
 24 the homes sending me the guidance when it was being  
 25 released because it was getting sent directly to the

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1 care home managers. So I think getting access to the  
 2 guidance initially was a challenge and then trying to  
 3 understand what changed and how quickly we should  
 4 implement that and what that meant.  
 5 MR STEPHEN: Was it the same?  
 6 MS DI GIACOMO: Yeah, it was the same for us. It was about  
 7 them understanding, and sometimes we would put guidance  
 8 out and then we would get new guidance. So then, having  
 9 embedded the first tranche of guidance, we were then  
 10 saying, "No, actually, don't do that anymore. This is  
 11 what we need to do". So that was quite challenging as  
 12 well.  
 13 MR STEPHEN: You speak about that guidance being given to  
 14 you which leads me to ask then about consultation. Did  
 15 the Scottish Government consult with you about this  
 16 guidance before it was ---  
 17 MS DI GIACOMO: No.  
 18 MR FINNIGAN: No.  
 19 MR STEPHEN: And despite the pace of the pandemic, the way  
 20 things were moving, do you consider that you should have  
 21 been consulted about that?  
 22 MS DI GIACOMO: Yes.  
 23 MR FINNIGAN: Yes. Yes, I think the guidance is kind of  
 24 perfect world scenario but daily life isn't perfect  
 25 world. But there was really no consideration for the

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1 practicality of applying this guidance in a care home  
 2 setting. And I think the people writing the guidance  
 3 were obviously using the best of intentions, but I think  
 4 it was written very clinically for an NHS acute setting.  
 5 I don't think there was any considerations for the  
 6 practicalities that actually fundamentally it's people's  
 7 homes, this is where people live, and then the  
 8 understanding of people being able to actually apply  
 9 that because of cognitive impairments.  
 10 MR STEPHEN: And do you think it would have been feasible  
 11 for that consultation to have taken place with care  
 12 homes given the way in which this was moving?  
 13 MR FINNIGAN: Absolutely.  
 14 MS DI GIACOMO: Yeah. Yeah, I think they could have spoken  
 15 to the Health and Social Care Partnership and the local  
 16 authorities , any of the care home membership  
 17 organisations or the care homes directly in order to get  
 18 just a better understanding of what happens in social  
 19 care as opposed to an NHS setting.  
 20 MR STEPHEN: Thank you. Earlier on, Scott, I think you  
 21 mentioned about guidance feeling like it was mandatory.  
 22 MR FINNIGAN: Yes.  
 23 MR STEPHEN: So I suppose --- you touch on this at  
 24 paragraphs 117 and 118 of this statement. I wanted to  
 25 ask what in general were the lessons learned on the use

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1 of guidance during the pandemic but I suppose  
 2 specifically do you think that guidance was the correct  
 3 or appropriate label or do you think things should have  
 4 been done differently?  
 5 MR FINNIGAN: I think things -- I think there's lots of  
 6 things that should have been done differently. I think  
 7 guidance -- well, the name "guidance" gives inference  
 8 that it's a guide and "Here's kind of best practice",  
 9 but that's not how it was being applied. We were being  
 10 inspected on this guidance and robust action taken when  
 11 we werenae -- where they felt that there was not that  
 12 application of that guidance anywhere, so that created  
 13 a real fear. So the guidance didn't become guidance.  
 14 The guidance became a set of rules that we had to  
 15 follow.  
 16 MS DI GIACOMO: Yeah, I would totally agree. It wasn't --  
 17 it may have been called "guidance" but we -- when we  
 18 received that information, we would do our best to  
 19 follow it to the letter.  
 20 MR FINNIGAN: And I think that presented challenges for  
 21 residents because I know from speaking with some  
 22 relatives personally that the message they were getting  
 23 when they were speaking to Public Health was, "Well,  
 24 it's guidance. The care home can apply that in how it's  
 25 suitable for that individual facility". But there was

