

OPUS2

Scottish Covid-19 Inquiry

Day 59

November 12, 2024

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 2 Tuesday, 12 November 2024
 3 (10.00 am)
 4 MR STEPHEN: Good morning, my Lord.
 5 THE CHAIR: Good morning, Mr Stephen.
 6 MR STEPHEN: We have one witness this morning.
 7 THE CHAIR: Good morning. Thank you for coming. When
 8 you're ready, Mr Stephen.
 9 MR STEPHEN: I am obliged.
 10 MS KELLY MUNRO (called)
 11 Questions by MR STEPHEN
 12 Q. Could you confirm your full name, please?
 13 A. Kelly Marie Munro.
 14 Q. Thank you, and you have already helpfully provided a
 15 written statement to the Inquiry; is that correct?
 16 A. Yes.
 17 Q. Thank you. For the Inquiry's record, the reference
 18 number for that witness statement is SCI-WT0221-000001.
 19 Just to reiterate at the outset, Ms Munro, that
 20 everything you have said in that written statement will
 21 be taken into account by the Inquiry, even if we don't
 22 touch on every single aspect of it in oral evidence
 23 today.
 24 A. Okay.
 25 Q. Just a gentle reminder that the hearing is being
 transcribed, and there will be stenographers taking

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1 notes, and no doubt his Lordship will be too, so just a
 2 reminder to speak at an appropriate pace and I will do
 3 the same. Thank you. Now, you're here today to give
 4 evidence on behalf of the charity, Carers Trust
 5 Scotland; is that right?
 6 A. That's correct.
 7 Q. How would you describe in headline terms the main
 8 purpose or aims of Carers Trust Scotland?
 9 A. We are one of the national carer organisations in
 10 Scotland. We are an organisation that works with local
 11 young carer services. We — in my role, I work across
 12 strategic organisations, so COSLA, Scottish Government,
 13 local authorities, local young carers' services; and I
 14 get to work with young carers as well, advocating for
 15 their rights and listening to challenges that they have.
 16 Q. Thank you, and I was going to come on to, what is your
 17 job role, your title within the organisation?
 18 A. My title is education officer primary and secondary, so
 19 a lot of my work is raising awareness of young carers
 20 throughout education and the challenges that they have.
 21 Q. And how long have you held that role for?
 22 A. Over five years now, 2019 I started, so June 2019, so
 23 over five years.
 24 Q. I think the main focus of your written statement, and no
 25 doubt evidence today, is unpaid carers and specifically

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1 young carers. How many unpaid carers are there roughly
 2 in Scotland?
 3 A. So there's — the number that we identify would be
 4 66,000, but of that, young carers, there's — recognised
 5 there's at least 30,000 young carers in Scotland.
 6 Q. When we're talking about young carers, what age or ages
 7 are we talking about?
 8 A. There's no definition in the legislation that states a
 9 young carer is someone under the age of 18. Our
 10 services that we work with, our local young carer
 11 organisations, tend to support from ages 4 or 5, and up
 12 to 18, and then you have like young adult carers which
 13 are 18 to 25.
 14 Q. So potentially very young then. I think the legislation
 15 you're referring to, you refer to this in your statement
 16 at paragraph 69, this is the Carers (Scotland) Act 2016?
 17 A. Yes, that's correct.
 18 Q. Thank you. How would you describe in high level terms
 19 the range of responsibilities that young carers have,
 20 the things that they are typically asked or undertake?
 21 A. It can range anywhere from helping with housework,
 22 looking after brothers and sisters, providing
 23 communication, right up to personal care. They can help
 24 with — helping a member of family or the person they
 25 care for get dressed. They can deal with budgeting for

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1 the household, they can deal with shopping for the
 2 household, collecting and providing medication. They
 3 can accompany the cared—for person to appointments. It
 4 ranges from everything they can do an hour or two caring
 5 a week, right up to 90 hours or more a week.
 6 Q. I was going to ask, I mean, is that typically then quite
 7 a large part of their time spent on that role?
 8 A. Yes, it will vary. Every young carer is different, but
 9 it will vary. A lot of young carers, it will impact
 10 their day-to-day life, so everything from education to
 11 their own health and wellbeing, to even spending time
 12 with friends or engaging in hobbies and other
 13 extracurricular activities.
 14 Q. You touched on it there, but is there a reality or
 15 expectation on young carers, then, that they have to
 16 balance or juggle those responsibilities perhaps with
 17 other things like education or employment perhaps?
 18 A. Definitely. Young carers that we have worked with in
 19 young carer services will report that actually they
 20 often find tasks difficult, so perhaps in school, they
 21 may find homework difficult if they're carrying out
 22 caring responsibilities when they get home. They often
 23 report that they can't take part in extracurricular
 24 activities, so hobbies after school, football clubs,
 25 perhaps a drama club, because they need to get home due

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1 to caring responsibilities . Perhaps the same at
 2 weekends.
 3 They also sometimes take time off school if they
 4 need to accompany a cared-for person to a medical
 5 appointment, or if somebody is coming into the house and
 6 they need to translate, or perhaps they just need to
 7 support that person.
 8 Q. To be clear, are you saying that will be the case even
 9 without the pandemic, and the pandemic is obviously
 10 something the Inquiry is interested in ---
 11 A. Yes.
 12 Q. --- and we will come on to in a moment. That's the
 13 reality for them even outwith that?
 14 A. Yes.
 15 Q. Thank you. Against that background, I want to turn and
 16 discuss with you the pandemic.
 17 A. Okay.
 18 Q. I thought to start firstly with the closure of schools,
 19 if I may, and lockdown. At paragraph 12 of your
 20 statement, you say that even in relevance advance of
 21 lockdown in March 2020, that your organisation was
 22 learning that a lot of young carers were already
 23 starting to get worried about going into school. What
 24 was the cause or causes of their anxiety at that stage?
 25 A. So I think that the media had obviously been reporting,

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1 I think we had all seen that, but what we were hearing
 2 from young carer services and other young carers is they
 3 care for someone who would be potentially shielding, so
 4 they may have a terminal illness, they may be
 5 immuno-compromised, and they were worried about being in
 6 school and getting the virus and taking it home to that
 7 person; because with that they were saying there may be
 8 guilt, that they were passing that onus on, so they were
 9 really concerned about going into school, because there
 10 was large numbers of people congregating, and they
 11 didn't want to pass that back home to person they cared
 12 for, or other people in the house, but particularly the
 13 person they cared for, in any case they would be ---
 14 I think it was going to be admitted to hospital, or if
 15 they had --- there was real fear around getting the
 16 virus, and they didn't know outcomes of the virus at
 17 that point.
 18 Q. Thank you. At paragraph 13 of your statement, you say
 19 that your organisation had not yet conducted any
 20 studies, so how were you being made aware of these
 21 concerns at that time?
 22 A. So we work with local young carer organisations in every
 23 local authority in Scotland, and we were reaching out to
 24 them just to say: do you need any support, we understand
 25 it's uncertain times. Our young carers were reporting

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1 anything --- they need additional support, and this is
 2 what the workers on the ground that were interacting
 3 with young carers daily, this is information that they
 4 were being given and reported back to us.
 5 Q. Thank you. At paragraph 14 of your statement, you say
 6 that anecdotally, you became aware that young carers
 7 stopped attending school, university and respite
 8 services, and again, this is in advance of lockdown
 9 itself. Again, what were you being told or were you
 10 hearing was the reason for that, that they were stopping
 11 going altogether?
 12 A. The fear of getting the virus. They had heard at that
 13 point that perhaps somebody they knew or someone they
 14 knew had contracted the virus, and the fear was real, so
 15 they were withdrawn from school, didn't want to go in
 16 again. This was information coming through from our
 17 young carer services. They were also stopping going to
 18 their young carer services that often offered respite
 19 groups. They had withdrawn from those groups as well,
 20 from real fear of contracting the virus and taking it
 21 home.
 22 Q. When you say in advance of lockdown, do you know, again,
 23 it might be roughly, how far in advance we are talking
 24 about, weeks, months ---
 25 A. I think it was weeks. I don't think it was months.

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1 I think it was probably about three or four weeks before
 2 lockdown.
 3 Q. Okay, and that was having a chilling effect, perhaps, on
 4 their attendance in an education setting?
 5 A. Yes.
 6 Q. Thank you. Now, if we turn then to when schools did
 7 indeed close, at paragraph 16 of your statement, you say
 8 that young carers really struggled with the closure of
 9 schools, and in that context, you cite one of the
 10 surveys that was carried out by Carers Trust Scotland in
 11 June 2020, I think published then in July 2020. For the
 12 Inquiry record, the reference for that is
 13 SCI-CTSxxx-000003. I won't take you in detail to that
 14 document itself, but I do want to ask you a few
 15 questions about it. This is the "2020 Vision: Hear Me,
 16 See Me, Support Me And Don't Forget Me". That's the
 17 document that I'm referring to. First things first, was
 18 the aim of that survey then to understand the experience
 19 of young carers during the pandemic?
 20 A. Yes. We wanted to hear from young carers and what
 21 challenges they were facing if any. We wanted to hear
 22 about their lived experience during the pandemic, and
 23 also to find out what more they needed support with, if
 24 there was gaps in areas that we weren't providing.
 25 Q. Do you know what the survey sample was that was taken at

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1 that time?
 2 A. I can't remember off the top of my head.
 3 Q. No, that's fine. I think in the document itself at the
 4 outset, I think it's around about 214 carers aged
 5 between 12 and 25, I think. What did that survey tell
 6 you then about the impact of school closures upon the
 7 time, the number of hours that young carers were having
 8 to spend on caring?
 9 A. It showed that young carers had an increase in their
 10 caring responsibilities in their home. One of the
 11 figures that's in my statement relates to young carers,
 12 I think they show an increase of 6% of up to 90 hours or
 13 more caring, whilst still trying to engage in online
 14 education. That figure rose to 11% for young adult
 15 carers, so those over 18. So if they're caring for 90
 16 hours, they're still trying to do their learning at home
 17 alongside that, and the person they care for being there
 18 as well.
 19 Q. So was that in your view a significant increase in their
 20 caring responsibilities?
 21 A. Yes, because they would normally be at school for,
 22 I would say, at least 25 hours a week if they were there
 23 in full-time education where they wouldn't be — where
 24 they would be focusing on their learning, they weren't
 25 in that environment, and they were then having to take

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1 on caring roles at home, more responsibilities at home.
 2 Q. I think that same document talks about one in ten young
 3 carers seeing their caring role increasing by 30 hours
 4 or more as well. Given that increase then in caring
 5 responsibilities, what did young carers have to tell you
 6 in that survey about the impact upon their education
 7 specifically, for example, upon their ability to do
 8 their schoolwork?
 9 A. They were finding it really difficult to engage in
 10 online education, because they felt they had to check on
 11 the cared-for person more at home. They were being
 12 interrupted during their online learning, if they were
 13 able to get online. If they had siblings as well at
 14 home, that was a really hard environment, and — relate
 15 to it later in the statement, but also there's that
 16 being able to actually get online, the use of digital
 17 technology if it was working or if they had access to
 18 it.
 19 Q. Yes, and we'll come on to digital inclusion in due
 20 course. I certainly want to cover that with you.
 21 I think at paragraph 51, just on this point about
 22 schoolwork or homework, I think you say in your
 23 statement that they were caring all day and struggling
 24 to do their homework. That was the reality for them?
 25 A. That's correct, yes. They would — if they were able to

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1 engage on online learning, even if it was only an hour,
 2 they struggled, and then they would struggle to do
 3 further study around that. So they would stress about
 4 not getting their schoolwork done, but they would also
 5 be worried about the person — like not providing enough
 6 care to the person they cared for, so they struggled to
 7 do that because of their caring roles, or because of the
 8 home environment they were in.
 9 Q. Was that tension, that divided loyalties, if you like,
 10 you're talking about there between their own education
 11 and the person they were caring for, is that something
 12 that you were hearing from young carer organisations,
 13 young carers themselves?
 14 A. That would be correct. They had to engage in online
 15 learning for five hours or — go and make lunch to go
 16 and provide medication to the person they cared for, so,
 17 yes, there was conflict there with them.
 18 Q. Thank you. And you say at paragraph 17 of your
 19 statement that the feedback you were getting was that it
 20 was a difficult period, particularly if you were at home
 21 all the time, young carers at home all the time with a
 22 cared-for person. Can you elaborate on the feedback
 23 that you were receiving in terms of respite, for
 24 example?
 25 A. So normally at school, if a young carer was at school

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1 throughout the day, they tend to — they would let us
 2 know previous to the pandemic that perhaps they phoned
 3 home to check on the cared-for person, they sent a text.
 4 The odd young carer, if they stayed close, may go home
 5 at lunchtime. However, when they were home all day with
 6 the person that they cared for, even if they weren't the
 7 main carer, they still felt that need to check on them,
 8 to check if they were okay, if they needed medication,
 9 if they needed food, if they needed anything at all, any
 10 kind of support. Particularly perhaps those with mental
 11 health, they perhaps needed a bit more extra support
 12 during the pandemic, so they felt they needed to
 13 constantly check on them.
 14 Q. Thank you. Now, again, sticking with school closures
 15 and moving beyond, I suppose, schoolwork itself, you say
 16 at paragraph 37 of your statement, you say that when
 17 schools were open, young carers would be there, I think
 18 25 hours a week, you said the same a moment ago,
 19 I think, and teachers who knew those young carers would
 20 be looking out for them, recognising if they were tired
 21 or troubled, for example, due to something that was
 22 happening at home, a family issue. Did that teacher
 23 supervision or pastoral role, did that go missing in
 24 your view during the school closures?
 25 A. In our view, yes. When a young carer is in class or any

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1 learner is in class, teachers are able to identify that
 2 through behaviours, in-person behaviours. Those
 3 behaviours are harder to identify. A lot of young
 4 carers go unnoticed because — or don't identify
 5 themselves because they're worried about social work
 6 intervention, they're embarrassed, they don't know
 7 they're a young carer. So for young carers that have
 8 taken on that caring role during the pandemic, it almost
 9 felt normal to them, or this is something they should be
 10 doing.

11 So we feel like a lot — we were informed that a lot
 12 of young carers probably weren't identified during this
 13 time. And I think that shows — the SEEMis figures that
 14 we'll talk about later on. I'm sure the school
 15 recording system actually dropped with the number of
 16 young carers identified during school, so we feel that
 17 they weren't getting the support from school that they
 18 probably needed during that time.

19 Q. Thank you. I think at paragraph 80, you say nobody was
 20 checking on them, and nobody was recognising those
 21 responsibilities?

22 A. If they weren't attached to a young carer service, and
 23 they weren't known to their schools, then no one was
 24 recognising the responsibilities they were carrying out
 25 during this time. There was no support that they were

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1 getting during this time; particularly if they had an
 2 increase in caring responsibilities, or if they needed
 3 respite, these factors weren't being identified.

4 Q. You talk in that same paragraph, paragraph 80, about
 5 I think perhaps an embarrassment sometimes about young
 6 carers. Is there a reticence amongst young carers
 7 sometimes to want to disclose the extent of perhaps the
 8 responsibilities they have?

9 A. Yes. Young carers have disclosed to us that it has
 10 taken time for them to recognise they're young carers,
 11 or want to say that they're a young carer for fear of
 12 embarrassment. Now, the embarrassment may come around
 13 the condition of the cared-for person, particularly if
 14 it's mental health or addiction issues. It may be
 15 embarrassment because they're having to help with
 16 personal care or dressing, or it may just be that
 17 actually their friends and peers don't do the same role
 18 as them, so they don't want to come forward and tell
 19 people what they do.

20 Q. Thank you. Again, on school closures, you talk at
 21 paragraph 67 of your statement about young carers
 22 struggling during the pandemic to access healthy meals
 23 and food. Again, in your view, to your knowledge, did
 24 the closure of schools have an impact on young carers
 25 being able to access those things?

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1 A. Yes. I would say when they're at school, they have
 2 access to canteen, they have access to food, they have
 3 access for those in free school meals, they have access
 4 to that, to school meals, and being able to have that
 5 break from their caring role — as well. The report
 6 that we published, like 35% of young carers were
 7 struggling to look after themselves, and that could be
 8 because they're focused on the cared-for person, so they
 9 want to make sure that they're eating, and they're
 10 getting their medication, and they're getting enough
 11 sleep before they look after themselves to do it.

12 Q. Thank you. You mention at paragraph 68 that when
 13 schools were closed, some young carers at least were
 14 receiving wellbeing boxes of food. Where were those
 15 boxes originating from, do you know?

16 A. So some of the boxes, I think, were provided by the
 17 government or local authorities, as part of the COVID
 18 pandemic, but they would often get ingredients that they
 19 didn't know how to cook with or they didn't have the
 20 life skills to deal with. Local young carer services
 21 did have good practice initiatives where they would drop
 22 bags of ingredients at their door, and then they would
 23 have like an online cook-along, so they were learning
 24 some life skills, where — they would get to learn life
 25 skills but also they would have the chance to be able to

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1 make a hot meal for them and their families, for
 2 families that weren't sure how to do this, or perhaps
 3 the young carer was the only one able to do that.

4 Q. You mention that lack of life skills. Why was there
 5 that lack of life skills, do you think? Is that a
 6 reflection of age, or what is the reason for that?

7 A. It could be a reflection in age. You could have like
 8 10, 11-year-olds that perhaps just haven't been shown
 9 how to cook meals or shop, or perhaps it was just the
 10 main carer was now a key worker and out of the
 11 household, and it wasn't a skill that they had learned,
 12 and had to do it as you went along. So there was
 13 different reasons for it.

14 Q. At paragraph 71 of your statement, you also mention,
 15 I think, perhaps supermarket vouchers sometimes being
 16 issued to young carers. Again, was that something they
 17 were able to utilise?