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1 no support to sort of understand that application and,  
 2 as I say, we were inspected on it, so it was "Well,  
 3 that's what's written in the guidance. That's what you  
 4 should be doing".  
 5 MR STEPHEN: So if you were drawing up a blueprint on what  
 6 you would do next time -- hopefully there isn't a next  
 7 time, but if there was, are you saying that it should be  
 8 clear, the distinction between guidance on the one hand  
 9 and something that's legally mandatory on the other?  
 10 MR FINNIGAN: Absolutely.  
 11 MR STEPHEN: Thank you.  
 12 I wanted to turn now to infection prevention and  
 13 control or IPC for short. You describe the level of IPC  
 14 expected during the pandemic as a completely new way of  
 15 working for care home staff and as a steep learning  
 16 curve. Can I ask you what these demands -- these new  
 17 demands were that were placed upon those working in your  
 18 homes?  
 19 MS DI GIACOMO: It was really about an increase. They were  
 20 expecting us to be like a hospital setting, a clinical  
 21 setting. So it's like somebody coming into your own  
 22 home and, although you may have a high standard of  
 23 cleanliness in your house, to compare that against  
 24 a hospital can't -- there's obviously going to be  
 25 significant differences. And care homes in general do

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1 work to a high standard of IPC because we deal with  
 2 norovirus outbreaks and things of that nature, but this  
 3 was on a whole new level. And the care home staff are  
 4 already under increased pressure because of staff  
 5 shortages and because of staff falling ill under COVID  
 6 and then the expectation was we had to up our game, if  
 7 you like, and take it to a whole new level, where we  
 8 didn't have the resources or the training in order to  
 9 fully implement that.  
 10 MR FINNIGAN: Yeah, I think one thing that sticks out for me  
 11 was one of my managers saying during a session they had  
 12 done with their team was the team felt that they had to  
 13 become infection control specialists overnight, and  
 14 that's not what the role of a care home staff is.  
 15 I think use of masks wasnae something that was routine  
 16 in care homes. Actually I don't know that I've actually  
 17 seen it prior to the pandemic as something that's  
 18 routine. So all these changes were coming into effect:  
 19 how things were cleaned; the chemicals we had to use to  
 20 clean things all changed; cleaning schedules, the  
 21 expectation of what that schedule would include. And  
 22 these were all brand new things to care homes that we  
 23 were kind of expected to implement straightaway without  
 24 any sort of support or guidance or training for staff.  
 25 That sort of stuff we had to facilitate ourselves

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1 because any of the available teams, like the Care Home  
 2 Assurance team, were always being used for scrutiny  
 3 services. It was all about, "Go in and check that  
 4 that's been done properly. Go and check that that's  
 5 been done". So I think there was that lack of support  
 6 round about staff's understanding of what that should  
 7 be.  
 8 There's examples of the guidance just being very  
 9 unspecific again. As I say, masks was a new thing for  
 10 us to use in care homes and it talks about sessional use  
 11 of the masks, so -- but there wasn't a definition for  
 12 what that session was, so was that session after you  
 13 left the resident's room, when you went on your break,  
 14 after your shift? So they were all things that took  
 15 a long time to get definitions for, which meant there  
 16 was varying degrees of how that was applied in practice  
 17 because it was very, very generic.  
 18 MR STEPHEN: What impact, if any, is that having then on  
 19 your staff in terms of these additional things? You  
 20 talked about -- cleaning I think was one example you  
 21 gave. But what's happening to their working hours and  
 22 their workload if they're having to implement these --  
 23 MR FINNIGAN: Oh, massively increased. So the workload  
 24 increased for everybody tenfold. I think even just for  
 25 our housekeeping teams, things like cleaning frequently

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1 touched points, so light switches, door handles — that  
 2 was being done up to seven/eight times a day on top of  
 3 having to keep clean the general areas of the home, and  
 4 bear in mind there was lots of areas in the home not  
 5 being used so we also had to keep the areas clean.  
 6 Yeah, so it was — the workload for everybody was just  
 7 increased, including in the care staff about cleaning  
 8 every piece of equipment more thoroughly, more  
 9 generally; again all very acute based, so things that  
 10 you would generally have seen in a hospital setting but  
 11 not in a care home setting.  
 12 MS DI GIACOMO: And the products, they asked us — they  
 13 would come in and change the products we were using. We  
 14 have quite a comprehensive suite of cleaning products  
 15 for different parts of the care home, but they would  
 16 change that overnight and we had to then source  
 17 different cleaning products. And it was just about  
 18 having the resources because another layer of paperwork  
 19 came in because we had to evidence the additional  
 20 cleaning that they were doing on a more frequent, more  
 21 regular basis with new products and having the time to  
 22 obtain the products, because they were going in to all  
 23 care homes and saying this, so we were all trying to  
 24 look for the same product that we don't normally use at  
 25 the same time, which made availability a little

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1 sparse — supply and demand. The prices of things just  
 2 escalated and it was — in one case we were paying five  
 3 times more what we would normally pay for a product.  
 4 Then to bring that in and have the training and — just  
 5 the people, just the bodies in order to help, you know,  
 6 manage all of that, on top of what we were dealing with.  
 7 It's, "What do we prioritise? How do we do this? How  
 8 do we manage it?"  
 9 MR STEPHEN: You mentioned earlier about that distinction  
 10 between a clinical setting and a hospital and care  
 11 homes, at least as traditionally understood. Do you  
 12 think that a distinction should have been drawn in the  
 13 guidance that was issued between those two settings?  
 14 MR FINNIGAN: Absolutely.  
 15 MS DI GIACOMO: Absolutely. If they had a better  
 16 understanding, then they may have made a more informed  
 17 decision about the social care aspect of it.  
 18 MR STEPHEN: I think in paragraph 119 of your statement you  
 19 talk about the fundamental purpose of care homes being  
 20 to maximise the quality of life and having to balance  
 21 that with the requirements of infection prevention and  
 22 control. In your view, do you think that balance was  
 23 struck correctly? Lissa, you talked earlier about the  
 24 effect that PPE might have on those who perhaps don't  
 25 recognise or fear those who are caring for them. Do you

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1 think that balance was struck correctly?  
 2 MS DI GIACOMO: Not really. I understood their intention  
 3 but the challenge that we faced was the implementation  
 4 of that because you're talking about — when you were  
 5 going into a resident's bedroom, for example, that is  
 6 their bedroom, so I don't know how I would feel about  
 7 somebody coming into my bedroom multiple times. And not  
 8 only did we have that aspect of it but we were advised  
 9 under the guidance about items that had a personal  
 10 meaning. So you have residents who haven't seen their  
 11 family, that would maybe have photographs or an ornament  
 12 in their bedroom and, as these were being cleaned, some  
 13 of them they were suggesting that we remove for — to  
 14 prevent infection. And that's just not right. It is  
 15 not — I understand it, I definitely don't agree with it  
 16 and I think the impact on the mental welfare and  
 17 well-being of the residents was hugely impacted not by  
 18 one specific thing but a catalogue of things.  
 19 MR FINNIGAN: Yeah, I think similar situation. Care homes,  
 20 although they support people who are unwell, usually  
 21 when people were acutely unwell, that would have been  
 22 when colleagues from Health would step in. I think  
 23 there was an expectation that we just — we just had to  
 24 go on with caring for people and it was forgotten about  
 25 that it was people's homes, and it was that — that's