18 A. So in some areas, families were given vouchers, and
 19 particularly for those in poverty were given supermarket
 20 vouchers to use, but if the — if the cared-for person
 21 couldn't leave the house, then the young carer had to
 22 use them, but the vouchers were often for supermarkets
 23 many miles away, particularly in the Highlands and
 24 Islands, so either they had to travel by bus, because
 25 young carers may not have been able to drive, they may

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1 not have been at an age where — or been able to get a
 2 lift , because it would have been someone outwith the
 3 family, or they had to walk a few miles. It wouldn't be
 4 their local supermarket that the voucher was provided
 5 for. It might be one, two or three miles across town
 6 where they would have to walk to and then walk back.
 7 Q. Thank you. I want to move on then. With the closure of
 8 schools, delivery of education then moves online. At
 9 paragraph 18 of your statement, you say that a lot of
 10 young carers reported struggling with online learning.
 11 We'll come on to digital inclusion more broadly in a
 12 moment, but I wanted to start by asking, in your
 13 experience, was the home environment for young carers,
 14 many young carers, was that suitable for online
 15 learning?
 16 A. The feedback that we received from young carers and
 17 young carers' organisations was that it was difficult
 18 for them to engage in online learning. We held a focus
 19 group with young carers, and during that time, a few of
 20 the young carers disclosed that if they had a sibling
 21 that had a learning disability , was neurodivergent, even
 22 a physical disability , was keen to be in the same room,
 23 be on the Google Classroom with them, there was constant
 24 interruptions for them, and they wouldn't have had this
 25 interruption had they been in a physical classroom in

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1 the school. So they found it really difficult to engage
 2 in online learning. Sometimes they just wouldn't go to
 3 the class if they thought it was going to be too
 4 chaotic, or they would have too many interruptions,
 5 because they couldn't focus on their learning.
 6 Q. And is that a lesson learned, do you think?
 7 A. Yes, I definitely would say it was a lesson learned
 8 particularly for young carers, I think, that they had no
 9 other choice. I don't think they were able to take a
 10 laptop and go to a different room. I think that
 11 scenario would still work out the same, I think, but if
 12 they had access to school hubs, then it would make life
 13 easier for them, not to say that every young carer would
 14 have went to a hub, but the opportunity would have been
 15 there for them to get a break and been able to engage in
 16 online learning.
 17 Q. We'll come back to hub schools, but moving more to
 18 digital inclusion more generally, at paragraph 30 of
 19 your statement you say that numerous young carers and
 20 young adult carers were isolated, due to being digitally
 21 excluded.
 22 Now, I understand at paragraph 27, that was an issue
 23 that was highlighted to the Scottish ministers in a
 24 letter of 11 June 2020. For the Inquiry's record that
 25 document is SCI-CTSxxx-000005. For completeness, at

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1 paragraph 28, you say that your organisation received a
 2 response to that letter in July of 2020, and again for
 3 the Inquiry record, that reference is SCI-CTSxxx-000007.
 4 I don't want to go into the detail of that exchange
 5 because the Inquiry will move on to implementation and
 6 decision-making phases in due course. But what I do
 7 want to ask you is are there any particular examples of
 8 digital inclusion or exclusion that you would like to
 9 highlight to the Inquiry. I think you cover a couple of
 10 these in your statement, but it would be helpful to hear
 11 those?
 12 A. We heard from some young carers. One young carer had to
 13 use her mother's mobile phone to access education,
 14 online classrooms, because they had no other device in
 15 the house. They also didn't have wi-fi, so they were
 16 using mobile data, and she found this really difficult
 17 because some — certain apps weren't supported on it, so
 18 the young person couldn't use that — within there —
 19 there was another young person who was missing some
 20 online classrooms because the family only had one
 21 device. His mother was a full-time university student,
 22 and they were also trying to use that device for the
 23 cared-for person's hospital appointments. Despite
 24 asking the school for further — and the local young
 25 carers' organisation also asked for help with devices,

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1 the school had said that these devices had been passed
 2 to other vulnerable children, and unfortunately there
 3 was nothing else available for them. They repeatedly
 4 asked for printed copies of schoolwork, and this was
 5 never delivered.
 6 Q. And to sum up then, what was the consequence for them
 7 being able to undertake their education at that time?
 8 A. They were digitally excluded. They weren't able to
 9 access online education, or if they were, it was very
 10 limited, being able to access, so therefore they didn't
 11 have the same — the same access as their peers that
 12 would have laptops or mobile phones, or — so it had an
 13 impact on their education. They felt that they didn't
 14 get exam results that they wanted or access to study
 15 that they needed, so they felt that that had a big
 16 impact on their education and further education.
 17 Q. And just to be clear, these examples that you have
 18 given, these were highlighted to the
 19 Scottish Government; is that right?
 20 A. Yes, in the letters we sent to them.
 21 Q. Thank you. In your experience then, was there a
 22 consistent approach by local authorities to digital
 23 inclusion for young carers in Scotland?
 24 A. No. Every local authority was different, and every
 25 young carer had a different experience. One of the ones

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1 that I do highlight in my statement that we heard a
2 positive story was in Stirling, every person, every
3 pupil learner in first year is given a laptop which sees
4 them through the whole of secondary school. So they all
5 have equality, they all have the same chance to have
6 that.

7 In other areas, this wasn't — there wasn't the same
8 rules applied. They had to — young carers were trying
9 to get digital devices from their school. Their local
10 young carer service managed to get some refurbished
11 tablets or refurbished laptops from local businesses.
12 Perhaps they got given grants which they were able to
13 then purchase technology online, and give a loan to
14 young people.

15 The other thing that we have seen was where schools
16 may be like: here you can have a laptop or a tablet or a
17 digital device, they were in areas where they couldn't
18 get wi-fi, or it was really poor wi-fi or poor mobile
19 data. So they were given the mobile phone dongles, but
20 actually that wouldn't connect, so they would have
21 enough to perhaps download one document, but they
22 couldn't engage in a video classroom.

23 Q. Thank you. I think at paragraph 29 of your statement,
24 I think the phrase you use is a postcode lottery; that's
25 your view in terms of digital inclusion across local

21

1 authorities ?

2 A. Yes, I would agree with that; there wasn't a consistent
3 approach, and young carers were disadvantaged, depending
4 on what local authority they lived in.

5 Q. Thank you. Now, you touched on it there, but I will
6 come back to it now. At paragraph 34 of your statement,
7 you highlight young carers in rural areas of Scotland,
8 and I think you just said that perhaps their access and
9 use of digital devices was not necessarily a
10 straightforward one; is that correct?

11 A. That's correct. So although they may have had the
12 hardware, like in regards to a laptop or a tablet or a
13 device, there was a lack of consideration given to young
14 people in remote areas and the lack of infrastructure
15 there as well, because it's all very well given a dongle
16 or a mobile wi-fi device, but if you're in a really
17 rural area and can't get on, they had no option. They
18 just had to not engage in their education.

19 Q. Is it your evidence, then, that those in rural areas
20 might have been more affected than those perhaps living
21 more centrally in terms of digital inclusion?

22 A. Yes, and means to get online, yes, I would say so.

23 Q. Is that a lesson to be learned, do you think, for the
24 Inquiry to consider?

25 A. I would say definitely in the future that infrastructure

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1 has to be there. If there's going to be more home
2 learning or online learning, then infrastructure has to
3 be there and has to be given consideration, particularly
4 in very rural areas of Scotland.

5 Q. You mentioned grants for technology, and those perhaps
6 were used, I think you say, for laptops, tablets, things
7 like that. At paragraph 33 you talk about that. In
8 your, or to your knowledge, was that application process
9 for young carers to obtain those devices, was that a
10 straightforward application process?

11 A. The grants from their local young carers' service that
12 they had to apply for — so I wouldn't say the young
13 carer had to apply for that grant. It would be done
14 through a third sector service, it may not be a local
15 young carer service. But actually, that was additional
16 resources that the service needed, so they were already
17 quite stretched. It was during a pandemic, and then
18 they had to do further resourcing of — it was
19 Connecting Scotland, so they had to go through the
20 application, I think somebody had to register to be like
21 an online contact for them as well. So although there
22 was grants available, it relied heavily on the third
23 sector organisation supporting the young carers applying
24 for those grants, buying the technology and then
25 distributing that technology for them.

23

1 Q. Thank you. I want to move on then to hub schools which
2 you have mentioned slightly earlier on in your evidence.
3 At paragraph 21 of your statement, you say that your
4 organisation learned that the criteria for attendance
5 for hub schools was set by each local authority. In
6 your view or experience, were those criteria clear and
7 consistently applied?

8 A. No, it was different in every local authority area, so
9 in some areas, young carers were able to attend hub
10 schools, they were part of the criteria, and it was open
11 to them if they wanted to attend. In other areas they
12 couldn't attend unless they met specific criteria, so if
13 they were a looked-after child or young person was one
14 example we were given.

15 Q. Because at paragraph 22 of your statement, I think you
16 say that your organisation had a good relationship with
17 certain local authorities who were flexible in approach,
18 so that in that instance, young carers were able to
19 attend hubs; is that correct?

20 A. Yes, we had a meeting in one local authority, online
21 meeting with their quality improvement manager, who —
22 and the local young carer organisation who actually
23 said, yes, they would open that up to young carers, and
24 would there be specific young carers. Also, they were
25 asking if there was any additional support they could

24

1 give to a young carer; for example, did they prefer to
 2 be in a separate room so they weren't with other young
 3 people to increase the risk of the virus. But it was —
 4 I'll go back to my previous one, it was a postcode
 5 lottery. The criteria was different in every local
 6 authority area, and I think for learning in the future,
 7 I think there needs to be national guidance rather than
 8 local guidance, so that young carers aren't
 9 disadvantaged.

10 Q. At paragraph 23 of your statement, you highlight that
 11 there were some young carers, I think you say those that
 12 were caring for those with mental health conditions or
 13 addiction, being denied attendance at hub schools. Do
 14 you know or were you told the reasons as to why that
 15 was?

16 A. They just — they were told that young carers, being a
 17 young carer wasn't part of the criteria. They had
 18 limited spaces within hubs, and young carers didn't meet
 19 that criteria. If they had another criteria, then they
 20 could apply under that, but they couldn't go because —
 21 just because they were a young carer. It wasn't part of
 22 the criteria. They feel their education suffered from
 23 not being able to get respite from those caring roles
 24 and the trauma that they had to go through, particularly
 25 for those with addiction issues and mental health issues

25

1 during that time. In two local authorities, that was
 2 highlighted to us.

3 Q. Thank you, I want to move on then now to the reopening
 4 of schools. At paragraph 76 of your statement, you say,
 5 based on anecdotal information, that many young carers,
 6 I think around three-quarters is what you say, were
 7 hesitant to go back to school. What was causing that
 8 hesitancy?

9 A. I think it was the same reasons for withdrawing from
 10 school. Before lockdown, I think the virus was still
 11 very much present. They were scared they were going to
 12 go back to school and pass it on. They were scared that
 13 people wouldn't be wearing masks and that they had built
 14 up this bond with the cared-for person, so they were
 15 also worried about, if they weren't going to be there,
 16 who was going to do all these caring responsibilities
 17 that they had been doing during that time.

18 Q. At paragraph 50, I think you highlight a tension that
 19 you mentioned earlier. You are talking about a Young
 20 Carer Voice online event for young carers, where I think
 21 the topic for discussion was the reopening of education
 22 or establishments, and you say that:

23 "If young carers did return, they had to think not
 24 about their education but the health and safety of the
 25 relative they were caring for."

26

1 Was that a choice that young carers were making you
 2 aware of, that they were wrestling with?

3 A. Yes, they were worried about going back. I think —
 4 they had to think about mixing with people, people not
 5 wearing masks. I think they were doing — like the hand
 6 washing, some young carers were reporting back that they
 7 were changing again before going into school in case
 8 they were taking this virus back. And they were
 9 highlighting again that — who was carrying out the
 10 caring responsibilities that they had been delivering or
 11 they'd been doing while they were off school and at
 12 home. So a lot of this is going round in their head
 13 when they're back, and this anxiety is very real for
 14 them when they're back in education.

15 Q. At paragraph 77 of your statement, you say that there
 16 were worries about the ventilation within schools. I
 17 just wanted to ask if you could elaborate upon what
 18 those worries about ventilation were at that time?

19 A. I think some of the young carers were reporting back
 20 that if they wanted windows open, then people were
 21 saying it was too cold, or it was too hot because some
 22 of the schools' ventilation system, the — one young
 23 carer had reported back that perhaps she had heard about
 24 ventilation carrying the virus, and they were worried
 25 about that. So that's the information that we had

27

1 around ventilation.

2 Q. Did all young carers return to school?

3 A. No, we've heard that some young carers withdrew from
 4 education completely, I think around that anxiety of
 5 bringing the virus back, or just their experience during
 6 lockdown, and they were already withdrawn from online
 7 classrooms; and I think also for those caring
 8 responsibilities, they felt that they were unable to
 9 return to school because the care wouldn't be there,
 10 replacement care wouldn't be there while they were in
 11 education.

12 Q. I think at paragraph 66 of your statement, you say that:
 13 "Some of our young people lost their way in
 14 education and did not return..."

15 A. Yes.

16 Q. Thank you. I would like to move on now to the impact of
 17 the cancellation of the exam diet. This is something
 18 that you talk about in your statement and the
 19 development of the alternative certification model. At
 20 paragraph 40 of your statement, you describe that policy
 21 change as causing worry to young carers. What were the
 22 main reasons for that concern?

23 A. So a lot of young carers were worried about the change,
 24 because perhaps they hadn't done so well in their
 25 prelims. It may have been due to something had happened

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1 with the cared—for person. It was a really anxious
 2 time. They weren't able to study as much. Perhaps
 3 their caring role had increased during that time, but
 4 following the prelims, they tried to make up for that.
 5 They tried to be in class more, they tried to be part of
 6 study more, so they were also worried that the results
 7 that teachers would give them may be lower because of
 8 their attendance due to caring responsibilities .

9 So that was — they were reporting back that they
 10 were quite anxious and stressed about that, as it was
 11 going to determine their future on the grades that they
 12 got.

13 Q. Were those concerns, those worries, something that was
 14 made known by your organisation to the Scottish
 15 Government?

16 A. Yes. We sent a briefing to the Scottish Government to
 17 highlight these worries around the exams. We also
 18 worked with SQA. We were part of a working group.
 19 However, the policy wasn't going to change around that,
 20 and we were informed to let them know about appeals
 21 processes, should they want to do that. We let all
 22 young carer services know that as well, and provided
 23 additional support.

24 Q. That briefing paper you mentioned, you have provided a
 25 copy of that to the Inquiry, so for the record that

29

1 reference is SCI and then xxx—000009. Given what you
 2 have just said, how would you describe the impact of
 3 that policy change upon the educational attainment of
 4 those young carers?

5 A. They were really concerned. We don't hold what grades
 6 they got in school, we don't know what their attainment
 7 exam results were, but we did hear that through our
 8 local young carer services, that some young carers
 9 didn't get the grades that they were expecting and went
 10 through an appeal process.

11 Q. I think you say at paragraph 38 that the impact of this
 12 was life—changing for some young carers, is the way you
 13 put it?

14 A. Yes. If they were hoping to get a certain grade to get
 15 into college or university and didn't get that grade,
 16 then it was life—changing for them. They had to go down
 17 a different path than they wanted to go down.

18 Q. Thank you. I wanted to move on now to, I suppose, the
 19 change in the role for young carers during the pandemic.
 20 For example, at paragraph 19, you talk about how for
 21 some young carers, the pandemic changed the caring
 22 dynamic within the household. I think the example you
 23 give is if a principal carer was a key worker, they
 24 would then be out of the house more.

25 Then at paragraph 24, you also talk about how young

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1 carers were having to backfill for paid support. You
 2 highlight that as an issue. So my question really for
 3 you is, given those increased caring responsibilities ,
 4 and this gap in paid support that you've highlighted,
 5 what respite was available for those young carers at
 6 that time?

7 A. The young carers didn't have any respite. They were at
 8 home 24/7 with the person they cared for. I think when
 9 the legislation changed and they could get out for an
 10 hour a day, if they were able to do that, then they
 11 could do that. But I think even then, if they were with
 12 someone that was shielding, they wouldn't leave the
 13 house.

14 There was occasional respite where they could
 15 perhaps go on a tablet or listen to music or — but they
 16 were in the home with the cared—for person 24/7. We
 17 talk about it in my statement later on, but young carer
 18 services would provide wellbeing boxes with perhaps like
 19 bath salts and colouring books for younger ones, or like
 20 sweets and hot chocolates and things like that, but
 21 there was no respite from the home. That would just be
 22 a small respite or a small luxury for them within the
 23 house.

24 Q. In your view, is that backfill in paid support something
 25 that young carers should have had to do?

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1 A. No. Young carers were disadvantaged by being — having
 2 to do that back support, but they felt they had no
 3 choice. When support was cancelled, when day centres
 4 were cancelled, they had no one else to turn to to do
 5 that support, so they took it upon themselves to do
 6 that.

7 Q. Given what you have said about the respite or lack
 8 thereof, was the social isolation of young carers a
 9 concern that was brought to your attention to your
 10 organisation?

11 A. Yes. Young carers reported loneliness. They had no one
 12 to talk to about their caring role. They had no friends
 13 to socialise with. They couldn't really talk about
 14 their caring role, if it was with a support worker or
 15 with friends, because more often than not, the cared—for
 16 person would be in the room with them or in another
 17 room, where they may have heard, so they felt it
 18 really — they felt it was really difficult to talk
 19 about their caring role and any challenges they were
 20 having.

21 Q. What about the ability of young carers to look after
 22 themselves in terms of their physical wellbeing? What
 23 were you hearing on that?

24 A. We were hearing that actually they were using all their
 25 energy for the cared—for person, so when it came for

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1 them, there was very little sort of time and energy they
 2 used on themselves. They probably didn't eat the best,
 3 they were struggling with sleeping, there was
 4 increased — in that report, the one that we referred to
 5 earlier, the Hear Me, See Me, Support Me And Don't
 6 Forget Me, they report increase in stress and anxiety of
 7 being at home.

8 Q. I think you mentioned in your answer earlier the welfare
 9 checks, and that's something you talk about in your
 10 statement at paragraphs — 41 and 42. I think that's
 11 something you say was another challenge for young
 12 carers. You say that prior to the pandemic, young carer
 13 support workers would have carried out welfare check—in
 14 sessions with young carers. What was the aim of those
 15 checks pre—pandemic?

16 A. So pre—pandemic, if a local young carers' service and
 17 worker, if a young carer was registered with them, they
 18 would often go into school and do check—ins, just to see
 19 how they were getting on with their caring role at home,
 20 to see if they needed more support perhaps with
 21 schoolwork, if they needed more respite, if they were
 22 wanting some group work, if they were perhaps going on a
 23 trip away from their caring role, or they just wanted
 24 somebody to talk to. Perhaps they were getting referred
 25 for counselling in more one—to—one sessions, or they

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1 would often have guest speakers come in and speak to
 2 them about certain conditions. So maybe like
 3 Deafblind Scotland would come in and speak about that.

4 And then during the pandemic, the young carer
 5 workers weren't able to talk to them. It would just be
 6 through phone, and just to repeat what I said earlier,
 7 they were really reluctant to come forward and talk. I
 8 think if the young carers' workers were quite
 9 innovative, then they set up different, like, WhatsApp
 10 groups and chat groups where they could talk to one
 11 another, but it wasn't the same as having that
 12 face—to—face discussion.

13 Q. So pre—pandemic, these would have been face—to—face, but
 14 then schools close, and then I think alternative ways
 15 have to be found, as you have just described.

16 I think you also go on to say, I think when
 17 restrictions ease, I think this is paragraph 44 of your
 18 statement, there was then — walk and talk was then
 19 possible, people could actually leave?

20 A. Yes, they were allowed to — I think it was when you
 21 were allowed to see one person per day or two people per
 22 day, they could go out and do a walk and talk. Young
 23 carers were desperate to get out of the house. They
 24 would get a take—away hot chocolate. Even if it was
 25 raining, they were happy to walk around the park with an

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1 umbrella, but the young carer workers reported getting
 2 some, like, very detailed information for them because
 3 it was maybe the only person they had seen all week, and
 4 they were being really honest about their caring role.

5 So the young carer worker would often just take notes on
 6 their phone, because it was quite hard, when they were
 7 walking round the park, to try and get notes, and they
 8 noticed a massive change in this from only being able to
 9 talk for one to two minutes online or on the phone, to
 10 actually — these young carers being able to express
 11 themselves and any challenges they were facing.

12 Q. And prior to the pandemic, school would have been one of
 13 those safe spaces where these meetings could have taken
 14 place?

15 A. Yes. Young carer workers would often set up in a room
 16 within a school and speak to four or five young carers
 17 within a day.

18 Q. Thank you, I want to now move on to mental health of
 19 young carers. You state at paragraph 53 that that was a
 20 key concern of your organisation at that time. Again,
 21 we'll go back to the survey that we touched on in your
 22 evidence earlier on. At paragraph 55, you say that
 23 there was survey research done into the impact of the
 24 pandemic restrictions upon those young carers and the
 25 mental health. What were the key findings that came out

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1 of that survey?

2 A. So some of the key findings were that young carers were
 3 reporting that their mental health was worse than before
 4 the pandemic. One in four young carers were unable to
 5 take any break from their caring role. I think it's 74%
 6 young carers felt less connected to others since the
 7 pandemic, and 69% of young carers reported that they
 8 felt more stressed. One quote from a young carer says:
 9 "It's hard to care for someone when I can't care for
 10 myself."

11 That's within the survey.

12 Q. To your knowledge, was there a particular group of young
 13 carers who were most or more adversely affected by
 14 mental health issues during this time?

15 A. I would say that they would all be affected by mental
 16 health. I would say particularly those that were caring
 17 for someone with a mental health condition or those with
 18 an addiction were more — they were highlighted more,
 19 and probably that was one of the areas that we were
 20 seeing young carers report on, if they were caring for
 21 someone with mental health or addiction issues.