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1 the homely environment for them and how they should be  
 2 comfortable. A similar scenario to Lissa mentioned,  
 3 I personally was in a home one day when we had an  
 4 inspection from Care Home Assurance teams and there was  
 5 a suggestion we lifted every carpet in the home and laid  
 6 lino because carpets can't be cleaned effectively, and  
 7 that was a bit of a debate with me to try and get that  
 8 resolved, but that was a huge discussion actually that  
 9 took quite a lot of time and involved quite a lot of  
 10 people because people didn't understand the care home  
 11 setting.  
 12 MR STEPHEN: It's timely you mentioned it because I was just  
 13 going to ask you about inspections anyway so we'll go  
 14 there now.  
 15 Prior to the pandemic, I think you say that these  
 16 were generally — inspections were conducted annually  
 17 I think more or less for your care homes.  
 18 MR FINNIGAN: Yes.  
 19 MS DI GIACOMO: Yes.  
 20 MR STEPHEN: How and by what means were those inspections  
 21 carried out once we get into the pandemic? How was that  
 22 done?  
 23 MR FINNIGAN: I think inspection changed. Inspection before  
 24 a pandemic was generally via the Care Inspectorate and  
 25 that changed — the Care Inspectorate introduced a new

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1 key question which was round about the — how people are  
 2 supported during the pandemic. A lot of the inspections  
 3 were supported by Health Improvement Scotland, which  
 4 have never inspected care homes. That’s about acute  
 5 settings. And then latterly the Care Home Assurance  
 6 teams, who ultimately are all made up from people who  
 7 havnae worked in care homes either. So it presented  
 8 lots of challenges and understanding various different  
 9 pieces of guidance that were given at inspections or  
 10 advice which often wouldnae marry with each other. So  
 11 you could have a Care Inspectorate inspection and they  
 12 could be saying, "Oh, we’re quite happy with everything  
 13 you’re carrying out. Your report reflects that. Your  
 14 grades reflect that", and then we would have a visit  
 15 from the Care Home Assurance team that we would end up  
 16 with a six—page action plan from because they didn't  
 17 feel that our PPE storage was adequate — where PPE was  
 18 being stored was adequate. And there was no  
 19 consideration about, actually if you have PPE all on  
 20 your corridors where you have people who walk with  
 21 purpose, who are living with dementia, that would  
 22 actually present more of a risk because these things are  
 23 being touched regularly, but there wasnae any  
 24 understanding of that.  
 25 That’s a view that I challenged regularly and

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1 ultimately it was advised by the Care Inspectorate they  
 2 had a regulator, so we should follow a regulator. But  
 3 that presented challenges when dealing with colleagues  
 4 at NHS because they’ve been sent in to scrutinise you on  
 5 this guidance that’s been issued, and again it’s back to  
 6 the practicality of how that guidance should be applied  
 7 in a care home setting.  
 8 MS DI GIACOMO: Yeah, a similar experience for us. It  
 9 became known as "the COVID inspection". There was three  
 10 questions. Two were being covered by the  
 11 Care Inspectorate and one by Health Improvement  
 12 Scotland. And when they came in, they were inspecting  
 13 us against the standards of a hospital, and I don't know  
 14 how you can compare a care home to a hospital, but  
 15 that’s what we were inspected on. And from our own  
 16 personal experience, we did not too badly, but it was  
 17 scrutiny at a time where we probably felt more  
 18 pressurised as a sector than we ever have and I thought  
 19 a more supportive approach might have had a better  
 20 outcome for us than constant scrutiny of, "This was the  
 21 guidance, this is what we’re inspecting you on and we  
 22 expect you to meet that".  
 23 MR STEPHEN: So do you think those standards that you were  
 24 being held to were realistic in the circumstances that  
 25 you were facing?

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1 MS DI GIACOMO: Not all of them. There were some we do as  
 2 a matter of course, but they were inspecting us on  
 3 something that they had introduced to us during the  
 4 pandemic because this was a COVID inspection and we were  
 5 flat out. I don't know how they expected us to meet  
 6 those standards with a workforce that were — that was  
 7 virtually on its knees.  
 8 MR FINNIGAN: Yeah, I think just similar. It was just  
 9 unrealistic. I don't think there was any appreciation  
 10 for the challenges, and the health and social care  
 11 sector never had staff before the pandemic, so during  
 12 the pandemic it was even worse because you could have  
 13 half your workforce off at the one time isolating. So  
 14 there was all the challenges in line with that but there  
 15 was still an expectation, "Well, this guidance has been  
 16 issued. You should implement it".  
 17 MR STEPHEN: You mentioned the example I think of being  
 18 asked to lift up all the carpets.  
 19 MR FINNIGAN: Yes.  
 20 MR STEPHEN: I was going to ask you if there were any others  
 21 because I think it's at paragraph 110 of your statement  
 22 you talk about these inspections being far more  
 23 extensive — and "forensic" is the word you use — than  
 24 it was before.  
 25 MR FINNIGAN: Yes.

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1 MR STEPHEN: Are there any other examples you'd give?  
 2 You've mentioned the lifting of carpets that you were  
 3 being asked to do at this time.  
 4 MR FINNIGAN: I think same as some of the examples that  
 5 Lissa has given. There was one home in particular which  
 6 was younger adults that live in it, and there was advice  
 7 given and it was written in an action plan that we  
 8 should remove personal belongings from people's bedrooms  
 9 because some rooms were — "overly cluttered" is how it  
 10 was put.  
 11 MR STEPHEN: I think, Lissa, you've answered this to an  
 12 extent already, but I'll ask you the same question,  
 13 Scott. How might you suggest these inspections could  
 14 have been handled differently during this time?  
 15 MR FINNIGAN: I think there should have been input from  
 16 people who understand care homes. I think that  
 17 should — fundamentally should have been what happened.  
 18 I personally offered several times to — if there was  
 19 a way to get involved in that, to help that be carried  
 20 out, because I think there was — we were the only  
 21 people in it, and with the best intentions there,  
 22 they've come in with a set of guidance, thinking,  
 23 "Right, this is what the care home has been told". But  
 24 it'd be only people who were seconded from the  
 25 continence service and from acute settings that had

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1 been — due to the pandemic had been stopped, so they've  
 2 never been in a care home, they've never looked at  
 3 a care plan. I mean, these are things that they didn't  
 4 understand, but they were producing an action plan  
 5 telling us how to do better, and often I was going back,  
 6 saying, "These actions actually are nae appropriate".  
 7 MR STEPHEN: Thank you. I'll just move on to  
 8 Operation Koper because it's something that you  
 9 specifically mention in your statement. As you'll be  
 10 aware and as is clear in the Inquiry's terms of  
 11 reference, the Inquiry very much respects the  
 12 independent role the Lord Advocate has here in relation  
 13 to the prosecution of crime and investigation of deaths  
 14 in Scotland, but in keeping with the purpose of these  
 15 hearings, Impact Hearings, I would like to ask you about  
 16 the impact that that had on your staff.  
 17 I'd like to take that in two stages if I can, first .  
 18 So firstly I'd like to ask what was the effect of  
 19 Operation Koper on the workload or administrative  
 20 responsibilities that your staff had to carry out?  
 21 MR FINNIGAN: I think that was an inevitable increase in  
 22 that you had — when somebody had passed away from  
 23 a COVID or suspected COVID death, you would be contacted  
 24 by the police, you had to fill out this questionnaire  
 25 with 37 questions on it, you had to provide numerous

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1 pieces of evidence and documentation with that,  
 2 including copies of all the guidance that had been  
 3 issued from the Scottish Government, which was readily  
 4 available on the Scottish Government's website, and six  
 5 months' worth of off-duties for staffing, contact  
 6 details. It was a huge piece of work that actually we  
 7 had to have somebody solely working on that to  
 8 facilitate it.  
 9 It was also distressing for people who have — these  
 10 staff have cared for a lot of these residents for  
 11 a long, long time and care deeply about the people they  
 12 support, and then it was almost being an inference that  
 13 they felt they were being questioned about did they  
 14 actually support somebody correctly. So it was a huge  
 15 increase in workload.  
 16 MR STEPHEN: I was going to ask that. What's the impact  
 17 upon the staff, on their morale, I suppose, or mental  
 18 well-being in light of this investigation?  
 19 MS DI GIACOMO: It was devastating and I remember, apart  
 20 from the tasks, a lot of this information was archived,  
 21 and so you had this questionnaire and, as Scott said,  
 22 all this information going, but for me it was one of our  
 23 managers, and after our managers were on the floor  
 24 during the pandemic in uniform, as were our ops team,  
 25 supporting the staff, trying to keep morale up, lending