22 Q. Thank you. At paragraph 58 of your statement, I think
 23 you highlight that young carers not being in school when
 24 they were closed could mean that in some instances, they
 25 were missing out on referrals to mental health services;

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1 is that right?
 2 A. Yes. Some young carers were saying that actually they
 3 had previously perhaps had a referral to CAMHS, child
 4 and adolescent mental health services, but we feel that
 5 others who would have benefited from it were perhaps
 6 being missed during this time, and they weren't getting
 7 the referrals that they otherwise would be getting, or
 8 additional support within the school that would be
 9 happening if there wasn't a pandemic, and they weren't
 10 at home.
 11 Q. At paragraph 56, I think you also mention school nurses,
 12 and I think when schools were open, referrals for
 13 wellbeing assessments would be possible, but again, when
 14 schools closed, is that something that was off the
 15 table?
 16 A. Yes, young carers were referred to school nurses —
 17 well, no young carers that had reported to us that they
 18 had any referrals to school nurses, whereas within the
 19 school, if the young person particularly is going
 20 through a bad time, or if they feel they need more
 21 support, then they should be having a wellbeing
 22 assessment, if the young carer agrees, obviously, but
 23 that didn't happen during the pandemic.
 24 Q. What coping mechanisms for mental health were available
 25 then, given what happened?

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1 A. I would say that they had their local young carer
 2 service who did do the check-ins that were available.
 3 They had wellbeing boxes. Young Scot provide a local
 4 young carer's package where they were able to get — it
 5 used to be in-person, that they could access like
 6 in-person discounts, in-person cinema vouchers and
 7 things like this. But this moved online, and they were
 8 able to access — sort of like mental health apps, they
 9 were able to access subscriptions to — certain, like,
 10 movie subscriptions or music subscriptions, but a lot of
 11 the time, they would pass this on to the cared-for
 12 person, because they felt that they needed it more,
 13 rather than use the respite for themselves.
 14 Q. Thank you. Now, moving on then to the lessons learned,
 15 I suppose, section of your statement, there was one I
 16 specifically wanted to ask you about. At paragraph 84,
 17 you identify a lesson to be learned. You say there
 18 needs to be more robust data around young carers in
 19 school, a more accurate recording of their attendance
 20 and attainment. Why do you consider that to be
 21 important?
 22 A. Because I feel that if more young carers were recorded
 23 within schools, if there was more accurate recording,
 24 then they could get more support that they're entitled
 25 to. Young carers weren't identified during the

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1 pandemic, and I think even those that were recorded in
 2 school could have — should have had more support, so if
 3 all education professionals are trained to identify
 4 young carers, then they will receive the support they're
 5 entitled to. I think stronger working partnerships with
 6 the third sector, particularly young carer service in
 7 schools, would also provide more support and more young
 8 carers being identified.
 9 Q. Thank you. Are there any other particular lessons to be
 10 learned or things that we haven't covered today that you
 11 would like to mention at this stage?
 12 A. Just that I think that all children and young people
 13 should have access, equal access to digital technology
 14 and digital literacy to allow them all to have equal
 15 opportunities within education, and increased
 16 availability of counselling within schools, because the
 17 pandemic was a traumatic experience for them.
 18 MR STEPHEN: Thank you. My Lord, I don't have any further
 19 questions for the witness, subject to anything you may
 20 wish to add?
 21 THE CHAIR: No, I have no questions, you'll be pleased to
 22 know, Ms Munro. Thank you very much for your attendance
 23 and your evidence today, and that brings an end to this
 24 session and we'll come back in a short time at 11.15.
 25 Thank you all very much.

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1 (10.54 am)
 2 (A short break)
 3 (11.15 am)
 4 THE CHAIR: Good morning, Ms van der Westhuizen.
 5 MS VAN DER WESTHUIZEN: Good morning, my Lord. Our next
 6 witness is Mr Glenn Carter who is the head of the
 7 Scotland office of the Royal College of Speech and
 8 Language Therapists.
 9 MR GLENN CARTER (called)
 10 THE CHAIR: Very good. Good morning, Mr Carter.
 11 A. Good morning.
 12 THE CHAIR: Right, when you're ready.
 13 Questions by MS VAN DER WESTHUIZEN
 14 MS VAN DER WESTHUIZEN: Thank you, my Lord. Good morning,
 15 Mr Carter.
 16 A. Good morning.
 17 Q. Could I please ask you to confirm your full names?
 18 A. Glenn Alan Carter.
 19 Q. You gave a witness statement to the Inquiry and, my
 20 Lord, that statement can be found using reference number
 21 WT0643. Mr Carter, you say in your witness statement
 22 that you're a qualified speech and language therapist
 23 and that you have worked in the NHS in Scotland for
 24 23 years; is that correct?
 25 A. That's correct.

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1 Q. For how long have you been in your current role as head
2 of the Royal College of Speech and Language Therapists
3 in Scotland?
4 A. Two—and—a-half years, almost three years.
5 Q. And immediately before that, you say you led a
6 children's speech and language therapy service in NHS
7 Forth Valley; is that correct?
8 A. That's right.
9 Q. I understand from your statement that the Royal College
10 of Speech and Language Therapists is a professional body
11 representing speech and language therapists in the UK,
12 and it has approximately 22,000 therapists in the UK, of
13 which approximately 1,100 are in Scotland; is that
14 right?
15 A. That's correct.
16 Q. Could I please ask you to outline broadly what the aims
17 of the Royal College of Speech and Language Therapists
18 are?
19 A. Yes. Broadly, the aims of the Royal College of Speech
20 and Language Therapists is to promote the speech and
21 language therapy profession, and to improve the lives of
22 people with communication and swallowing needs.
23 Q. Thank you, and how does it do that? I'll come on to ask
24 you about the role of speech and language therapy but
25 broadly, how does the Royal College do that?

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1 A. It's a number of ways, one of which is professional
2 support, so we develop guidance, tools, resources and
3 training for speech and language therapists. Also, we
4 promote and support quality research and evidence to
5 advance the effectiveness of speech and language
6 therapy, and also policy and advocacy where we seek to
7 influence national and local government to ensure the
8 policy is high quality, mature and that it represents
9 the needs of people with communication and swallowing
10 needs.
11 Q. Thank you. Before I go on to ask you about the role of
12 speech and language therapy in educational contexts
13 specifically, please could you explain briefly what
14 speech and language therapists do more generally?
15 A. Yes, so it's a broad remit. So people talk about it
16 from a cradle to grave service, but sometimes it's
17 pre-birth, where we're supporting new families to
18 understand the importance of speaking to their babies
19 and promoting language development. But right the way
20 up to end of life, where that could be working with
21 cancer patients, stroke, motor neurone disease and
22 everything in between.
23 So speech and language therapists, there is two main
24 areas they work in. There is communication and eating
25 and drinking, which is known as dysphagia. On the

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1 communication side, 20% of the population will
2 experience some level of communication need in their
3 lifetime. That is a very broad range. So for children,
4 it could be around their ability to produce sounds,
5 speech sounds for instance. Traditionally, people view
6 it as difficulties with stammering or lisp, but it's
7 broader than that. So it could be with children, some
8 children struggle to understand and express spoken
9 language, it's as if it's a different language for them,
10 but also there's issues with voice, how they use their
11 voice, and social communication.
12 For adults, there can be acquired neurological
13 conditions that affect communication like stroke, motor
14 neuron disease, Parkinson's, dementia. And on the
15 dysphagia side, eating and drinking, there's one in 17
16 people will experience some level of eating and drinking
17 difficulties in their lifetime.
18 For children, that could be about their ability to
19 suck, to wean, to manage solid foods, sensory issues
20 around that. For adults, again, quite a high proportion
21 of acquired conditions can come with dysphagia. For
22 instance, stroke patients, 50 to 75% of them will have
23 some form of eating and drinking difficulty. And speech
24 and language therapists work in a range of places, so it
25 can be in the home, in nurseries, in schools, care

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1 homes, acute hospitals. Also justice settings as well.
2 Q. Thank you. In your witness statement in particular at
3 paragraphs 11 and then at 16 and 18 to 19, you refer to
4 the importance of communication and spoken language
5 skills for children's development and for longer term
6 outcomes. Could I ask you, please, to spend a bit of
7 time explaining some of what is known about this?
8 A. Yes. Communication is core to who we are as humans, and
9 the important aspect is that — it is about the ability
10 to connect with others. So when communication is broken
11 down or hasn't developed, then that can cause distress.
12 So that can be a range of issues where either there can
13 be increased behavioural difficulties or challenges with
14 interacting with others, with learning etc. And so the
15 distress can lead to behavioural issues or indeed low
16 mental health and depression.
17 So there's lots of evidence to show that
18 communication is core to children's ability to learn, to
19 their mental health and their future life chances. We
20 know that if children have difficulties with their
21 vocabulary at the age of 5, they are more — they are
22 three times more likely to have mental health
23 difficulties when they're older. We know that 88% of
24 young, unemployed men have communication needs, and 60%
25 of young people in contact with the justice sector have

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1 communication difficulties.

2 Q. Thank you. At paragraph 11, specifically you refer to
3 the fact that:

4 "If a child has a communication difficulty, then
5 that is likely to affect their ability to learn and
6 access the curriculum, their ability to interact with
7 peers; and to manage and navigate the playground. The
8 impact is wide reaching, and it is important to prevent
9 harm."

10 Would you care to elaborate a little bit on that,
11 please?

12 A. Yes, I think it's important to know how important spoken
13 language is for learning within that context, so it's
14 the foundation on which learning is built. Much of
15 teaching and learning is predicated on language of some
16 degree, whether that's spoken or written language, and
17 therefore children who struggle to communicate in any
18 forms I have described will find navigating the school
19 and the curriculum very challenging. Communication is a
20 dynamic skill. It's one of the most complex skills that
21 humans learn, and therefore being able to make friends
22 and navigate friendships, navigate the challenges of the
23 playground and understanding what's said and what's not
24 said can be quite difficult for children with
25 communication needs.

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1 Q. Thank you. You've already touched on it in your
2 explanation about the consequences of it, but mental
3 health in paragraph 18, you say:

4 "... is closely linked with communication skills ...
5 also a connection between spoken language abilities and
6 behaviour. All behaviour is a form of communication,
7 and we know when children have communication
8 difficulties, they can become distressed and will find
9 different ways to convey that their needs aren't being
10 met."

11 You say that this is manifest:
12 "... in low mood, disengagement with learning, or in
13 more disruptive behaviours."

14 We'll come on to discuss some of the studies that
15 were undertaken during and just after the pandemic, but
16 is there anything more that you would like to elaborate
17 on on this link between communication skills and mental
18 health?

19 A. I think the nature of communication difficulties is lots
20 of children can go under the radar, particularly if
21 they're not making — acting out in school or at home,
22 and their mood is quite low, and they just get by and go
23 under the radar. I think the challenge of behaviour is
24 that it can mask a lot of difficulties, so if a child
25 has particularly challenging behaviours, then that's

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1 what the focus is on, rather than the cause of
2 behaviour, rather than how they're feeling about the
3 lack of contact and connection within the home or school
4 environment.

5 Q. Thank you. I would then like to move on to ask you
6 about the role of speech and language therapy and
7 educational contexts pre-pandemic. If I could ask you
8 first to please explain some of the different types of
9 speech and language communication difficulties that
10 speech and language therapists work with, with children
11 in particular?

12 A. Yes, so in terms of education settings, whether that's
13 nursery or school, there's very wide range of
14 difficulties that can present. So with the... I
15 mentioned speech sound difficulties, some children can
16 be quite unintelligible, and find it difficult to get
17 their point across, which can lead to high levels of
18 frustration and anger. Interestingly, with the speech
19 sounds, that's very closely linked with the ability to
20 read and write, because it's about phonemes and sounds,
21 and so their ability to distinguish between sounds, to
22 process what's being said, and anything that happens
23 within spoken language is translated into written
24 language.

25 There are children with issues such as developmental

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1 language disorder. I think people understand dyslexia
2 far better than developmental language disorder.
3 Dyslexia is obviously a specific difficulty in reading
4 and writing, whereas developmental language disorder is
5 a specific difficulty in the ability to express and
6 understand spoken language, but it also has an impact on
7 written language. These children, some of them are very
8 good non-verbally, they're good socially, and they're
9 good at copying their peers.

10 So sometimes right up to P3, their difficulties
11 aren't apparent because they get by by navigating the
12 environment, being hypervigilant about what's going on
13 and anticipating what they should do. However, when the
14 attainment levels increase and the demands on them
15 increase, then that's when it starts to become much more
16 difficult for them.

17 So the speech and language therapist will seek to
18 observe children in the context of education, identify
19 what strategy they're using, what strategies would be
20 helpful to navigate the educational context, and also to
21 assess their communication and understand what — the
22 range of vocabulary that they have, their ability to
23 understand what's being said, can they follow complex
24 instructions or not, and do they understand the nuance
25 of social communication.

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1 Q. You talk about the types of speech and language
2 difficulties and communication difficulties you work
3 with in paragraph 25, and specifically, you talk about
4 you're assisting children with delayed spoken language
5 skills who present as much younger than they are when
6 they come to school or nursery. You say that there are
7 quite a lot of environmental factors that play a part in
8 that. Would you care to elaborate on that, please?

9 A. Yes, so our members and educators are saying there's a
10 large number of children coming to school with
11 inadequate spoken language skills for learning. That
12 can be presented in lots of different ways, but the
13 reasons for that are complex. I suppose it's important
14 to understand the different types of needs that they can
15 present with. They can present with specific
16 difficulties or difficulties that you might expect a
17 younger child to present with.

18 So those environmental factors are really important,
19 and the pandemic shone a light on some of that. It's
20 around their access to quality interactions, their
21 experience of the world, how high quality adult-child
22 interaction is within the home or within the educational
23 placement. It's a complex situation, but a lot of
24 factors impact the child's ability to learn that
25 language and whether they have been exposed to enough

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1 words or enough high quality words.

2 Q. Thank you, and you also say that you assist children
3 with specific speech and language difficulties where
4 there is a genetic element, and they are born with those
5 needs. What type of needs — could you give us some
6 examples of what those look like?

7 A. Yes, so there are children who are born with risk
8 factors, whether that's genetic, biomedical,
9 neurodevelopmental. Those children — sometimes
10 described as disordered, so atypical communication
11 needs, whether that is children on the autism spectrum,
12 attention deficit disorder, speech and language —
13 sorry, speech disorders, language disorders, voice
14 challenges, disfluency, a huge range of needs.

15 Q. You also say that you work with children who have very
16 high complex need levels — high level needs where you
17 might have to use augmented and alternative
18 communication. Could you please elaborate a bit on that
19 as well?

20 A. Yes, that's right. There's children who have complex
21 needs, whether that's physical and learning disabilities
22 who are perhaps nonverbal, or who have very limited
23 verbal communication. Speech and language therapists
24 will seek to facilitate their communication to a range
25 of means; that could be low-tech aids which could be

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1 pictures, it could be high-tech aids where children
2 utilise eye-gaze devices, where they can look towards a
3 particular picture and the device will say the word, and
4 high-tech aids where there can be lots of complex
5 programmes on ipads, where children can access through
6 switches or accessing with their finger to touch a range
7 of pictures to get — communicate their point and their
8 needs and their wants.

9 Q. Thank you. Just continuing in relation to the role of
10 speech and language in educational contexts
11 pre-pandemic, you note at paragraph 7 of your witness
12 statement that speech and language therapists are
13 primarily employed by the NHS, but that most local
14 authorities — sorry, I'll wait until we get there. You
15 say that they are primarily employed by the NHS, but
16 that most local authorities have a service level
17 agreement to provide SALT services within educational
18 contexts.

19 Could you please just describe how speech and
20 language therapy services are traditionally provided
21 outwith educational settings?

22 A. The traditional model of speech and language therapists
23 would be within community clinic settings, where the
24 families attend the clinic in a central position, and it
25 would be one-to-one therapy where the therapist works

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1 alongside the parent or a therapy partner with that
2 child to identify and support and provide therapy for
3 their particular needs.

4 Q. Could you please then explain how and to what extent
5 speech and language therapy services were integrated
6 into educational settings in Scotland prior to the
7 pandemic?

8 A. This was variable across Scotland and does depend on the
9 level of funding that the local authorities provide, so
10 it's quite patchy. I would say that the majority of
11 local authorities in Scotland do have a service level
12 agreement with the NHS to provide those services, to
13 provide speech and language therapy in mainstream
14 schools or in more complex special schools. Funding for
15 speech and language therapy is reducing from local
16 authorities and from health boards, actually, which is
17 impacting their ability to provide some of these
18 services in an educational context, and has been
19 reducing for a number of years. So that will affect how
20 consistent or how much speech and language therapy can
21 provide in that context. Sometimes if the threshold
22 resource is not sufficient, then they have to centralise
23 and provide speech and language therapy within a
24 community clinic for instance.

25 Q. Please could you explain what speech and language

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1 therapists do in educational settings, and the different
 2 levels of speech and language therapy support that is
 3 provided within those settings, and specifically prior
 4 to the pandemic, and I think you refer to universal,
 5 targeted and individualised therapy. If you could
 6 please explain a bit about each of those?
 7 A. So we described the traditional form of speech and
 8 language therapy. Evidence and practice has moved on
 9 from then to show the importance of providing support
 10 and approaches for children in the context in which they
 11 function, whether that is in the home or nursery or
 12 school. That is to acknowledge how key communication is
 13 for learning and wellbeing, which — the key outcome for
 14 education, but also to acknowledge that the biggest
 15 impact sometimes happens within the education context,
 16 so by that, I mean the dynamic and varied environment
 17 which children function in, we have to ensure our
 18 approaches and our aims are relevant for that child, and
 19 that we are working on what's most important for them.
 20 What are the barriers to them learning, what are the
 21 barriers to them interacting and then participating in
 22 an education context.
 23 The model which we have described as — what we
 24 should expect is high quality provisions at universal,
 25 targeted and individualised. The traditional model is

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1 that whenever there was a concern, it would go straight
 2 to the individualised, but what we know from research is
 3 how important it is to have the whole environment
 4 supported around the child.
 5 So universal offers, we know, for instance, if you
 6 improve children's vocabulary, you improve their
 7 attainment, whether they have communication needs or
 8 not. In the context of an early years setting, you
 9 would hope that adults are interacting with children in
 10 a way that will promote their language development, and
 11 not get in the way of that.
 12 So that could be universal offer where speech and
 13 language therapists can work with early years
 14 practitioners to support and promote behaviour change
 15 and how they're interacting, and that could be about
 16 getting down to the child's level, commenting on what
 17 the child is doing, repeating back what the child is
 18 saying and adding language to it and avoiding lots of
 19 questions.
 20 Q. Could I ask you just to pause there, so practically what
 21 is the role of the speech and language therapist,
 22 compared to the early learning and childcare
 23 practitioner, for example? How do they interact to
 24 deliver this universal support?
 25 A. So in that context, the speech and language therapist is

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1 a facilitator, where they're functioning within the
 2 environment. We know how important it is for them to
 3 develop relationships and trust to make it feel safe for
 4 those practitioners to change their practice, so they
 5 will there — in a coaching and modeling role. We
 6 sometimes use video feedback. We video the interactions
 7 of the practitioner with the child, and then we spend
 8 time dissecting that and discussing ways in which to
 9 facilitate communication. So in that context, a speech
 10 and language therapist is there to facilitate and
 11 promote and develop the skills of the practitioner.
 12 Q. Then if you could move on to explain a bit more about
 13 targeted, what sort of children would require targeted
 14 interventions, and what do those look like in practice?
 15 A. So what we would hope is we can meet the needs of quite
 16 a lot of children at the universal level. If that's not
 17 adequate, then it would move up to targeted level, and
 18 that's about giving a bit more concentrated support for
 19 a group of kids, perhaps, who require a bit more
 20 additional input. Sometimes that can be working with a
 21 practitioner to give advice about how to promote the
 22 needs of these children.
 23 Practically speaking, that could be facilitating
 24 group interventions around developing vocabulary, having
 25 fun with words, improving their ability to tell stories.

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1 The therapist, again, it's always about building the
 2 skill of the people who are there all the time with the
 3 child, rather than a therapist who could be coming in
 4 once a week or once every three weeks, and if that's not
 5 adequate at a targeted level —
 6 Q. Before you move on to the individualised, could you
 7 please just describe some of the communication, speech
 8 and language issues that would require targeted
 9 intervention?
 10 A. So the type of difficulties you may come across are
 11 children who have got a very limited vocabulary. They
 12 have got — they use perhaps very general words rather
 13 than specific words to get their point across. The use
 14 of verbs is very important. That's the core of a
 15 sentence. So if they're using very general purpose word
 16 verbs like "doing", it makes it very difficult for them
 17 to get their point across. So it's about expanding
 18 their vocabulary of nouns, but also verbs, and being
 19 able to help them structure a story in such a way that
 20 they can communicate it in a well and complex way, which
 21 will then support their reading and writing in later
 22 years.
 23 Q. That targeted — that type of targeted support, would
 24 that be for a group of children?
 25 A. Typically, it's a group of children who require more

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1 than the universal offer , or in addition to the
2 universal offer . So those children can have identified
3 needs of specific speech and language difficulties , or
4 they could present with communication needs that are
5 behind what we would expect for their age.

6 Q. Then if I could ask you to move on to discuss the
7 individualised support?

8 A. So the individualised support in the context of an
9 education could be the speech and language therapist
10 comes in, observes the child in the real context, works
11 out how they're interacting , if there's any barriers to
12 their ability to participate fully in that setting ,
13 meeting with their key person, or with the teacher, and
14 giving advice and strategies about how to promote that
15 child 's communication in that context.

16 Sometimes that requires individual assessment where
17 the child is seen by the therapist . They provide
18 standardised assessments to work out even what their age
19 equivalent is on comprehension or expression, and then
20 using all of that information to develop a plan in
21 partnership with educators, to see how do we promote,
22 what aims are we going to be working on for these
23 individual children . They're the children who require a
24 bit more specific attention . Perhaps their needs are a
25 bit more complex, and it needs a coordinated approach.

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1 That could also involve actual therapy about
2 identifying what the need is, and providing support, so
3 an example of that would be colour—coding sentences to
4 be able to understand what needs to be in a sentence,
5 whether that's the subject, the doing word, the verb and
6 the where and the when. And we can do that in lots of
7 fun ways, which includes signing, colour, and a huge
8 range of activities which promotes children's
9 communication. It should feel fun to the child .

10 Q. Is that delivered one—to—one; is that delivered to an
11 individual child?

12 A. That's right . So some of those interventions I've just
13 described could be delivered even at a whole class or at
14 a small group, but also at a one—to—one, but the
15 children one—to—one perhaps need a bit more focused
16 attention, more regular input, more reinforcement or
17 differentiation for those activities .

18 Q. In terms of embedding of speech and language therapy
19 within educational settings , what are some of the
20 benefits of doing that?

21 A. This is — having done this for many, many years, the
22 key to embedding these type of approaches where people
23 feel empowered to support and promote spoken language,
24 it 's all about getting the speech and language therapist
25 in the context regularly and building up relationships

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1 with teachers, with early years practitioners . So
2 you're working alongside them, you're able to have those
3 conversations in the staff room, those corridor
4 conversations where you check in with each other and
5 you're building trust .

6 So the therapist is learning from the educators, the
7 educators are learning from the speech and language
8 therapist . So it 's not about giving the educators more
9 work to do. This is about everybody's business to
10 promote spoken language, and the therapist is there as a
11 facilitator and, yes, to provide quality provisions at
12 all the levels we've described, but it 's the
13 relationships and the trust that 's key that supports the
14 effective development of children's communication.

15 Q. Thank you. You've already touched on and suggested that
16 it 's not consistent or that provision pre—pandemic was
17 not consistent across Scotland prior to the pandemic
18 especially in relation to education settings.

19 I think in your witness statement, you talk about
20 some of the reasons why it was not consistent, and you
21 talk about depends on funding available. You also talk
22 about recognition in an Equity for All report that
23 highlighted this variability . Could you please
24 elaborate on some of the reasons for that variability
25 and what was recognised in terms of this lack of

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1 consistency pre—pandemic?

2 A. Equity for All was a report commissioned by the Scottish
3 Government, where for the first time in the world that
4 we know, we were able to map the needs of a country, and
5 so because we have got high quality prevalence data, we
6 are able to map the need across Scotland, align it with
7 local information about deprivation, et cetera, and able
8 to demonstrate that there's 275,000 children with
9 predicted communication needs in Scotland.

10 That report was able to demonstrate that for the
11 areas of highest need in Scotland, there was the lowest
12 level of speech and language therapy resource. It also
13 identified that the — there was areas where speech and
14 language therapy provision was inadequate to meet the
15 needs of the population of that local area.

16 So that points to postcode lottery, if you like, in
17 terms of the level of support and provision in place
18 across Scotland, and where the resource should be
19 positioned. So there's definitely inequity across
20 Scotland, there's inequity in terms of funding from
21 health, but also local authorities in terms of level of
22 funding, and the funding — the transformation and
23 working that way is important, but you need a threshold
24 resource to be able to do that.

25 So where the resource isn't available, it forces the

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1 hand of the service to centralise speech and language
 2 therapy, and perhaps bring it towards community clinics
 3 and be working in a more isolated way than a more
 4 integrated way, which is where the research and practice
 5 suggests it should be delivered.

6 Q. Just in relation to differential service provision, you
 7 also refer in paragraph 21 to the fact that there was
 8 pre-existing inequality which was exacerbated by the
 9 pandemic. We'll come on to discuss the impacts of the
 10 pandemic. But you say:

11 " ... in respect of the level of provision provided
 12 in areas of socioeconomic deprivation, ie, areas with
 13 the highest need have the lowest level of speech and
 14 language therapy resource available. Families living in
 15 poverty really struggle to access services where they
 16 have to travel distances or to pay for that travel.
 17 This is another reason why it is so important that
 18 speech and language therapists can work where children
 19 are situated."

20 Would you care to expand on that pre-existing
 21 inequality? Is there anything to add to what you have
 22 in there?

23 A. I think the very concerning element of this is that we
 24 should be providing the highest quality support for
 25 those in greatest need, and typically families living in

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1 poverty are one of those groups, and our concern is that
 2 even pre-pandemic that was not the case. We weren't
 3 able to provide that high quality service for the most
 4 in need, and people living in poverty find it very
 5 difficult to get to particular central places, or to get
 6 to buses or to engage in speech and language therapy to
 7 follow it up, given how stressful their lives can be,
 8 and the impact of lack of income to be able to support
 9 that type of approach. So that just underlines the
 10 challenges we are facing from pre-pandemic.

11 Q. Further in relation to inequalities pre-pandemic, at
 12 paragraph 15, you talk about:

13 "There were inequalities for children and young
 14 people with speech and language difficulties
 15 pre-pandemic."

16 You say:

17 "One of the most prominent inequalities relates to
 18 delays in spoken language skills."

19 You referred to a Scottish study finding that 50% of
 20 children who start school present with inadequate spoken
 21 language skills.

22 You go on:

23 "As a speech and language therapist I observed
 24 children who were 15 to 18 months behind their peers in
 25 respect of these skills. From the very beginning, these

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1 children have to play catch up."
 2 Was that pre-pandemic?

3 A. That was pre-pandemic. That study is actually quite
 4 old. It has been refreshed recently but it points to
 5 something our members and educators are saying, that
 6 this was in place. We were seeing a lot of children
 7 coming to school with inadequate spoken language skills
 8 for learning, and well behind what you would expect for
 9 children of that age.

10 So even before the pandemic, you would experience
 11 some children coming to school with very, very little
 12 spoken language, and therefore struggling to catch up
 13 with their peers and to try and close that gap.

14 Q. Were there any particular groups of children manifesting
 15 in these difficulties?

16 A. Yes, typically it's the children living in poverty,
 17 areas of social deprivation, that were presenting with
 18 more of those spoken language difficulties pre-pandemic.

19 Q. Is it known what the reasons for those difficulties are?

20 A. Yes, so that is related to their exposure to new
 21 experiences, the level of interactions, the exposures to
 22 words, their access, or how consistent their access was
 23 to early years placements prior to coming to school, and
 24 the stress that the families were experiencing at that
 25 point.

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1 Q. Thank you. Could I then ask you just to explain briefly
 2 the role that health visitors play in identifying and
 3 referring children to speech and language therapy
 4 services, please?

5 A. Yes, health visitors have a very important role in
 6 identifying need. They get alongside families and visit
 7 them regularly, and they measure a number of areas of
 8 child development and identify communication needs.
 9 Quite often they are the first port of call. Speech and
 10 language therapy receives a lot of requests for
 11 assistance or referrals from health visitors for
 12 children who they're concerned about who aren't meeting
 13 their milestones. So they have a very important role.

14 Q. You also explain -- well, perhaps you can explain how
 15 important it is -- early identification is of issues in
 16 relation to speech and language, and how important that
 17 is for long-term outcomes or successful outcomes?

18 A. Yes, the identification early is critical. It's
 19 different from -- for a child to develop, you get the
 20 most development in the early years. The first 1,000
 21 days, the first three years of a child's life are
 22 particularly important for that language development.
 23 If you get in early, it's far more effective, there's
 24 more development, it saves money in the long-term, and
 25 the children, you know, in terms of long-term outcomes,

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1 communication needs are critical.
 2 So if you don't get that development and
 3 improvement, then they will find it very difficult to
 4 interact with others, to engage in nursery or school,
 5 and be able to — ultimately, I think there's sometimes
 6 a thinking that if we close the gap at a certain point,
 7 that gap will stay closed. However, the research does
 8 demonstrate that you need to keep engaging with those
 9 children to maintain improved communication throughout
 10 their school career in order to achieve positive
 11 outcomes.
 12 Q. So you have identified the importance of health
 13 workers — health visitors, but what if any role are you
 14 learning that childcare practitioners and teachers play
 15 in identifying and referring issues in relation to older
 16 children?
 17 A. Yes, I think we get a lot of requests for assistance,
 18 and they see these children very often, and will refer
 19 them to speech and language therapy. They get to see
 20 them in context, they get to see how they're functioning
 21 with their peers, and whether they're able to interact
 22 with adults otherwise, and they are therefore also very
 23 important in identifying need early.
 24 Q. Thank you. Mr Carter, I would like to move on now to
 25 discuss the impact of pandemic restriction measures,

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1 including the closure of early learning and childcare
 2 settings and schools on the provision of SALT services.
 3 We've just touched on health visitors, but could you
 4 please, if you can, give an indication of to what extent
 5 disruptions to health visitor assessments and newborn
 6 hearing screening impacted on early identification of
 7 speech and language difficulties during the pandemic?
 8 A. We know the health visitors struggled to access families
 9 during the pandemic. They will have had fewer
 10 appointments. They had to move to remote offers,
 11 telehealth offers, which led to fewer appointments and
 12 incomplete data. Therefore, as the first port of call,
 13 the fact that they didn't have access to families meant
 14 that we weren't identifying children early, and there
 15 was a significant dip in requests for assistance at one
 16 point during the pandemic because of that.
 17 Q. In relation to health visitors, you note in paragraph 22
 18 of your statement that they noted a significant spike in
 19 around 27 to 30-month mark that was concerning and that
 20 this was also observed in Public Health Scotland data.
 21 Could you please explain in a bit more detail what was
 22 observed and why it's concerning?
 23 A. Public Health Scotland produced a few excellent reports
 24 on this. They monitor health visitor data. Health
 25 visitors engage with children across their development,

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1 including 13 to 15 months and 27 to 30 months. They
 2 noticed a significant peak in concerns about
 3 communication. Now, health visitors monitor many areas
 4 of child development. It's important to know that
 5 pre-pandemic, communications was the highest area of
 6 concern anyway, sitting about 10% of that 27 to
 7 30 month. From January 2021, Public Health Scotland
 8 noticed a significant increase compared to pre-pandemic
 9 levels. This peaked in August 2021 and actually has
 10 remained above pre-pandemic levels until now.
 11 This is particularly concerning because the area —
 12 the time that these children are being assessed, this is
 13 a critical time for children's language development, and
 14 so Public Health Scotland noticed it, and were flagging
 15 it up as a concern, and health visitors were saying they
 16 were seeing far more of these children. The area
 17 where — the most concern was communication.
 18 Interestingly, you can differentiate between
 19 children in the highest areas of deprivation versus the
 20 most affluent areas. For those in the highest areas of
 21 deprivation it was sitting about 20% plus along that
 22 timeline, and for more affluent areas it was sitting
 23 about 7 or 8 or 9%. So there's a significant different
 24 between the two.
 25 Q. And again, what were some of the reasons for the spike

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1 and that differential again?
 2 A. So the reasons are complex. I suppose if we go back to
 3 the different types of children that we have, we've got
 4 the children who were born with risk factors, with
 5 communication needs; we've got the other children who
 6 have socioeconomic disadvantage. The first children
 7 with specific communication difficulties what we've
 8 noticed is that having come to services, speech and
 9 language therapists and educators, they're noting far
 10 more complexity of need, and they are noting that these
 11 children have experienced more harm, struggling with
 12 their mental health, struggling to engage with
 13 education, and that will have been because of the lack
 14 of access to the services.
 15 The other children with socioeconomic disadvantage,
 16 the research seems to be showing that the reasons for
 17 that peak was because of seeing fewer — their world has
 18 become much smaller, they were seeing fewer of their
 19 family members and friends, and therefore interacting
 20 far less. They also weren't experiencing the world.
 21 Learning language is a dynamic process where you need to
 22 experience different parts of the world. Going out to
 23 see stuff, seeing animals etc helps develop vocabulary
 24 and also lack of access to education. I think the very
 25 significant point here is that stress has had a

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1 significant impact and points to why we saw the spike.
 2 For families during the pandemic they were
 3 experiencing much higher levels of stress, they were
 4 struggling with home schooling, home working. They
 5 found it stressful to manage all the demands,
 6 particularly around economic demands. We know that more
 7 people went into poverty, and when you consider even at
 8 a baby level, what you're hoping to see is a mother or
 9 father being responsive to the babies. The baby makes a
 10 noise, babbles, smiles, and it's called serve and
 11 return, where you try and have good quality
 12 interactions.

13 We know when families are experiencing stress that
 14 that serve and return and the opportunities for those
 15 types of interactions is reduced significantly. Those
 16 serve and returns at baby levels is really important for
 17 activating the baby's brain to ready themselves for more
 18 communication and future development.

19 We can scale that up to the peak that we saw around
 20 toddlers. Again, it's important about this adult-child
 21 interaction where they have high quality interactions at
 22 home and wherever they are, and so -- there's good
 23 quality research to show that actually at the
 24 conversational exchanges, there should be a significant
 25 number of them per hour. So there's some research which

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1 suggests that the optimal number is about 40 per hour.
 2 Now, it can be more than that, it can be less than that,
 3 but around 40 is the optimal range for promoting
 4 language development.

5 If that is very, very low, so 5 and below, that is a
 6 very serious issue where children are in language
 7 deprivation and will find it very difficult to develop
 8 the skills that they need in future life.

9 So I think stress is a very important factor in all
 10 of this. We're still seeing it. Families are still
 11 experiencing very significant levels of stress, but that
 12 impacts families' ability to play, talk, read, sing with
 13 their children. These are all things that help promote
 14 language development.

15 Q. Thank you. We'll go on in a moment to speak about
 16 redeployment of speech and language therapists in
 17 Scotland, but if we could just pause to discuss some of
 18 the other observed increases in speech and language
 19 difficulties that were observed. So please could you
 20 explain some of the additional increases in speech and
 21 language difficulties that were observed? You discuss
 22 these at paragraphs 22 to 28 of your statement. You
 23 discuss there some of the surveys that the Royal College
 24 of Speech and Language Therapists conducted.

25 A. So in addition to the Public Health Scotland evidence,

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1 we provided -- we did a survey with Early Years
 2 Scotland, where they support early years practitioners
 3 working in nurseries across Scotland. We had 245
 4 responses to that survey and 89% of respondents said
 5 they had seen an increase or a significant increase in
 6 the numbers of children with communication and the
 7 complexity in which they presented.

8 They also highlighted the impact that was having on
 9 children, so they said: it's impacting their ability to
 10 participate, to make friends, to learn. They're seeing
 11 more behavioural issues because of it, and more
 12 challenges with the children's mental health and
 13 wellbeing.

14 So -- and anecdotally, we have heard from our
 15 members and teachers that they were seeing a very
 16 significant number of children coming to school who have
 17 very little language, if any, at the P level, and
 18 they're raising high levels of concern about that.

19 Q. Thank you, and just some of the reasons for these
 20 increases, I think probably mirrors some of what you
 21 have already discussed, but you discuss those at
 22 paragraphs 25 to 27. You attribute these changes that
 23 have been seen to factors such as reduced opportunities
 24 for interaction and exploration, decreased access to
 25 critical services like education and speech and language

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1 therapy, and challenges experienced by families,
 2 although some of the challenges and issues you have
 3 already described in relation to --

4 A. Yes, I think so. The one thing I would add to that is
 5 that the lack of -- we know that education and the
 6 opportunities to play and engage and play alongside
 7 children are very important for child development within
 8 the education context.

9 Now, within the education context, they still need
 10 to experience regular interaction with others and that
 11 conversational exchange in order to make it -- promote
 12 their language development, but if they do experience
 13 that, that could be a very good thing for their language
 14 development.

15 Q. I think you have already touched on it. Presumably some
 16 of these needs would have been experienced regardless of
 17 the pandemic in relation to certain children, and I
 18 think you've already indicated that the consequences of
 19 the impacts of the pandemic are that some of these are
 20 more complex that you're seeing, that maybe would not
 21 have been as complex but for...

22 A. Yes, I think the pandemic exacerbated an already urgent
 23 need around children's communication. Even the data
 24 around health visitors at 27/30 month, which will
 25 underrepresent those with communication needs that

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1 become more apparent later on, but in areas of
 2 deprivation, we are seeing double levels of concern in
 3 those areas.
 4 Q. And why are they more complex?
 5 A. So some of the needs are more complex because --
 6 because -- so for children with -- who were born with
 7 some of these risk factors, environmental factors also
 8 affect them, so if they haven't had exposure to all of
 9 the things we have discussed, they will experience more
 10 challenges and more complexity. I think the complexity
 11 comes from having not had access or having to wait for a
 12 long time to access services. So, if you like, for want
 13 of a better word, if they haven't had support that they
 14 needed or quality advice, then the level of harm will
 15 have increased, and therefore the complexity will have
 16 increased in those needs over that time.
 17 Q. Thank you. If we could then turn to discuss the issue
 18 of the redeployment of speech and language therapists in
 19 Scotland, which you discuss at paragraphs 29 to 34 of
 20 your witness statement. Could you please describe the
 21 extent to which speech and language therapists were
 22 redeployed to other healthcare roles during the
 23 pandemic, and how this impacted on the provision of
 24 services for children and young people?
 25 A. Yes, the redeployment of speech and language therapists

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1 was variable across the country. Most services did have
 2 an element of redeployment. Some were almost stopped
 3 entirely and switched to adult services. They had --
 4 they were redeployed into a range of roles. It could be
 5 vaccination clinics, it could be intermediate care, it
 6 could be acute settings. Depending on the skills of the
 7 speech and language therapists, they could use their
 8 eating and drinking skills in an adult setting, an acute
 9 setting, although there was obviously anxiety around
 10 that.
 11 Some were deployed as nurse auxiliaries into adult
 12 services to prepare for what we saw coming in with the
 13 pandemic, and I think most services maintained some
 14 level of offer for the most urgent requests, and by that
 15 I mean eating/drinking. So the child -- if there was
 16 concern about a child choking, or not managing liquids
 17 or solids, then they would be able to go and see those
 18 children, so we maintained that level as a core offer.
 19 Now, that was challenging, because we know that some
 20 of those children tended to have more complex needs or
 21 physical and more vulnerable, and therefore were
 22 shielding, so therefore parents had anxiety about
 23 someone else coming into the home or going to a central
 24 hub but, you know, speech and language therapists
 25 navigated that. So speech and language therapists,

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1 there's a lot of redeployment out of children services
 2 into adult services at that initial time.
 3 Q. And what was the reason -- what were the reasons for
 4 that redeployment?
 5 A. The reason we think is -- well, initially we didn't
 6 really understand COVID. We had some level of
 7 understanding that it affected adults more than it
 8 affected children, and therefore there was decisions
 9 made locally to redeploy staff to ready the system. So
 10 the system didn't collapse, if you like. So I think the
 11 reasons in part are -- in that they deprioritised
 12 children's services and didn't foresee perhaps the
 13 impact it would have on children.
 14 Q. How did the Royal College of Speech and Language
 15 Therapists view the decision to redeploy therapists, and
 16 did that change over time?
 17 A. Initially, given the lack of understanding about this,
 18 the Royal College wanted to be supportive and therefore
 19 were supporting our members in terms of redeployment and
 20 were open to that. I think after time what we were
 21 hearing from the members was that their skills weren't
 22 being fully utilised. They are highly qualified,
 23 they've got lots of skills in which they could be
 24 utilised, but -- and also concerns from our members
 25 about the harm that would be occurring for the people