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1 a helping hand. And she came and — the manager sat at  
 2 her desk and she opened an email regarding  
 3 Operation Koper and the subject line was "Major crime"  
 4 that came into her inbox and the signature on it was  
 5 from the detective sergeant of Operation Koper,  
 6 Major Crime Division, Major Crime Police Scotland — or  
 7 Serious Crime Division it was. And she just broke down.  
 8 She just — now, there was probably no intention behind  
 9 that, they were given a job to do and they were doing it  
 10 as they would normally, but for somebody who has seen  
 11 a staff — we had a staff member, a young lady, who  
 12 contracted COVID, spent several months in hospital and  
 13 is now at home with her young family and she hasn't been  
 14 able to speak since then, and her managers are still  
 15 doing sort of welfare meetings; care staff have lost  
 16 their life, as have many. But to sit after your shift  
 17 and — ready to do your paperwork and to be greeted with  
 18 that kind of email is just devastating and she broke  
 19 down because there's an inference of, "We've done  
 20 something wrong. We haven't got something right".  
 21 MR STEPHEN: How did you manage that with your staff to the  
 22 extent that you could?  
 23 MS DI GIACOMO: Support them, reassure them, actually go in  
 24 and take some of the burden away in terms of the  
 25 paperwork side of it and the questionnaires, but there's

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1 ultimately information that they will have that we need  
 2 to get from them. But as it's still going on, it's  
 3 still quite — it's just devastating because we're the  
 4 only sector to come under that kind of scrutiny and  
 5 nobody really knows what it was like for us during that  
 6 time. I think somebody had described it as a "war zone"  
 7 and it was a bit like that, only they were trying to get  
 8 statistics and information from us at the same time, so  
 9 it was really hard.  
 10 MR STEPHEN: Thank you. You mentioned paperwork and you  
 11 touch on this in your statement, the administrative  
 12 burden that I think your staff were all facing. I think  
 13 words like "staggering" and "immense" were used.  
 14 I wonder if there are any specific examples you could  
 15 give of that and I suppose also what you think might  
 16 have eased that burden, looking back.  
 17 MR FINNIGAN: I think it's just answering these  
 18 37 questions, I think, and providing all the supporting  
 19 documentation that went with that. And, as I mentioned  
 20 there, I think there was some of this that actually  
 21 could have been given from — they're asking for  
 22 guidance issued by Public Health. Well, we're then away  
 23 coming up with all these different versions of guidance  
 24 to provide that. That could have been something that  
 25 could have been got from Public Health.

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1 I think it's just the immense workload in terms of  
 2 every resident having to go through that, and that  
 3 presented an ongoing --- when we had more deaths after it  
 4 had been --- Operation Koper had been announced, that  
 5 dread, "Oh, my God, I've got another death", and  
 6 actually the numbers of people who died of COVID are  
 7 very skewed because there's --- lots of people who just  
 8 took unwell were classed as suspected COVID without any  
 9 test being carried out. So there was lots of workload  
 10 that actually --- because it seemed that other kind of  
 11 health conditions didn't exist during COVID, and if you  
 12 took unwell when you were living in a care home, you  
 13 were just automatically considered as being  
 14 COVID-positive. And I think there was a lot of  
 15 frustration round about that as well because the numbers  
 16 don't actually reflect the amount of people that sadly  
 17 passed away with COVID.