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1 that they normally serve.
 2 And so at that point, once the initial phase is over
 3 and we were hearing feedback from the members, that was
 4 when we were encouraging government to bring those
 5 speech and language therapists back to their core roles
 6 to be able to serve the children and young people's
 7 communication and swallowing needs.
 8 Q. We'll touch on a bit later about the long waiting times
 9 that we're seeing now, but to what extent did this
 10 redeployment contribute to the increased waiting times
 11 that you described later in your statement?
 12 A. Given that it was variable across Scotland, but
 13 typically I would say it had a very big impact on having
 14 to pause the majority of services, and therefore we
 15 weren't able to reach families, had a very significant
 16 impact on waiting times. There's other aspects of that
 17 that would have impacted waiting times, but the
 18 redeployment will absolutely have caused a pause and
 19 therefore a back-up of need.
 20 Q. Thank you. I think you have already touched on this,
 21 but what types of speech and language services for
 22 children and young people continued to be delivered in
 23 person, and how were they delivered? I think you
 24 mentioned highest priority was given to people with
 25 complex needs, and you mentioned going into homes. What

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1 was the full sort of range of face-to-face?
 2 A. So the face-to-face offer, depending on where we were in
 3 the pandemic, the key thing that we tried to maintain
 4 was that offer of eating and drinking, because whilst we
 5 could do some telehealth on that, it's important to get
 6 close to the child and to hear and observe and to touch
 7 to check on their swallowing, because that is such a
 8 critical area and high risk. Other offers were
 9 telehealth. Now, it depended on how well set up
 10 services were, whether they had access to IT, ipads.
 11 Q. Was that face-to-face or was that —
 12 A. Sorry, so, no, so most of the face-to-face stopped,
 13 depending on where we were in the pandemic, as it opened
 14 up, we would prioritise some face-to-face that needed to
 15 happen. That could be around speech and sound
 16 difficulties, so the highest need of kids who were
 17 really struggling that needed therapy as soon as
 18 possible, but the lack of face-to-face will have
 19 affected how effective the interventions were and
 20 therefore how quickly we were able to promote
 21 improvement.
 22 Q. And then you mentioned telehealth; could you please
 23 describe that and some of the other remote offerings
 24 that were provided?
 25 A. So telehealth obviously is reliant on both sides having

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1 access to IT equipment. Now, some areas in Scotland for
 2 speech and language therapy services, they didn't have
 3 access for a very, very long time, which obviously
 4 impacted their ability to provide telehealth, which
 5 basically is the family on one side, you on the other
 6 side, and you can do a bit of assessment with the child
 7 if they're of an age. You can observe the child, you
 8 can promote, you can coach and model — well, you can
 9 coach the parent.
 10 So the therapists were — very quickly adapted to
 11 that, provided lots of high quality — as high quality
 12 as they could approaches and interventions remotely, if
 13 they had the IT equipment. The challenge would be on
 14 the other side as well, whether the families had access
 15 to wi-fi or the adequate IT equipment to facilitate
 16 that, and that wasn't always the case.
 17 So telehealth was an offer which we rapidly moved
 18 on. We also relied on phoning all staff — all the
 19 people on the case loads to talk to the parents and give
 20 advice and strategies and reassurance, but also we
 21 had — typically a lot of the services had good social
 22 media presence, and the demand for that increased
 23 significantly during the pandemic with the parents keen
 24 to access high quality advice and strategies for their
 25 child, to be signposted to good resources online, and

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1 speech and language therapists spent a lot of time
 2 developing videos and signposting to the best
 3 information online that they could offer at that point.
 4 Q. Thank you. You mentioned sort of the issue of whether
 5 or not parents were able to access because of digital
 6 inclusion issues. Was there any evidence of literacy
 7 levels and language skills of parents impacting on their
 8 ability to access services, specifically speech and
 9 language services, for or on behalf of their children?
 10 A. Well, I only have anecdotal evidence about that. We
 11 know, however, that parents with literacy difficulties,
 12 but also parents with communication difficulties,
 13 because quite often it's an intergenerational cycle of
 14 parents with communication needs and their children with
 15 communication needs so the — sorry, I have lost my
 16 train of thought, what was that?
 17 Q. It was about whether there was any evidence for literacy
 18 levels and language skills of parents impacting on their
 19 ability to access support, and you were mentioning the
 20 intergenerational issues?
 21 A. Yes. So literacy difficulties absolutely impact
 22 people's ability to engage with services, as does
 23 communication needs as well as poverty as I have
 24 mentioned before. But I only have anecdotal evidence
 25 that that could be a challenge, but also families with

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1 additional language who — we did have access to
 2 interpreters during that time, and utilise them and try
 3 to facilitate three-way conversations. It's additional
 4 organisation, but it is possible, but made it a bit more
 5 complex to ensure that those families' needs were being
 6 met.
 7 Q. And again, just in terms of, when you were describing
 8 the in-person continuing and that being for the highest
 9 priority being given to ones with complex needs, what
 10 sort of priority level were these other offerings, these
 11 remote offerings being delivered to? Was this available
 12 to everyone, or was there an order of priority?
 13 A. So for services who were able to maintain a certain
 14 level of resource and who weren't redeployed and had to
 15 pause significant aspects, it was an offer to all those
 16 parents and families. For those who had less of an
 17 offer or resource, then they did need to prioritise
 18 which families they reached out to. Some weren't able
 19 to prioritise very many children at all, because they
 20 didn't have the resource available, but typically, there
 21 were — interestingly I think sometimes in the initial
 22 stages, the parents felt that there wasn't a service —
 23 just assumed that there wasn't a service available, so
 24 they weren't reaching out, and therefore it was
 25 imperative that the speech and language therapy services

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1 reached out to them and made it --- aware on social media
2 if there was an offer, and what that offer was.

3 Q. Thank you. If we could turn now to discuss briefly the
4 impacts on mental health and wellbeing. In paragraphs
5 37 to 39, you discuss a number of surveys that were
6 carried out during the pandemic that asked specifically
7 about impacts on children and young people in relation
8 to mental health and wellbeing. That was as a result of
9 a reduction in speech and language therapy. I think
10 these were ones that were conducted by the Royal College
11 of Speech and Language Therapists. What are the ---
12 could you please outline the concerns that were
13 identified by or on behalf of children and young people
14 in relation to these impacts on mental health and
15 wellbeing, and also explain what the connection is with
16 the reduction in speech and language therapy services?

17 A. I think --- we've got very high quality research to show
18 the connection between children's vocabulary, for
19 instance, or communication, and mental health and future
20 life, but also the mental health at the time. These
21 were snapshots, so they're small surveys, but we did
22 survey parents just to ask about the impact.

23 We know from some of those surveys that 1% had
24 experienced telehealth prior to the pandemic; 87% said
25 they received less speech and language therapy during

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1 the lockdown, during the pandemic; and 63% said they
2 didn't receive any specialist level speech and language
3 therapy or any speech and language therapy at all.

4 Now, it depends on your interpretation of what
5 speech and language therapy is, because some elements
6 were continuing within educational placements that were
7 reopening. However, in terms of the mental health, when
8 we asked parents the impact of not receiving speech and
9 language therapy, there was a few things they
10 identified. They identified there was an impact on
11 children's ability to make friends, their ability to
12 access education when they were there and on their
13 mental health. We also had surveys for our members who
14 were identifying high levels of concerns of children not
15 accessing speech and language therapy on the children's
16 mental health and their behaviour which is all
17 connected.

18 So in terms of the connection, it's multifactual. I
19 suppose what we see is that there's an element of what
20 speech and language therapy do to reassure parents (a)
21 that they're doing the right thing, or to provide real
22 solutions to adapt the environment, the home
23 environment, and to promote spoken language, so parents
24 can see improvement.

25 When the parent is anxious and has poor mental

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1 health, that obviously influences the child as well, but
2 if the child doesn't have the right strategies and
3 advice, whether that's at home or in school, and they
4 experience those barriers and the disconnect in terms of
5 relationships, then what you see on the surface quite
6 often is behavioural difficulties, and some children
7 will give up, if you like, in terms of learning and then
8 find other ways to engage and get attention.

9 So that's the sort of connection, and so speech and
10 language therapists were there to unlock some of the
11 challenge, to understand the communication and to know
12 what works to facilitate that need. Sometimes that
13 involves improving the communication, sometimes that's a
14 strategy which can support the child to flourish in the
15 environment that they're in.

16 Q. Thank you, and I think you say at paragraph 37:

17 "One of the surveys carried out by the RCSLT asked
18 questions about this issue. The key pieces of
19 information that respondents shared with us were around
20 the impact that the loss of speech and language therapy
21 had on social life and friendships for children and
22 young people, followed by access to education, then
23 impact on home and domestic life, and finally, their
24 mental health."

25 Again, all tied presumably to the loss of speech and

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1 language therapy?

2 A. That's right.

3 Q. Then you go on in paragraph 38 to say:

4 "In the same survey, we also asked a question about
5 the impact on the family more broadly..."

6 So was this not just specifically on the children
7 and young people?

8 A. I think this points to the issue that when there's ---
9 one of your children is struggling and one --- in a
10 significant area of their life, parents instinctively
11 know how important communication is, and they worry
12 about their child's communication. It's the one area
13 they seem to worry about most, and that's because of
14 what I've talked about, how important it is in terms of
15 connection, expressing love and their hope for the
16 future.

17 And so more broadly, when we're asking questions
18 about this, parents will quite often mention about: this
19 is having a big impact on our family, on how we
20 function, how we access --- what we decide to do and what
21 we decide not to do; and the stress of a child accessing
22 education.

23 Q. Then in the next paragraph at 39, you talk about a
24 survey done in 2020 where you surveyed your membership
25 to ask them about the impact of the pandemic and

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1 lockdown on children and young people with communication
2 needs. So was this asking similar questions but of your
3 membership of the practitioners?

4 A. That's right.

5 Q. You say:

6 "The respondents to this survey noted deteriorating
7 mental health and an increase in challenging
8 behaviours."

9 So again, similar to what were being reported by the
10 parents and children and young people themselves?

11 A. That's right, yes.

12 Q. You also mention:

13 "The respondents also raised concerns about barriers
14 to accessing services; about the deterioration of
15 communication skills and swallowing needs; and an
16 increase in safeguarding concerns."

17 What were those specific concerns in relation to
18 safeguarding, if you can remember?

19 A. Yes, I think this — I am assuming this relates to
20 isolation of families, where there's safeguarding
21 concerns. It's a general reflection on the concern of
22 what would be happening with children who were not able
23 to get access to public services or schools or
24 education, but I don't know specifically about the
25 detail of that.

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1 Q. If we could then move on to discuss the issues around
2 schools reopening and operating with restrictions. When
3 education settings reopened with restrictions, what
4 access did speech and language therapists have to
5 children, and — probably thinking more about the ones
6 where the services were embedded in schools and then
7 separately ones where they weren't.

8 A. So again this was variable across Scotland. Different
9 local authorities interpreted the guidance differently
10 and interestingly it would seem that those services who
11 were more embedded pre-pandemic and had a close
12 relationship and were viewed as a core member of the
13 team got access to education far quicker than those who
14 were seen as an external agency who were kept away from
15 education settings. So for services where there's
16 established relationships they got on very, very fast,
17 or reasonably fast, and then for those who weren't or
18 didn't have as close a relationship, then it could be
19 many, many months before they got anywhere near an
20 educational placement and that was a concern for us.

21 Q. And just in terms of the concern, was that in relation
22 to impacts of children not being able to access those
23 services?

24 A. Yes, that was in relation to knowing how important
25 partnership working is in a multidisciplinary approach

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1 to meet the needs of children and to ensure that
2 children are accessing the highest quality services and
3 overcoming barriers and so it's about the connection and
4 how important communication is for children to access
5 educational establishments and deliver on the outcomes
6 that you would hope them to achieve in the education
7 setting.

8 Q. In terms of some of the practical challenges, you
9 discuss at paragraph 42 challenges that the use of
10 personal protective equipment had for speech and
11 language therapists and their ability to do their job
12 and you also outlined some of the difficulties or
13 tensions that arose in relation to guidance and
14 different guidance for health practitioners and
15 educators, if you could please just elaborate a little
16 bit more on some of those concerns and challenges?

17 A. Yes, obviously there was different guidance for health
18 professionals versus education and so what our members
19 found was that as a health professional you had to
20 follow guidance which is far stricter, which you might
21 expect, but that given that they were working in an
22 education context, that meant that they were going in
23 with full uniform, sometimes full PPE, apron, mask,
24 gloves, compared with their education colleagues who may
25 be wearing a mask, for instance. So this actually

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1 caused some tension and anxiety on both sides where
2 educators were wondering why the health staff were
3 wearing so much PPE and they weren't and also from the
4 health staff feeling, this felt like a barrier to the
5 job they were trying to do. In part it was reassuring
6 to educators that our members were supporting education,
7 to explain that we were being careful, we weren't
8 visiting too many places or one if at all before coming
9 to their educational placement but the fact that there
10 was different guidance and speech and language therapy
11 in this position where they straddle health and
12 education, it became a barrier and got in the way of our
13 partnership working when we did manage to get back into
14 education.

15 Q. And were there any discussions around that at the time?

16 A. Locally there was, as far as I can tell, and having
17 engaged with lots of speech and language therapy leads,
18 they had local negotiations. Some of the local
19 authorities took a harder stance and others negotiated,
20 so it was about trying to come up with a pragmatic
21 solution. But also you're trying to manage the anxiety
22 of staff on both sides so that was a tricky situation to
23 be in but, yes, I would say there was quite a lot of
24 local negotiations on that.

25 Q. Thank you. I think if we could then turn to look at

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1 some of the ongoing impacts and you mentioned
 2 specifically at paragraphs 43 to 47 increased waiting
 3 times for speech and language therapy post pandemic.
 4 Could you please explain a little bit more about that
 5 and in particular what the current waiting times are for
 6 speech and language therapy for children in Scotland?
 7 A. We started to hear anecdotally that the waiting times
 8 for speech and language therapists were very high and so
 9 therefore in May 2023 we sent a comprehensive freedom of
 10 information request to all services in Scotland. At
 11 that point the information came back demonstrating that
 12 there were 6,503 children waiting for speech and
 13 language therapy. The average wait at that point — the
 14 average longest wait for the initial contact with a
 15 therapist if they needed it was one year, one month; the
 16 average longest wait at that point if they needed
 17 therapy was one year, five months. Now, that — we also
 18 asked for data across the last five years which allowed
 19 us to demonstrate the increased wait during that period
 20 so we were able to show that the wait over the last five
 21 years for initial contact for speech and language
 22 therapy had deteriorated significantly and had decreased
 23 by eight months in those last five years. For wait for
 24 therapy it increased significantly and the average
 25 longest wait had increased by ten months over those last

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1 five years. So the wait was very significant and we
 2 refreshed some of that, that data in May 2024. There
 3 are more children waiting for speech and language
 4 therapy now, 6,727, and — the waits are variable though
 5 so in some areas they could wait for 12 weeks, in some
 6 areas it's more than 3 years, but for the data we have
 7 most recently, the longest wait was over six months for
 8 50% of the health boards in Scotland. And the reason
 9 that is very significant, which I alluded to earlier, is
 10 that for children's development that level of wait it's
 11 like a lifetime because they're doing so much
 12 development during that period compared with an adult
 13 waiting for something similar so that is a particular
 14 concern because they're not getting the support they
 15 need and they're developing or should be developing
 16 rapidly during that period.
 17 Q. Thank you. And just you've touched on it, or some of
 18 the reasons, but what is contributed to this increase in
 19 waiting time?
 20 A. I think what's contributed to the wait is that services
 21 were paused, for some services that was a significant
 22 wait, speech and language therapists were deployed, it
 23 was harder to get to children face-to-face so actually
 24 progress for children and therefore throughput, if you
 25 like, was delayed and restricted. In addition to that,

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1 we have got recent freedom of information requests to
 2 show — to give us insight into the capacity in the
 3 system for Scotland to deal with this number of
 4 children, so we know that the increase in speech and
 5 language therapist headcount in the last five years has
 6 increased by 2% in Scotland, but compared with the rest
 7 of the UK, the rest of the UK have increased the
 8 headcount of speech and language therapists on average
 9 by 15%, so the capacity in Scotland is a concern and
 10 shows, we're able to highlight, that also will be
 11 affecting how quickly we can get to children and meet
 12 their needs.
 13 Q. And again you've touched on this already but given what
 14 you have already told us about the impact of the
 15 pandemic on restrictions on children's communication and
 16 language skills that have already been observed and how
 17 important early intervention is, how concerning are
 18 these waiting times for the profession in terms of
 19 outcomes for the children and more generally?
 20 A. I think our members speech and language therapists know
 21 this better than most, they don't want children to have
 22 to wait a long time because they know how urgent it is
 23 to see some of these children and trying to express to
 24 those people in the system why this wait is far too long
 25 and they are trying to do that, as are we. I think it's

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1 been described as a Public Health crisis. I think, as I
 2 have expressed before, there was a concern pre-pandemic,
 3 the pandemic has worsened this and we're concerned that
 4 we don't have the resources in Scotland. We do need to
 5 do the transformation in Scotland to support new ways of
 6 working but you need a threshold resource to deliver
 7 that. And these are real children we are talking about,
 8 real children who are experiencing harm, and therefore
 9 there is an urgency about supporting the children who
 10 have experienced this and supporting the improved needs
 11 but also other children who are coming through so the
 12 outcomes are clear, research is demonstrating how
 13 important it is and we need to take it seriously and
 14 address it as soon as possible.
 15 Q. Thank you, Mr Carter, I'm going to come on just finally
 16 to some of the lessons to be learned but one moment,
 17 please. Mr Carter, then finally you have from
 18 paragraphs 51 onwards to the end of your statement, you
 19 identify some potential lessons to be learned. If I
 20 could just ask you to go through those and just
 21 elaborate where appropriate on any particular ones that
 22 you would like to draw to the Inquiry's attention.
 23 A. There's the general one about the eating and drinking
 24 and swallowing about protective equipment for members.
 25 I think for a while for a period during the pandemic we

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1 were making the case that coughing is an
 2 aerosol-generating procedure and therefore our members
 3 needed to be protected against that because when they're
 4 dealing with people with eating and drinking needs,
 5 they're getting very close. When you choke or cough, if
 6 you have a problem with your swallowing, you're more
 7 likely to cough and we were seeking the highest level of
 8 protection FP3 masks, so that's a key lesson, I would
 9 say.
 10 Q. Just pausing on that, you spoke about difficulties of
 11 wearing PPE when trying to do the job of providing
 12 therapy. Were these special masks the transparent
 13 masks, face coverings?
 14 A. Well, for speech and language therapists working with
 15 children or adults with dysphagia, ie the eating and
 16 drinking difficulties, the transparent mask was less
 17 important because they just needed to be able to get
 18 close to them to be able to touch their neck, to feel
 19 the swallow and to assess that adequately. For children
 20 with communication needs and indeed particularly speech
 21 sound difficulties, transparent masks are critical so
 22 the child can actually see what you're doing with your
 23 lips, your tongue, and so therapists did get access to
 24 transparent masks, it was quite a long way into the
 25 pandemic before we got that but that is a key — a key

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1 learning for if this was to happen again.
 2 Q. And then I think the next one you have relates to the
 3 redeployment issue. You say that.
 4 " ... after that initial lockdown period, it would
 5 have been useful to have had a period of reflection.
 6 The best use of the workforce should have been
 7 reconsidered and staff should have been returned to
 8 services where their skills should have been of most
 9 value."
 10 Do you care to elaborate on that? I assume that
 11 relates to the redeployment issue?
 12 A. Yes, I think that once the pandemic was understood and
 13 it became obvious what was happening, we would want to
 14 avoid deprioritisation of children's services to ensure
 15 the harm didn't occur and so our strong recommendation
 16 is that children's services are protected and that
 17 speech and language therapists stay in their core role
 18 to be able to meet the needs of these children.
 19 Q. And then you have got at paragraph 54, you again refer
 20 to maintaining children's services and more importantly,
 21 maintaining a level of integrated teams around children.
 22 Do you care to elaborate on that potential lesson?
 23 A. I think the interesting thing about the pandemic is it
 24 shone a light on how important it is to be fully
 25 integrated, to be close to each other, and so a rigid

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1 view as a health-only service got in the way of that in
 2 terms of guidance and our ability to engage in an
 3 integrated manner and services who recovered more
 4 quickly and who saw improved access were those who are
 5 more integrated prior to the pandemic so this is a key
 6 lesson about the importance of speech and language
 7 therapists being embedded within educational placements.
 8 Q. And then at 55, I'm not sure how related this is to the
 9 previous one, but you talk about therapy services that
 10 remained most effective had adopted a preventative
 11 approach pre-pandemic. Could you please elaborate a
 12 little bit on that?
 13 A. Yes, so services who had delivered transformation
 14 pre-pandemic and who were working that whole system
 15 approach which I described around universal targeted and
 16 individualised observed that even when they weren't able
 17 to get into an educational context that some of that
 18 work could continue even if they weren't there and that
 19 was the whole point of being able to prevent harm and
 20 continue work and support and provide a sustainable
 21 approach to some of these needs so that was the point
 22 that we were trying to make there.
 23 Q. And was that work ongoing being delivered by educators,
 24 by teachers and ...
 25 A. That's right, educators, early years practitioners, and

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1 because they had the skills and the approaches and the
 2 knowledge of particular interventions, then that would
 3 have continued even as a whole class offer or a small
 4 group or even individual.
 5 Q. You've made the point very clearly in your evidence
 6 about how critical children's spoken language skills are
 7 in respect of their outcomes. Is there anything you
 8 would want to add to that lesson that you have got in
 9 paragraph 56?
 10 A. I think it's been the awareness in the general public
 11 and in the system of how important communication is, is
 12 relatively low. The pandemic clearly showed the
 13 exacerbated need. It highlighted how urgent it is to
 14 address children's spoken language and that this is a
 15 public health crisis and we need adequate levels of
 16 speech and language therapy to serve these children in
 17 an integrated manner and I would hope the lessons
 18 learned are how critical communication is for children's
 19 learning and how it can be promoted and also what gets
 20 in the way of it.
 21 Q. Thank you, and then just finally, you say it's
 22 important:
 23 "We need to learn the lessons and develop a
 24 nationwide approach to meet the needs of children with
 25 communication needs."

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1 Why is a nationwide approach important?
 2 A. I think there's learning across Scotland. We're
 3 actually working with a collaborative at the moment to
 4 identify the principles for transformation across
 5 Scotland so that collaborative includes the association
 6 and directors of education, COSLA, Scottish directors of
 7 allied health professions, children speech and language
 8 needs, and we've identified clear principles for what
 9 needs to happen which includes prevention, it also ties
 10 up together with adequate resource and we're speaking to
 11 the Scottish Government about that, so there is an
 12 opportunity to take a nationwide approach to this. You
 13 also need though to identify the local needs, so the
 14 needs of those in Orkney might be different from inner
 15 city Glasgow so, yes, the one for Scotland approach but
 16 actually need the ability to adapt the approaches and
 17 resource for the needs of that local community.
 18 Q. Thank you, Mr Carter, and then finally is there anything
 19 else you would want to add to your evidence in relation
 20 to either lessons learned or otherwise?
 21 A. No, thank you.
 22 Q. Thank you, my Lord. I have no further questions unless
 23 your Lordship has any?
 24 THE CHAIR: Thank you very much indeed and thank you
 25 Mr Carter, that's all. We'll now take a break until, a

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1 little bit longer than we had planned, until 1.45, very
 2 good.
 3 (12.32 pm)
 4 (Luncheon adjournment)
 5 (1.45 pm)
 6 THE CHAIR: Good afternoon, Ms Stewart.
 7 MS STEWART: Good afternoon, my Lord. Giving evidence this
 8 afternoon is a panel of two, Dr Shannan and Mrs McCann,
 9 both representing the Scottish Sensory Centre.
 10 THE CHAIR: Very good. Good afternoon, Dr Shannan and
 11 Mrs McCann. Very good. When you're ready, Ms Stewart.
 12 DR BRIAN SHANNAN (called)
 13 MRS ELIZABETH MCCANN (called)
 14 Questions by MS STEWART
 15 MS STEWART: Thank you. Dr Shannan, can you please confirm
 16 your full name for us?
 17 DR BRIAN SHANNAN: Yes. Dr Brian Shannan.
 18 Q. And Mrs McCann?
 19 ELIZABETH McCANN: Mrs Elizabeth Jane McCann.
 20 Q. Now, the Scottish Sensory Centre has provided a response
 21 to the Inquiry's Rule 8 request. My Lord, this can be
 22 found at SCI-SSC-000001. This document was signed by
 23 Professor John Ravenscroft who is the head of the
 24 Scottish Sensory Centre. But I understand that you both
 25 had input to this response, Dr Shannan, in respect of

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1 the impacts on the deaf and Mrs McCann in relation to
 2 those who are visually impaired; is that right?
 3 DR BRIAN SHANNAN: Yes.
 4 ELIZABETH McCANN: That's correct.
 5 Q. In terms of your professional experience, I want to come
 6 to you first, Dr Shannan. You are a qualified teacher
 7 of the deaf, a qualified educational audiologist, and
 8 since January of this year, you have been the
 9 co-ordinator for deaf education at the Scottish Sensory
 10 Centre?
 11 DR BRIAN SHANNAN: That is correct.
 12 MS STEWART: Thank you. During the pandemic can you explain
 13 to us a bit about what your role was?
 14 DR BRIAN SHANNAN: Yes, during the pandemic, I was the
 15 manager of the service for deaf children in Fife, and I
 16 was also employed at the university as a placement tutor
 17 within deaf education, and I also was the course
 18 organiser and lecturer in audiology at the university.
 19 MS STEWART: Thank you. Can I just say, my Lord, the
 20 Scottish Sensory Centre is based within Moray House,
 21 which is Edinburgh University, School of Education and
 22 Sport.
 23 What did your role within the university or within
 24 the Scottish Sensory Centre entail?
 25 DR BRIAN SHANNAN: At the Scottish Sensory Centre, I'm

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1 involved in a variety of groups that are there to
 2 support deaf education. I also help organise courses
 3 for teachers of the deaf and other professionals working
 4 in deaf education.
 5 Q. Thank you, and I understand you were commissioned by the
 6 National Deaf Children's Society to undertake some
 7 research into the views and experiences of deaf children
 8 and their families using assistive devices at home
 9 before and during the pandemic. And, my Lord, this
 10 research was published in 2022 and it has been disclosed
 11 to core participants and can be found at SCI-SSC-000006.
 12 If I can turn to you now, Mrs McCann, you're a
 13 qualified teacher of visual impairment, and you are the
 14 professional learning co-ordinator at the Scottish
 15 Sensory Centre again for visual impairment; is that
 16 right?
 17 ELIZABETH McCANN: That is correct.
 18 Q. And during the pandemic, can you tell us what role you
 19 had?
 20 ELIZABETH McCANN: So I had multiple roles at that time, so
 21 I was working as a qualified teacher of visual
 22 impairment within a local authority, and I had a
 23 caseload spanning a range of ages from children in
 24 primary school, secondary and in special schools. So I
 25 did that for two days a week, I also worked at the

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1 Scottish Sensory Centre, and again, I had a dual role
 2 there, so very similar to Dr Shannan, I was organising
 3 courses for teachers of visual impairment, so
 4 professional learning, and not just for teachers but
 5 also for a range of other professionals as well and
 6 third sector.
 7 I also teach on the postgraduate diploma in visual
 8 impairment. This is a mandatory qualification for
 9 teachers to gain the qualification to become qualified
 10 teachers of visual impairment.
 11 Q. Thank you, and that was something I wanted to come on to
 12 ask you about, was the qualifications for teachers of
 13 the visually impaired; what additional skills and
 14 qualifications do they have? Do they do the
 15 postgraduate diploma in education in the usual way and
 16 then additional training?
 17 ELIZABETH McCANN: Yes. So they do their teacher training
 18 as per normal. They would go and work in a mainstream
 19 school, and then they would generally be appointed in
 20 the role of teacher of visual impairment, and they would
 21 come to Edinburgh University. We are the only provider
 22 of the qualification in Scotland, and they come on on
 23 blocks and undertake the postgraduate diploma which is
 24 at Masters level 11. It generally takes around
 25 two—and—a-half to three years to complete.

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1 Q. Thank you, and do these teachers, specialist teachers
 2 tend to be employed by a local authority or a charity
 3 or ...
 4 ELIZABETH McCANN: They are — in the main they are employed
 5 by a local authority, the only exception being if the
 6 teacher was working in a grant-aided school, but that's
 7 the only real exception. I should also add, just for
 8 context as well, that while I mostly teach teachers who
 9 are gaining the qualification, I also have some students
 10 who are there on a full-time basis who may undertake a
 11 course in visual impairment as part of the MSc on
 12 inclusive education.
 13 Q. Following qualification, are these teachers based
 14 typically within a single school, or are they
 15 peripatetic?
 16 ELIZABETH McCANN: So it can vary. They will either be in a
 17 service, so they would be peripatetic in nature,
 18 covering really from birth up until the age of 18, and
 19 working — going into schools, visiting these learners
 20 in school and at home, and again across all types of
 21 schools and early years provision, or they may be based
 22 in one school if they are employed by a grant-aided
 23 school.
 24 Q. Thank you. In relation to the qualifications for the
 25 teachers of the deaf, Dr Shannan, can you explain a

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1 little bit to us about their additional qualifications
 2 and skills?
 3 DR BRIAN SHANNAN: So in many ways it follows a similar
 4 format to the one that's just been described. The
 5 primary difference is that the teachers also require to
 6 have a specific training level in British Sign Language,
 7 but it's exactly the same. They're employed by the
 8 local authority. The course is delivered at the
 9 university. I just should have added one additional
 10 point to my role during the pandemic that just came to
 11 mind, I was also working, as well as managing the
 12 service in Fife, I ran weekly clinics at the audiology
 13 department with my colleagues from NHS Fife. So we ran
 14 joint audiology education clinics throughout the
 15 pandemic.
 16 Q. Thank you, that's helpful. That's something I will come
 17 on to, to speak about the link between education and
 18 health in a short while. Dr Shannan, can you explain
 19 for us just in high level terms a bit about the Scottish
 20 Sensory Centre's work, its aims and objectives?
 21 DR BRIAN SHANNAN: Sure. So the Scottish Sensory Centre is
 22 there to try to promote and provide skills and training
 23 for — for professionals working within the field,
 24 specifically deaf education, and visual impairment.
 25 The — as I said, it will engage with different

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1 government organisations and bodies such as third sector
 2 organisations to try to work and promote work that will
 3 enhance the profession as well as providing training,
 4 specific courses for professionals.
 5 Q. Thank you. We're interested to learn from you today
 6 about the impacts on — on learners who are blind and
 7 deaf as they go through their various stages of
 8 education, principally in early years and school
 9 education. Staying with you, just now, Dr Shannan, in
 10 terms of how those identified as being deaf are referred
 11 to the correct organisations prior to entering formal
 12 education, can you tell us a bit about how that
 13 operates?
 14 DR BRIAN SHANNAN: Yes, so it's important probably to try
 15 and look at the origins of deafness for a child, so for
 16 a percentage of the children, they are born, have
 17 congenital deafness, and that deafness is permanent.
 18 It's primarily identified through the newborn hearing
 19 screening programme. For another percentage of deaf
 20 children, they will acquire permanent deafness later in
 21 life at some point during their childhood. Those two
 22 groups of children will generally be referred by an
 23 audiology department, or in some areas by an ear, nose
 24 and throat department to a central education system.
 25 However, there are another group of children that

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1 primarily have a temporary or transient form of
 2 deafness. It normally affects the middle ear, and it's
 3 quite commonly been referred to as "glue ear". So this
 4 condition, there's a high percentage of children, around
 5 80% of the population will at some point suffer that
 6 glue ear, especially in the very early years, and so
 7 that is usually managed by the ear, nose and throat
 8 department and that will generally have either a
 9 surgical procedure to remove the blockage in the ear or
 10 have hearing aids, because it's important to put
 11 deafness as not being an inability to, say, to hear, but
 12 deafness is a challenge accessing communication.
 13 For some children, they will have a form of deafness
 14 which means that accessing speech, even in a quiet
 15 environment, can be challenging; but for children that
 16 have got a permanent form of deafness, they find it ---
 17 listening in noise accessing communication a challenge.
 18 But we also have deaf children that, you know, require
 19 British Sign Language because it's important to see
 20 deafness not as a medical condition, but as a sense of
 21 identity about who you are.
 22 Therefore parents, when they find out their child is
 23 deaf, need to make decisions about communication because
 24 all children require language and communication, and
 25 it's important to state that children develop their

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1 language and communication within really the first four
 2 years of life, so it's not --- it's not as if, you know,
 3 for a few years as happened potentially in the pandemic
 4 where, you know, things were put on hold, the children
 5 only have a very narrow window to develop those
 6 communication skills, and families have a time to make
 7 decisions and informed choices about the communication,
 8 whether that be BSL or spoken communication.
 9 Q. Thank you. That provides us with a helpful context when
 10 we come on to look at the impacts. Can you tell us how
 11 it is that these children are made known to education
 12 services?
 13 DR BRIAN SHANNAN: So for the permanent form of deaf
 14 children, they will be referred generally by an
 15 audiology department to a central education service.
 16 For the children that have got a temporary form of
 17 deafness, unfortunately, there is --- currently within
 18 Scotland, there is no national referral pathway for
 19 those children, and therefore some children will go to
 20 audiology services, and they might, depending, be
 21 referred on a central service, but for some, they might
 22 just be referred back to the local school. And for some
 23 children with glue ear, they might be managed on a "wait
 24 and see" basis by a GP, so they're unknown to a whole
 25 group of people that need to have an intervention, and

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1 their language and communication will be compromised
 2 without it.
 3 Q. Thank you. Staying with teaching of the deaf,
 4 Dr Shannan, it will be helpful if you could ---
 5 I understand there's those who use BSL and there are
 6 those who use spoken communication. Could you provide a
 7 bit of context for us in terms of telling us how and
 8 where these two groups of children are educated by and
 9 large, those who use BSL and those who are deaf but able
 10 to speak?
 11 DR BRIAN SHANNAN: So for deaf children, the vast majority
 12 of deaf children are now educated in a mainstream
 13 school. That would be true whether children are using
 14 spoken communication or British Sign Language. For a
 15 percentage of children, they will go to an enhanced
 16 provision which would generally be a resource base for
 17 the deaf, or sometimes are called schools for the deaf.
 18 They are places within --- normally within a mainstream
 19 school that have specific staff and acoustic conditions
 20 that will be --- enhance their ability to access
 21 communication.
 22 So for BSL children, they would require access to a
 23 communication support worker or a support staff member
 24 that ideally should have a high level of British Sign
 25 Language skills, to be able to allow them to access the

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1 communication, and for children, whether it be in a
 2 resource base or in a mainstream provision, they would
 3 require additional devices and support to make the
 4 curriculum accessible. A hearing aid has a range of
 5 about 1 to 1.5 metres, some of them maybe more ---
 6 2 metres. After that you're relying on the sounds
 7 reflecting in the room.
 8 So if the acoustics in the room are not good for
 9 speech, therefore they can make speech more difficult to
 10 hear, and therefore you require a device where the
 11 teacher or the person speaking would wear a transmitter
 12 that would communicate directly to a receiver that
 13 attaches either to a hearing aid; or for some children,
 14 they have an implantable hearing aid called a cochlear
 15 implant, and it would communicate and therefore by
 16 increasing what's called the ability to have direct
 17 speech being communicated to the device and therefore to
 18 the hearing mechanism, you could try to mitigate to some
 19 extent the challenges of poor acoustics or distance.
 20 Q. Thank you, I want to ask you in a short while about the
 21 assistive devices that are used, but before I do, just
 22 staying just now with the individual professionals who
 23 work alongside these children to provide their
 24 education, what is the role of other professionals
 25 beyond the teacher or the teacher for the deaf?

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1 DR BRIAN SHANNAN: So for a deaf child to be, you know, have
2 a successful outcome, a range of professionals need to
3 be involved, so at the point of finding out a child is
4 deaf, it's unusual for somebody to be identified as
5 deaf, and therefore the first person to become involved
6 would be a paediatrician. So a paediatrician would be
7 there to do what's called aetiological investigations,
8 so an investigation into why the child is deaf.

9 So for some families, they wish to find that out, so
10 they would — a paediatrician would be involved,
11 audiology would be involved, because they are the ones
12 that obviously do the initial assessment and continue to
13 check that hearing levels have stayed the same and to
14 issue any hearing aid. There would be ear, nose and
15 throat, if the child had some middle ear issue, because
16 as I said before, it's quite common.

17 In addition to that, there would be the need for a
18 speech and language therapist to be involved, to ensure
19 that the language and communication is developing as it
20 should. There would also be, for families being able to
21 make an informed choice, have access to a BSL tutor or
22 the ability to learn BSL. In addition to that, there
23 would be — a teacher of the deaf would be assigned in
24 one shape or form. For some children, they require a
25 weekly visit. For some it can be once every month or it

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1 could be once every year. It depends on the child's
2 needs. There would be a support staff member for when
3 they're in school or in nursery.

4 Then obviously there's the third sector
5 organisations that are there to provide support to the
6 families such as the National Deaf Children's Society,
7 there's the Deaf Action, British Deaf Association. So
8 there's a wide range of people involved.

9 Q. Thank you, and pre-pandemic, were those interactions
10 done all in person within a school or early learning
11 centre and also within the home?

12 DR BRIAN SHANNAN: Yes.

13 Q. Thank you. I want to turn now to you, Mrs McCann, and
14 your area of expertise. Again, can I ask you, in
15 connection with those children who are visually
16 impaired, how is it that they are, first of all,
17 identified and made known to education services?

18 ELIZABETH McCANN: So the majority of children are
19 identified in the clinical setting, so this would be by
20 an ophthalmologist. We also have an organisation called
21 VINCYP, which stands for Visual Impairment Network for
22 Children & Young People. VINCYP have a pathway, and so
23 once a child is identified as having a visual
24 impairment, and they have a set of criteria which is
25 actually quite broad, the referral would be made to

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1 education services, and also to habilitation, who deal
2 with orientation and mobility, so that is the ability to
3 move around safely both in the home, the school and the
4 wider environment as well. And there can also be
5 referral to third sector, so to charities as well.

6 So generally it's through health but schools can
7 also make referrals for children if they have a concern
8 about their vision, but the child in the first instance
9 or the parents would be expected to take their child to
10 a high street ophthalmologist to make sure there's not
11 just some simple refractive error.

12 Q. Thank you. In terms of the education of these children
13 and young people, I understand there are those who use
14 braille and those who require other adjustments. Can
15 you tell us a bit about how and where these two groups
16 of children and young people are educated?

17 ELIZABETH McCANN: So very much like children who are deaf,
18 children who have a visual impairment are educated in a
19 mainstream setting, so they would attend their local
20 nursery, primary or secondary school. There are a small
21 number of children who may attend a grant-aided school,
22 for example, for visual impairment, but the vast
23 majority are in a mainstream setting.

24 Now, we do have in Scotland some additional resource
25 spaces. They tend to be scattered through the central

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1 belt of Scotland, so these are a resource base within a
2 school where children who are likely to have the most
3 significant visual impairment, so they would require
4 large print, or would be braille users, and if they
5 lived within a local authority, that may be a choice
6 that is made for that young person to attend a base.

7 Q. In connection with the other professionals who are
8 integral to this child's education, in addition to the
9 teacher or the specially qualified teacher, can you tell
10 us a bit about the other professionals. You mentioned
11 habilitation, for example; are there others?