18 MS DI GIACOMO: Yeah, I would agree with everything that  
 19 Scott had said. It was a --- really when the staff ---  
 20 they used to --- they came in with newspaper articles and  
 21 the care homes --- it was almost like a league table,  
 22 with the highest number of COVID deaths against the name  
 23 of that particular care home and then it was in  
 24 descending order. And that was just --- it was  
 25 devastating to see because they didn't see the other

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1 side of it, of what they were facing. We had --- staff  
 2 were sitting with residents at end of life when families  
 3 couldn't come in, trying to reassure them, praying with  
 4 them in some cases because, for the residents, the staff  
 5 were the nearest thing they had to family, and then to  
 6 see you in a sort of league table with the COVID deaths.  
 7 And as Scott clearly said, it wasn't all about  
 8 COVID-positive deaths. It was suspected COVID or COVID  
 9 related, where it may have been another underlying  
 10 health condition.

11 MR STEPHEN: You mentioned media coverage there. I was  
 12 going to come on to it anyway. In your statement you  
 13 say --- at paragraphs, I think, 104 to 106 you talk about  
 14 being very unfair and one-sided and you've given an  
 15 example of that there.

16 Scott, I was going to ask you, what was the impact  
 17 upon your staff of --- did you experience something  
 18 similar in terms of headlines or ...

19 MR FINNIGAN: Yes, I think there was several of our care  
 20 homes that were featured in news articles. Inevitably  
 21 they were all viewed quite negatively. I think that's  
 22 very demoralising. We're asking --- people are giving up  
 23 their lives, the protection of their family, to provide  
 24 care to people. Everybody was working hard to do the  
 25 best job possible in a very difficult set of

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1 circumstances, with guidance that was forever changing,  
 2 working in ways that they had never been asked to work  
 3 before and hadn't been trained to work --- working at  
 4 that level --- and then you were splashed across  
 5 newspapers, and that was really demoralising. We lost  
 6 lots of people, lots of staff, because of instances like  
 7 that.

8 And I think there was also that fear of, "People  
 9 know that I work here and do they think that that's what  
 10 would happen in here?" --- because it was very generic  
 11 information, but that also presented lots of anxieties  
 12 for relatives because relatives can't get in to visit,  
 13 they're reading these headlines, and residents who have  
 14 capacity were reading these headlines and saying, "How  
 15 can they be saying this about the place that I live, my  
 16 home?".

17 MR STEPHEN: I was going to ask you about local communities  
 18 because, as you mentioned, your staff obviously have to  
 19 go home and have their own families and things.

20 MR FINNIGAN: Yes.

21 MR STEPHEN: Was that press coverage mirrored in the  
 22 experience of your members when they went back to the  
 23 communities or not?

24 MR FINNIGAN: I'd say generally not. There were lots of  
 25 examples of community rallying round and being

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1 supportive. We've got similar stories to kind of what  
 2 was heard this morning about children drawing pictures  
 3 and them being handed in and bakeries handing in cakes  
 4 and breakfasts and pizzas all that sort of stuff, so  
 5 there certainly seemed to be that support from the  
 6 immediate community anyway and, to my recollection,  
 7 I don't recall any individual staff members raising that  
 8 they felt that that was the view outside. The people  
 9 who knew them, of course --- but it was certainly  
 10 a difficult time and that fear round about that.

11 We're also talking about staff who are registered  
 12 with a regulated body, a professional body, and they're  
 13 then considering the implications of their practices  
 14 being in the newspaper and, "How does that affect my  
 15 registration and my ability to work?". Basically  
 16 they're feeling that their professional conduct is  
 17 coming under question.