12 ELIZABETH McCANN: Yes. So a lot of children or many
13 children would also have access to support for learning
14 assistant. They may be either employed centrally by the
15 local authority and only work with children who have got
16 a visual impairment, and they would have additional
17 skills. So, for example, they may be very good — or
18 they may be trained in the use of braille. We also have
19 other people who are employed again, maybe centrally, by
20 the local authority, as transcription, for working in
21 transcription. This means that they would prepare
22 curricula materials in alternative formats. It might be
23 braille, it could be large print, they would make
24 pictorial materials. They would adapt that into raised
25 diagrams for learners who are blind or need braille.

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1 They may convert texts into electronic documents so that
2 it could go to a young person's iPad that they could
3 access it that way. So we have these transcription
4 people as well.

5 We have also habilitation specialists who, as I
6 mentioned previously, support with safe movement and
7 access, and also do aspects of daily living, which can
8 involve basic things such as dressing, using cutlery,
9 learning how to make a hot drink safely and so on. And
10 also all of the health professionals that go round that
11 as well, so ophthalmologist, orthoptist, paediatricians
12 as well.

13 Q. Thank you very much. In terms of the impacts of
14 lockdown and other restrictions, I'm going to take
15 visual impairment and deafness separately, and also
16 blind deafness to which you have dedicated a section in
17 the Rule 8 response. Before I move on to that, I was
18 struck, Mrs McCann, at something you said at section 7
19 on page 5 of your Rule 8 response. You said that:

20 "As a result of online learning/use of video games
21 during Covid, more children have been diagnosed with ...
22 difficulties due to the much-increased ... screen time."

23 Can you explain to us how and to what extent
24 increased screen time can impact a child's eyesight?

25 ELIZABETH McCANN: So the longer that you spend looking at a

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1 screen, then your eyes have to converge or turn inwards
2 in order to be able to focus, and as adults who may have
3 a job working on screens generally, there's quite clear
4 health and safety advice about having a break away from
5 screens, but this didn't happen during COVID, and as a
6 result that continued and repeated convergence over a
7 long period of time has led to more children having
8 issues with alignment, issues of the eyes, and not ---
9 and therefore squints and so on and also myopia as well,
10 so shortsightedness. So these things have been
11 exacerbated by that additional screen time. Because of
12 lockdown and so on, things have not been picked up, not
13 been addressed again by clinics in the way that they
14 would have done.

15 Q. Thank you. Is this something that has impacted
16 children's eyesight, or is it something that applies to
17 the population at large?

18 ELIZABETH McCANN: So these would be children who would not
19 have been known previously to services, so this is a new
20 group of children, if you like, that are being
21 identified as a result of COVID, and whether they are
22 known to teachers of visual impairment now would depend
23 on how --- the significance of that visual impairment has
24 become, and whether it can be corrected with glasses.

25 Q. Thank you. Staying with the impact on those who are

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1 visually impaired, I want to ask you some questions
2 about the use of assistive devices and the impact of
3 school closures and the move to online learning. At
4 section --- perhaps, first of all, before we move on to
5 that we can look at the impact on the learners who use
6 braille. Can you set out for us how their learning was
7 impacted by learning from home, and doing so online?

8 ELIZABETH McCANN: So when we think about children who are
9 blind learning in school, we have a model called
10 "Learning to access and access to learning". When
11 children are young, perhaps in nursery and primary
12 school, it's very much about access to learning, so
13 their work is prepared for them in an alternative
14 format, and as that learner progresses through school
15 and as their skills develop, it changes from access to
16 learning and learning to access, so that they learn to
17 access independently, and that can be through braille
18 and through assistive technology, so over time that
19 changes.

20 The move to online learning had a significant impact
21 on that, because in order to be able to access learning,
22 your learning has to be created in a format that you can
23 access. In school, on a day-to-day basis, for a learner
24 who has got a significant visual impairment and is a
25 braille user, there's not a single piece of work that is

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1 presented to that learner that hasn't gone through some
2 kind of process before it goes to that learner. So
3 there will be multiple adaptations and modifications and
4 preparation of that work in a different format.

5 That didn't always happen during lockdown, and
6 didn't happen for multiple reasons. In order to make
7 that learning accessible, there has got to be close
8 communication between the teacher of visual impairment,
9 the class teacher and then also the person who's going
10 to do the transcription. Sometimes that can be someone
11 who has a dedicated role for transcription, and
12 sometimes it can be a support for learning assistant.

13 In some cases, the support for learning assistants
14 who may have been working with children with visual
15 impairment were diverted to do another job. So that,
16 for example, could have been to work in a hub school, so
17 the person who was doing that transcription support was
18 taken away to do another task. For some learners, they
19 didn't have the skills of access to learning or may have
20 been at the point of access to learning, and it's very
21 difficult and challenging to teach braille, for example,
22 when you're doing it online.

23 We had additional difficulties in terms of the
24 platform that we were being asked to use. During the
25 initial lockdown, I was actually --- or just before the

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1 lockdown, I was teaching a young person braille in
2 school, and when lockdown came, we were all asked to use
3 Teams, but again, while Teams was a function, many of
4 the aspects of that functionality were closed off, so,
5 for example, the use of the camera. So it was difficult
6 if that young person was sitting perhaps with a parent
7 or a sibling in the house to model things such as hand
8 technique for moving across the line of braille, because
9 there were no cameras, so all of those things were a
10 barrier.

11 Again, for other learners who are perhaps large
12 print users, they would access their work in school
13 using video magnifiers, and a video magnifier is a
14 fairly large piece of equipment, particularly if you're
15 in a primary school, because you're used to sitting in
16 one room in one seat for quite a lot of the time. So
17 these are fairly large pieces of equipment, expensive
18 pieces of equipment. When the first lockdown happened,
19 not all children got their equipment home with them, and
20 that could have been for a variety of reasons; first —
21 and one particular reason may be the need to transport
22 that piece of equipment home, and not having transport
23 to take it to the home as well, or, indeed, room to have
24 it at home as well. So that put learners at a
25 disadvantage, because they didn't have essential pieces

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1 of equipment that would allow them to access their work.
2 Q. Thank you. I want to just go back to something you
3 mentioned a short while ago, which is the redeployment
4 of specialist teachers, and I notice from your Rule 8
5 response, you talk also about the furlough of certain
6 specialists. What was the incidence of that
7 redeployment or furloughing, and what was the impact of
8 that?

9 ELIZABETH McCANN: So if I can take furloughing first of
10 all, furloughing, generally speaking, happened to those
11 who were working in the third sector, and those are
12 people who deliver habilitation so that orientation and
13 mobility and daily living, so these workers were
14 furloughed, and so there was no support for
15 habilitation.

16 So I can speak about a student who came from China
17 to do her full-time Masters at the University of
18 Edinburgh, and she arrived at the height of the
19 pandemic, and she decided to take one of my courses, and
20 I met her. So it became quite clear to me when we met
21 at the university that her mobility skills were not as
22 good as they might have been for someone of her age, so
23 there was nobody around to help her on how to navigate
24 independently and safely from her residence to, say, the
25 supermarket down the road.

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1 Prior to her arrival, we would have previously
2 alerted those services, and they would have come in to
3 the halls of residence and they would have done simple
4 things like marking up the washing machines, the cooker,
5 to allow her to cook independently, know when things are
6 turned on, you know, what programme to use on the
7 washing machine and so on, for washing her clothes. We
8 were not able to do that, so as a result, although I'm
9 not qualified in habilitation, I was — I was able to go
10 in, but I was able to do that because the University of
11 Edinburgh has the Scottish Sensory Centre there, and I
12 would hate to think of the impact that would have had on
13 other students across Scotland, who perhaps didn't have
14 that, at least some kind of service. But there was no
15 service across Scotland for anybody delivering
16 habilitation.

17 Unless in a very slim — and there are very few of
18 them, habilitation officers who are employed by the
19 local authority. I can probably think of two in the
20 whole of Scotland, so that was a huge issue. And again,
21 there was no habilitation for children and young people.

22 In terms of teachers, then, and also classroom
23 assistants, they were also being asked, or the potential
24 to be asked to go into hub schools, so, again, this made
25 planning and teaching very difficult. Even when we were

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1 doing our best to do online teaching, the difficulty was
2 that you could be called away at a moment's notice to
3 support in a hub school if that was needed, which then
4 left the teachers of visual impairment and the staff
5 also feeling that those children with visual impairment
6 were less important because hub schools were taking
7 priority.

8 Q. You mentioned a short while ago about the use of video
9 magnifiers. Are there other assistive devices that are
10 used by those who are visually impaired?

11 ELIZABETH McCANN: Yes. So video magnifiers are in the main
12 used by learners who are large print users. For our
13 learners who are braille users, they have a Perkins
14 brailler, which is a bit like an old-fashioned
15 typewriter. That is what most young people start to
16 learn with. As learners get older, they may have
17 braille notetaker devices which are small. It's like a
18 very mini computer which will speak, and also has pins
19 at the bottom which pop up and are your braille cells.
20 Also, young people have laptops with specialist
21 programmes such as speech output, and some may also have
22 braille displays as well. So as well as the computer
23 talking, what's on the screen, you have the text in
24 braille as well on the braille display.

25 Q. And were these devices available to the children who

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1 were learning online at home?
 2 ELIZABETH McCANN: Some children may have had those, but
 3 again, it becomes very challenging to teach those
 4 devices when you aren't there in person, because you
 5 cannot see what is on the screen in front of that young
 6 person. Not all children had the — were kind of far
 7 enough long in that access to learning, and to be able
 8 to be confident. Parents weren't confident either on
 9 how those devices worked, so it made learning of screen
 10 readers and also notetakers much more challenging.
 11 Q. You set out in your Rule 8 response that some pupils had
 12 IT devices provided by the local authority, and you
 13 referred to the difficulty or the inability to install
 14 software or update apps. Can you explain a bit about
 15 the software and apps necessary for the learning of a
 16 visually impaired young person?
 17 ELIZABETH McCANN: So many of our young people will have
 18 tablet devices as well, which sometimes can replace what
 19 a video magnifier does, so — and will access things,
 20 but these devices are owned by the local authority, and
 21 so they are quite, for security reasons, locked down, so
 22 when it comes to updating those devices, you can't do it
 23 unless you are actually on council premises, so
 24 therefore your device becomes out of date quite quickly,
 25 or you can't log in as well because your password has

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1 expired. So all of those things are challenges as well
 2 that prevents access.
 3 Q. I want to just ask you a little bit about hub schools
 4 just as my final, final question on this section. Were
 5 pupils who use braille given access to hub schools in
 6 the first lockdown?
 7 ELIZABETH McCANN: No. As far as I'm aware, children who
 8 are braille users did not. During the second lockdown,
 9 in some local authorities, young people who are braille
 10 users had access, but this was not universal across
 11 Scotland.
 12 Q. What about those with visual impairments who don't use
 13 braille, were they also given access in the second
 14 lockdown?
 15 ELIZABETH McCANN: As far as I am aware, most children who
 16 are large print users, unless there was some other
 17 reason, didn't have access to hub schools.
 18 Q. Thank you. I just wanted to ask you to describe to us,
 19 insofar as you're able to, what the hub schooling of
 20 these pupils who did attend the hubs looked like, for
 21 example, did they have the benefit of a qualified
 22 teacher of visual impairment, and the other necessary
 23 support you've outlined already?
 24 ELIZABETH McCANN: From what I have been told, because
 25 I wasn't actually in a hub school at that point during

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1 the second lockdown, and I wasn't working for a local
 2 authority, but my understanding is that teachers of
 3 visual impairment did go in to local — into the hub
 4 schools if there was a child, a young person there, who
 5 was a braille user, yes.

6 Q. Thank you. I want to turn now to you, Dr Shannan, to
 7 ask you very similar questions in relation to deaf
 8 learners. You set out in the Rule 8 response that at
 9 the first lockdown, not all pupils had the devices they
 10 needed to learn from home. Can you tell us a bit about
 11 the devices that deaf students, first of all, the BSL
 12 users might require to have?

13 DR BRIAN SHANNAN: So it's important to put in context that
 14 90% plus of children that are deaf are born into hearing
 15 families, so for the BSL users, in a sense fall into two
 16 groups. There are BSL users whose first language in the
 17 home are deaf parents that are using BSL, so — and in
 18 those cases, the children will be exposed to BSL and
 19 they will develop language in a similar way to a hearing
 20 child through exposure to a language.

21 However, for deaf children that were born into a
 22 hearing family, they were at a significant advantage,
 23 because to develop — basically you need to develop a
 24 language and you develop a language through exposure.
 25 The old saying is: language is caught, not taught. So

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1 you need to be able to have exposure to people that are
 2 proficient with that language. That was not happening
 3 across Scotland. So (inaudible) there's a limited
 4 number of skilled staff pre-pandemic, but within the
 5 pandemic situation, not all those — the cameras, as
 6 we've already heard, on Teams were switched off, so you
 7 need to physically see somebody, you need somebody —
 8 for family members who have a deaf child, they need to
 9 be able to access sight tutors to develop their skills
 10 so that they can communicate with their child.

11 It's quite an emotional wrench to be able to have a
 12 deaf child that you cannot communicate with, and all the
 13 support networks that you require have been removed.
 14 So, you know, deaf children, the parents were at home
 15 trying to support their deaf children as best that they
 16 could but without access physically to a BSL user. So
 17 in some areas they would try to access alternative video
 18 communication systems, but the blanket switch-off of the
 19 screen system basically, you know, denied deaf children
 20 their education, because you couldn't access
 21 communication. For — I interrupted myself so I'll stop
 22 there.

23 Q. That's fine, and I understand from those who perhaps
 24 rely on lip reading, also, that would have been an
 25 impact?

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1 DR BRIAN SHANNAN: Correct, because communication, every ---
 2 although we talk about BSL and spoken language, we call
 3 that multimodal communication, namely every language,
 4 spoken language involves looking at people's body
 5 language, looks at lip reading, all of those different
 6 things. So we all use different --- we all use visual
 7 and auditory parts to communication, so a BSL user or a
 8 deaf user that's using spoken language, the switching
 9 off of a screen basically switched off education.
 10 Q. You've set out in your Rule 8 that learners struggled to
 11 access laptops or computers where two-way communication
 12 was available. Is that what you mean, that there was a
 13 screen and cameras in both directions?
 14 DR BRIAN SHANNAN: Correct, so in some situations for some
 15 families where they had maybe multiple children in the
 16 family, there might have only been a single laptop. So
 17 some children were accessing their education through
 18 online learning that might have been on a phone or a
 19 tablet or a laptop or a shared device. So you --- not
 20 only did the technology --- the technology had full
 21 capacity but significant restrictions were imposed on
 22 that functionality. That disadvantaged children
 23 especially with an additional support need, and deaf
 24 children --- as I said, deafness is not a learning
 25 disability. Deaf children can achieve the same as

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1 hearing children if they have access to communication.
 2 What we did by removing that is we took away
 3 communication.
 4 Q. You say in your Rule 8 that there was limited input from
 5 teachers of the deaf, and this is something that
 6 Mrs McCann has touched on in relation to those who are
 7 visually impaired. Can you tell us a bit about why that
 8 was the case?
 9 DR BRIAN SHANNAN: So again, there was a variety of reasons.
 10 Some of those were, as Mrs McCann has said, that, you
 11 know, decision-makers within the local authorities were
 12 prioritising, you know, potentially support into hub
 13 schools because maybe staff members were absent, and
 14 they were looking to source staffing for those --- the
 15 hubs, but in some cases there was just a lack of
 16 priority given to deaf children. In some cases, we had
 17 unions telling staff members not to support children
 18 online, because they felt there were safety concerns,
 19 but again, all of these competing interests were
 20 happening, but at the heart of this was a deaf child;
 21 and as I said you can't --- if what is happening is
 22 occurring during the time when your window of
 23 opportunity to develop a language is happening, to
 24 remove that, you're taking away somebody's right to a
 25 language, to communication, to participation, and it has

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1 a lifelong effect. You can't come back after a year or
 2 two and say: we'll pick up your language. A human being
 3 has that window of opportunity.
 4 Q. Thank you. You mention your Rule 8 response, and,
 5 indeed, the parents you surveyed say that there was
 6 ineffective classroom management, and this was a
 7 barrier, and this brings us back to the helpful
 8 explanation you gave us before about the impact of
 9 noise, or noise coming from more than one source. Can
 10 you explain a bit to us about how the classroom
 11 management was ineffective?
 12 DR BRIAN SHANNAN: So in an ideal situation, a deaf student
 13 would have their assistive device, which they would be
 14 able to attach to a laptop, which would then mean that
 15 what was being transmitted from the laptop would go
 16 straight into the receiver of the hearing aid, and
 17 therefore into the hearing mechanism. As I have
 18 described, those systems were not routinely available.
 19 You then had an online learning platform. As I
 20 said, in many cases there was no access to a visual
 21 reinforcement. So you were then having somebody, the
 22 class teacher, on an online list having, not muting all
 23 the microphones, for instance on the computer, and so ---
 24 it's understandable, people were in busy households, so
 25 sometimes you have televisions on, or other things going

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1 on with the family, which was then polluting the
 2 learning environment.
 3 You then also had --- in a classroom, you would
 4 generally not expect to see everyone just shouting out
 5 the answers, but, you know, there wasn't --- there's a
 6 hand up option on Teams. That wasn't always being
 7 utilised. So really, for a lot of, you know, parents
 8 and certainly in the research we carried out, parents
 9 were saying, you know: basically, the kids were just
 10 becoming deflated and disengaged, because this was not a
 11 learning environment that was accessible to them, and so
 12 the pandemic in a sense amplified already issues around
 13 how deaf children access mainstream provision.
 14 I think it's important that policymakers have a
 15 greater understanding of the needs of deaf children so
 16 that --- those were not firmly established because if
 17 they were, then the online learning would have been
 18 more --- managed more organised, but, you know,
 19 mainstream teachers were thrown into suddenly learning
 20 online. So they were learning technology, technology
 21 that had been restricted, and there was no real
 22 communication with professionals in the field to say:
 23 we're doing this, you know, is there a way that we can
 24 make this better, or we can mitigate the effects.
 25 Q. In terms of the assistive devices, you have explained

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1 very powerfully for us that the absence of the
 2 face—to—face with the speaker or the speakers is
 3 important, but had that not been the case, did the child
 4 have access to the device needed to amplify the sound,
 5 for example?
 6 DR BRIAN SHANNAN: No, so in a sense if we think about
 7 hearing devices for deaf children that use them, there's
 8 either a hearing aid or a cochlear implant. Then, like
 9 I said, there's an assistive device that attaches a
 10 receiver to that, and a microphone. So for the hearing
 11 device, the hearing aid to work, you need to have ear
 12 moulds that are properly fitted. Because of the
 13 pandemic, there was a delay for some children being able
 14 to get access to new ear moulds. A lot of the health
 15 boards were going to scanned moulds that had been taken
 16 previously, and the manufacturers were adding on a
 17 millimetre here across the board to try to get a mould
 18 that fitted.
 19 So in some cases, the children's hearing devices
 20 were not working at an optimal level. Then on top of
 21 that, lots of services, the equipment is expensive,
 22 there is no doubt about that. However, that was not
 23 routinely made available to families. Equally, when
 24 there were problems, because you were a family being
 25 given a device, how do you connect this up, how does it

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1 all work, the support network around that was not always
 2 available.
 3 So, you know, it was a lack of access to universal
 4 devices, a lack of access to the hardware laptops, and
 5 also, you know, making sure that the equipment that the
 6 deaf children required to access the curriculum — that
 7 was suitably maintained.
 8 Q. In terms of access to hub schools, were those who are
 9 users of BSL given access to hub schools in the first
 10 lockdown, or indeed the second?
 11 DR BRIAN SHANNAN: So in the first lockdown, there was no
 12 deaf children that I was aware of that were accessing
 13 the hub schools. In the second lockdown, some deaf
 14 children did access those schools, but again it was not
 15 universal across the country. Certainly for BSL users,
 16 there would be a strong case to be made that they
 17 required that physical person to be there to communicate
 18 with them.
 19 Q. In connection with those who communicate with the spoken
 20 word, were they given access in the second lockdown?
 21 DR BRIAN SHANNAN: Again, this was not always universal, and
 22 again, it comes back to this lack of understanding.
 23 There's a conceptual understanding that a deaf child, if
 24 you provide them with a hearing aid, that suddenly they
 25 become an honorary hearing person, that they can hear

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1 and participate in society. That is not the case. A
 2 device is only as effective as the environment that it's
 3 in and the other equipment that is attached to it, and
 4 therefore making the case that deaf children required
 5 communication, they needed to learn and develop their
 6 language, and therefore were valid candidates for a hub,
 7 was not universally applied across the country.
 8 Q. Thank you, and if you're able, can you tell us a bit
 9 about what the hub schooling of these children looked
 10 like when they did attend the hubs?
 11 DR BRIAN SHANNAN: So I can only speak for the area that I
 12 worked in at the time, that we would send teachers of
 13 the deaf or support staff to the hub to support the
 14 young people. The hubs generally had a group of
 15 priority candidates, so children of parents that were
 16 working in the emergency services, or core services.
 17 There were children that had — whose needs were
 18 identified as being specific, but they were always
 19 trying to maintain a manageable number within the hubs,
 20 so again, it comes down to that case being made on a
 21 case—by—case basis, and it depended on, you know,
 22 different education managers. Within authorities
 23 generally, education managers will oversee an area of a
 24 region, and so it depended upon, were those educational
 25 managers mindful to accept the case being made.