18 MS DI GIACOMO: I think the community in a certain respect  
 19 was a lifeline because the care sector was seen at the  
 20 beginning as a sort of poor relation. When everybody  
 21 was out clapping for the NHS and the focus was on the  
 22 NHS and what a great job they were doing, it was sort  
 23 of --- care homes just didn't factor in that. But  
 24 certainly with our group and different care homes, we  
 25 had a local restaurant that brought --- an Indian

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1 restaurant brought curries up for all the staff, another  
 2 local supermarket brought Easter eggs for all the staff  
 3 as well, and there was bakeries. There was different —  
 4 there was neighbours handing in trays of doughnuts and  
 5 things just to acknowledge, and that was a real boost  
 6 for them, that somebody recognised what they were doing.  
 7 MR STEPHEN: I wanted, I suppose, to finish on the overall  
 8 impact on your staff. I think you mentioned earlier,  
 9 Lissa, but in your statement at paragraph 89, it talks  
 10 about it was "like nursing in a war zone". That same  
 11 paragraph also says:  
 12 "There was no hope of maintaining care standards  
 13 compared with pre-pandemic, despite the best efforts of  
 14 staff."  
 15 In view of the demands placed upon your staff and  
 16 we've obviously touched on a few of those today, not  
 17 necessarily all, what would you highlight to this  
 18 Inquiry in particular about the physical and mental  
 19 health impact that occurred on your staff?  
 20 MS DI GIACOMO: For those who have remained in the sector,  
 21 I don't think it will ever be the same again. Some of  
 22 them are still haunted by the images they saw at the  
 23 time, bearing in mind we are a care home, we don't have  
 24 access to oxygen or ventilators and our residents were  
 25 not being admitted to hospital, which some may argue is

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1 a basic human right. If you are not well and you need  
 2 hospital admission, that you should be allowed to have  
 3 that admission and not be discriminated against. So  
 4 I think for those who are still with us, it will never  
 5 leave them and it's something they have to carry.  
 6 I think for the sector, we've lost some good people  
 7 who just couldn't carry on and couldn't take it anymore.  
 8 Because — in summary, we weren't consulted, they didn't  
 9 have a conversation with us, which could have helped.  
 10 It might not have but we'll never know. We were given  
 11 guidance that we didn't fully understand and found it  
 12 challenging to implement and now we're being  
 13 investigated because we had COVID deaths. And we're the  
 14 only body to have gone through that. But we've lost  
 15 some good people that may not be there when my time  
 16 comes.  
 17 MR STEPHEN: Thank you.  
 18 MR FINNIGAN: I think just what Lissa said there, I think  
 19 that summarises it really well actually, and I would  
 20 just be repeating what Lissa said. I think just  
 21 difficult and actually lots of — I've heard lots of  
 22 people express it as "trauma", and through this process  
 23 I've obviously met with some of my team to talk about  
 24 some examples and you can see real hesitation about  
 25 speaking about it. When you bring it up, it just brings

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1 back all the memories. I've heard people saying that  
 2 they cannae watch any TV shows that have got — during  
 3 the pandemic, if it's a care home or hospital setting,  
 4 when people are all gowned and masked up, it really  
 5 brings back that experience that they had. And although  
 6 I personally never experienced lots of the challenges  
 7 that they faced, I think it was horrific at the time and  
 8 it's never going to leave them.  
 9 MR STEPHEN: Thank you. I don't have anymore questions for  
 10 you. If there's anything else that either of you would  
 11 like to add or you think that we've missed or you think  
 12 it's important to say, now is the time.  
 13 MR FINNIGAN: I don't think so.  
 14 MS DI GIACOMO: No, I think we've covered it.  
 15 MR STEPHEN: Thank you very much.  
 16 THE CHAIR: And I have to thank you very much as well.  
 17 Thank you both very much for your evidence. I'm very  
 18 grateful.  
 19 Very good. That finishes us for today, Mr Stephen.  
 20 MR STEPHEN: I tried my best.  
 21 THE CHAIR: You did very well. 9.45 tomorrow morning.  
 22 Thank you.  
 23 (12.50 pm)  
 24 (The hearing adjourned until  
 25 Wednesday, 27 March 2024 at 9.45 am)

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