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1 Q. And was the case made by the teaching staff or by the
 2 parent to the local authority?
 3 DR BRIAN SHANNAN: Our authority was generally made by
 4 either the staff, the teachers of the deaf approaching
 5 myself, or myself approaching the different education
 6 managers and making that case.
 7 Q. Thank you very much. I want to look now at another
 8 cohort and that is those who are deafblind. If I can
 9 bring you in on this, Mrs McCann. It's set out at
 10 page 6 at section 7(b) that online learning does not
 11 meet the needs of these children and young people, and
 12 you speak about a multisensory approach being required.
 13 Can you explain to us what's meant, first of all, by a
 14 multisensory approach?
 15 ELIZABETH McCANN: So I think if I talk just very briefly,
 16 first of all, about deafblind.
 17 Q. Of course.
 18 ELIZABETH McCANN: So these are children who have got a dual
 19 sensory impairment, but most of those learners that we
 20 find in Scotland, but perhaps not exclusively, do have
 21 additional support needs above and beyond having a
 22 hearing loss and a visual loss. So many of those young
 23 people would be found in special schools, but — so
 24 those young people had more access to learning during
 25 that time, but obviously if there were significant

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1 health concerns, then some parents may have taken the
 2 option not to send them to school because of the
 3 fragility of their health.
 4 Nonetheless, they are still entitled to education,
 5 but a multisensory approach to learning is exactly that:
 6 they need to have literacy, for example, through sensory
 7 storytelling that use simple language, but also have
 8 props and real objects, which will have a variety of
 9 touch and smell and perhaps taste as well that will
 10 enhance learning and be able to help them to understand
 11 concepts more readily.
 12 Q. Is a multisensory approach to learning about the
 13 environment in which the child is, or is it more about
 14 the pedagogy deployed by the teacher?
 15 ELIZABETH McCANN: Well, it's both, because as I have just
 16 really described the pedagogy, for those learners, they
 17 need to have an environment where there are few other
 18 distractions, because that can interfere with learning,
 19 so they want a low arousal environment where it is
 20 quiet, that allows them to focus on the language that is
 21 being used, and where there are a few distractions; for
 22 example, people moving around will be a distraction away
 23 from the learning, which will take the attention away,
 24 because they — sometimes they're hearing if they're —
 25 perhaps if their vision is quite low, then they may have

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1 a hearing loss, but actually their hearing is a better
 2 sense, so they will tune into that and they will use
 3 that very well.
 4 But for those children, anybody moving around will
 5 be a distraction. Also, you know, very bright rooms,
 6 light is also — positioning of that young person within
 7 the room is really important, because often again they
 8 can stare at light and not actually take their visual
 9 attention on to the thing that they are being presented
 10 with.
 11 Q. Is it, in your view, Mrs McCann, possible to have this
 12 multisensory education within a domestic setting?
 13 ELIZABETH McCANN: It's very, very challenging. In a home
 14 setting where everybody was at home, everybody — for
 15 some families, you know, their accommodation wasn't
 16 always ideal. So everybody was in the same room or in a
 17 couple of rooms. Again, as Dr Shannan has explained,
 18 about competing background information, and also
 19 something that I haven't mentioned, and I probably
 20 should have mentioned in my last question that you
 21 asked, there has been a lot of talk and discussion about
 22 the amount of input that parents need to have, or that
 23 another person needs to have with that child, whether
 24 they have a visual impairment or are deafblind.
 25 For some families, if there are a lot of children at

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1 home, trying to divide and split up your attention is
 2 really difficult. It's also really difficult in
 3 families where both parents worked, because they were
 4 juggling two jobs, each having a job, where they were
 5 having online meetings, and so it was very, very
 6 difficult that — when did you squeeze in — education
 7 had to be almost fitted around the needs of the parents
 8 first, because they had to keep hold of their job in
 9 order to have a family and a roof over their head. So
 10 that was another huge issue, but there were lots and
 11 lots of barriers, particularly for the learners who
 12 required that multisensory approach, because education
 13 for them, it's very difficult to squeeze in lessons that
 14 last an hour, because their attention and their level of
 15 fatigue is such that it needs to be short bursts
 16 throughout the day, and that's another additional
 17 challenge.
 18 Q. Thank you. One thing I did want to ask you, but I'm not
 19 sure who's best placed to respond to this, is about the
 20 assistive devices used by those who are deafblind, and
 21 in particular the switches that they use. You've set
 22 out that not all students had access to switches when
 23 they were at home, that sharing of switches was an
 24 issue. I don't know which one of you is best placed to
 25 speak to that?

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1 DR BRIAN SHANNAN: I'm happy, yes.
 2 Q. Please carry on.
 3 ELIZABETH McCANN: Yes, so for many children who are
 4 deafblind, they don't have speech, and so they may
 5 access switches. They would have been assessed by — it
 6 might have been an occupational therapist or in terms of
 7 where is the best position for that switch to be in to
 8 allow them to physically move either an arm or a head or
 9 a leg in order to access that switch.
 10 There are a variety of switches that are on the
 11 market, and switches that have — require minimal
 12 movement for a young person that's got quite restricted
 13 both gross motor and fine motor skills, so these are the
 14 kind of switches that you might just put your hand on,
 15 and a slight finger movement would trigger the switch;
 16 or other switches which are larger, as I say, that can
 17 be accessed by hitting it.
 18 So, again, in a classroom situation, those switches
 19 may be shared by a number of learners, and, indeed, for
 20 example, in a morning routine, for saying good morning
 21 to their classmates, that might be something that would
 22 be passed around a group of young people. But again,
 23 when learning moved to online learning and young people
 24 weren't accessing school, they didn't always have access
 25 to any switch, never mind one that was the most

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1 appropriate for them.
 2 DR BRIAN SHANNAN: Could I make just one point. It would be
 3 important also within the group that are deafblind, for
 4 some, they can be, say, born deaf, but they develop
 5 Usher Syndrome, which is where your sight becomes much
 6 narrower or narrow to the point of not being able to see
 7 at a later point. So they can become visually impaired,
 8 you know, into their early teens.

9 So for that group of children, especially for BSL
 10 users, they move from being able to use BSL
 11 communication to one where their world starts — and
 12 therefore their communication is removed, and therefore
 13 they need to move to a kind of on-body signing system.
 14 So there needs to be a transition from one type of
 15 communication to another, as well as the impact being,
 16 you know, in your early teens, discovering that you're
 17 going to begin to lose your eyesight and all the
 18 implications there, and the need for all those support
 19 services to be in place.

20 That absolutely has to happen in person, and, you
 21 know, you can't learn these things online. So it's just
 22 to kind of put in context that for some, the ones that
 23 we've been talking about where deafblindness was at
 24 birth, and there's maybe more complex needs, but there
 25 are other deafblind individuals that — whose

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1 communication and learning has followed a traditional
 2 path, other than, you know, being deaf or visually
 3 impaired, and they happen not in sync, and therefore
 4 it's a process, so within that group, also just needs to
 5 be considered.

6 Q. Thank you. In terms of these children's access to hub
 7 schools, I understand from your Rule 8 that there may
 8 be, for those who are born deafblind, certainly some
 9 additional health needs that perhaps would make hub
 10 schooling not an attractive option, but were these
 11 children offered hub school places in the first lockdown
 12 or the second?

13 ELIZABETH McCANN: So my understanding is that — that
 14 children who had complex additional support needs,
 15 including deafblindness, were offered — some of them
 16 were offered hub places in the first lockdown, and
 17 during the second lockdown as well.

18 Q. Thank you, and again, you mention that they typically
 19 attend special schools. Would their schooling replicate
 20 that which they would have had pre-pandemic?

21 ELIZABETH McCANN: For some, there were some issues in terms
 22 of many of these young people are transported to school
 23 by taxi which is paid for by a local authority. Again,
 24 as far as I'm aware, there were some issues around
 25 transport for those young people, and, you know, again,

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1 if they were sharing taxis and the availability of taxis
 2 to take young people to schools, so sometimes that then
 3 fell — that burden fell on parents as well, so there
 4 were issues; and again, also around issues with staffing
 5 as well, in those schools as well, and staff who
 6 themselves were vulnerable, and therefore couldn't work
 7 in a hub school. So all of those played a — had an
 8 impact on learning.

9 Q. Thank you. I want to move now on to looking at the
 10 reopening of schools and operating within the
 11 restrictions. If I can come to you first on this,
 12 Dr Shannan, at section 8(e), you say when schools
 13 reopened, family and anxiety issues meant some deaf
 14 learners remained at home.

15 Can you tell us a bit about what it was that led to
 16 these deaf learners not returning to school?

17 DR BRIAN SHANNAN: So this was certainly an experience that
 18 I witnessed in Fife where there were a number of deaf
 19 learners that had been very confident members attending
 20 school, great attendance, good attainment, and they just
 21 could not leave the house, they could not go into
 22 mainstream schools, they — for some, they would come on
 23 kind of a restricted timetable to try to reintegrate
 24 back into school, and for others, they would maybe stay
 25 within a room within the school and not be able to feel

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1 confident enough to go into the — into the classroom.
 2 I was shocked by the number of children that I had —
 3 you know, I had known most of these children since they
 4 were born, to see the impact on them and their families,
 5 and their families were certainly really worried about
 6 that and their children's future.

7 Q. You raised the issue of bubbles as being one aspect of
 8 the restrictions that impacted deaf pupils, insofar as
 9 it impacted the level of professional input that they
 10 might have. Can you expand on that a little for us?

11 DR BRIAN SHANNAN: So within a school, within a primary
 12 school, you know, the nursery could be classed as one
 13 bubble. The early years part of the school, you know,
 14 primary 1, 2 and 3 could be classed as another bubble,
 15 and then the senior school could be another bubble. So
 16 if you had a deaf student in each of those provisions,
 17 you weren't able to go and visit all of those because
 18 you would be crossing bubbles. So, you know, you were
 19 basically only able to go and see — you were restricted
 20 to a limited number of schools per day, but you were
 21 also limited to the number of bubbles that you could go
 22 and see, and therefore as I said, going back to the
 23 previous point about if you don't have the equipment, if
 24 there's a problem with your piece of equipment, then
 25 you're not able to access the curriculum that there was

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1 no --- that kind of flexibility to move between the
 2 bubbles just was not within any of the regulations .
 3 Q. Thank you. And Mrs McCann, you raised similar issues in
 4 connection with the bubbles. Is that for the same
 5 reasons as outlined by Dr Shannan?
 6 ELIZABETH McCANN: Yes, and also if you have a child, a
 7 young person in a classroom who perhaps already has a
 8 support for learning assistant, you know, you weren't
 9 able to go in as well as an additional adult into a room
 10 and then the opportunity for withdrawal which is perhaps
 11 not, you know, would be our normal way of working, we
 12 would rather be in the classroom to see what's
 13 happening, every available space was taken up, so there
 14 was no opportunity for withdrawal either, but yes,
 15 exactly as Dr Shannan mentioned, I think there was also
 16 another issue as well, particularly between the end of
 17 the first lockdown for learners who are transitioning as
 18 well. So for transition for a young person who has got
 19 a visual impairment requires a lot of thought especially
 20 if they're moving between schools, from nursery to
 21 primary, primary to secondary, and also secondary out of
 22 education, but if we think about in between stages, a
 23 lot of work again is done by habilitation specialists in
 24 order to familiarise that young person with the new
 25 environment that they are going into but obviously these

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1 people had been furloughed and so when schools were
 2 going to open up again in the August, at the end of that
 3 first lockdown, there was a lot of scrabbling around
 4 happening in order to get people back into work and see
 5 which children were going to be transitioning and make
 6 all of the arrangements to get access to the schools,
 7 which, prior to COVID and now as well, a lot of that
 8 work would happen during the holidays because
 9 habilitation specialists don't have teachers holidays
 10 but they're all being furloughed so there was a lot of
 11 work that had to be done in a very short space of time
 12 when teachers ostensibly were on holiday so that liaison
 13 and that was just missing.
 14 Q. One thing I wanted to ask you about in addition to what
 15 you said there is the functional visual assessments and
 16 you say it was difficult to undertake many aspects of
 17 such assessments. Can you tell us what these
 18 assessments are and how and why they're conducted?
 19 ELIZABETH McCANN: So, generally speaking, a teacher of
 20 visual impairment would carry out functional vision
 21 assessment within the school environment to find out how
 22 well that young person is using their vision and from
 23 the results of that assessment, generally speaking,
 24 distance assessment, testing of near vision as well,
 25 colour and contrast and so on, we then make

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1 recommendations to the class teacher in terms of where
 2 that young person should sit in class to make maximum
 3 use of their vision. We would give advice on teaching
 4 strategies as well and also on how their work should be
 5 prepared for them, for example, font size, font type,
 6 line spacing, all those sorts of things. In order to
 7 carry out a lot of those assessments, we need to be
 8 sitting close to that young person and there's an
 9 exchange of material and during a pandemic, of course
 10 there was great concern about materials being passed
 11 between people as well, touching things, being most ---
 12 and services have a limited number of tests because
 13 these tests are expensive so, generally speaking, those
 14 tests go out, they're used in a school, they come back
 15 and they're passed on to the next teacher, so during the
 16 pandemic that wasn't allowed to happen and so there was
 17 periods of time where tests were unavailable as well so
 18 that limited the ability of teachers of visual
 19 impairment to actually carry out a functional visual
 20 assessment. They were not happening in the clinic
 21 setting either and a lot of, you know, more clinical
 22 assessments, which are not the same, I have got to
 23 stress, as a function of vision assessment carried out
 24 by a teacher in a school weren't happening either so we
 25 weren't really getting good clinical information or able

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1 to get that information in a functional sense either .
 2 Q. What was the impact on the learner of not having that
 3 functional assessment?
 4 ELIZABETH McCANN: So if you don't have good data to work
 5 from, then you are not really able to make --- give good
 6 advice to teachers and again you're very much relying on
 7 the learner themselves saying "Well, this is ..." --- if
 8 they've got their text on an iPad or on a computer,
 9 "This is the text that I'm using" or "This is the size
 10 that I'm using" but we don't have --- we don't have good
 11 data so we're therefore unable to make the best advice
 12 and so learning is not optimised for that pupil.
 13 Q. Just one final question for you, Mrs McCann, in
 14 connection with this aspect. You mention that on the
 15 return to school, poor skills both in use of technology
 16 and in braille reading technique had to be unpicked and
 17 retaught.
 18 Why was this, why had pupils picked up these poor
 19 techniques?
 20 ELIZABETH McCANN: So there are a variety of reasons. Again
 21 the challenge of doing braille lessons remotely when
 22 there wasn't someone who knew braille sitting beside
 23 that young person, that was a difficulty and a challenge
 24 and sometimes learners didn't have braille so if they
 25 were using hard braille to read rather than using a

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1 braille device, they maybe perhaps didn't have as much
 2 hard braille as they normally did because the people who
 3 were doing the transcription when lockdown came didn't
 4 take home embossers. Very large pieces of equipment, at
 5 the first lockdown nobody knew how long this was going
 6 to take, thought it might be a week, maybe a fortnight,
 7 so they didn't have that equipment at home and again it
 8 needs a car or someone's strength to carry it. They're
 9 bulky, they're heavy pieces of equipment. And many
 10 embossers also have acoustic hoods. If you do
 11 transcription and you're at home and you have got
 12 family, you do not want to have an embosser running in
 13 your house. It's very, very noisy, and an acoustic hood
 14 is very large as well. So a lot of people didn't have
 15 hard braille and as a result they used the things that
 16 were there in front of them and so that would be a
 17 mobile phone because they had learned that they could
 18 listen and it's often something that's mentioned by
 19 people who don't really understand literacy for children
 20 and young people and indeed adults who are blind that
 21 listening does not replace literacy, because you do not
 22 know how to spell a word, you do not understand about
 23 layout on a page and so on. So listening alone is
 24 second rate, it's not literacy, but many young people
 25 had used listening alone as a way of accessing their

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1 learning in order to keep up with their sighted peers.
 2 It was the quick fix, if you like, when nothing else was
 3 available to them. And then for learners, some learners
 4 who did have their devices had learned to do things, if
 5 they were further down that road of learning to access,
 6 some of them learned by trial and error on what their
 7 devices could do for them but this then had subsequent
 8 issues. So, for example, I heard of one learner who was
 9 using their braille note-taker and was accessing their
 10 work quite well because work was either emailed to them
 11 or --- and they could open the file and access it, email
 12 it back to their teacher and so on, that had become
 13 their normal way of working.
 14 Now, on a note-taker, you would access a Word
 15 document because that's the document or the format
 16 that's most readily accessible, you can have speech, you
 17 can have braille, you can edit it and so on. When that
 18 young person then returned to school and they were still
 19 using that way of working, it had become their normal
 20 way of working. However, unfortunately due to the
 21 security of our exam system, they were not able to
 22 access the exam papers in Word format and so there was a
 23 lot of negotiation had to take place between the teacher
 24 of the local authority and SQA in order to have their
 25 paper in a format that they could access that was still

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1 their normal way of working because what they were doing
 2 was not something that previously had been allowed due
 3 to exam security.
 4 Q. Thank you, and you have answered what would have been my
 5 next question about SQA. And on attainment, Dr Shannan,
 6 you have set out at section 8(h) and I'm not going to go
 7 into this in any detail but just to tell you that the
 8 Inquiry has the BATOD survey that you refer to about the
 9 potentially widening attainment gap due to lack of
 10 specialist support and I understand from that that it
 11 was a lack of specialist support during the pandemic but
 12 I won't ask you further on that because I'm mindful of
 13 my time.
 14 Just before we close, I wanted to ask both of you,
 15 perhaps Dr Shannan first of all, were the impacts you've
 16 described both in the Rule 8 and here for us today, did
 17 you make representations to the Scottish Government to
 18 make them aware of these impacts either at the time or
 19 subsequently?
 20 DR BRIAN SHANNAN: At the time, there was no direct method
 21 that I had to make them aware of these issues for sure
 22 and subsequently obviously we have carried out the
 23 research that's already been submitted which sets out
 24 many of these issues and obviously in the submission
 25 here obviously part of that the Inquiry is to highlight

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1 these so the submissions that we've made today and also
 2 in the Relate addresses those issues.
 3 Q. Yes, thanks very much. And, Mrs McCann, is that a
 4 similar situation for you in the role that you had at
 5 the time of the pandemic?
 6 ELIZABETH McCANN: Yes, although I think it's also fair to
 7 say that Scottish Sensory Centre is funded by a Scottish
 8 Government and we do provide annual reports for them so
 9 they were aware or should have been aware through that
 10 report of the work that Scottish Sensory Centre was
 11 doing in terms of trying our best to support teachers of
 12 visual impairment and indeed teachers of the deaf in
 13 order to deliver as good a service as they possibly
 14 could.
 15 Q. Thank you very much. Just in closing, I wanted to ask
 16 you, you both, whether in addition to what you have said
 17 today and indeed, Dr Shannan, you have set out in the
 18 research paper we referred to recommendations to benefit
 19 deaf learners and mitigate some of the negative impacts
 20 but further to that, are there any other key lessons
 21 that Scottish Sensory Centre thinks should be applied to
 22 ensure these impacts are addressed and mitigated?
 23 DR BRIAN SHANNAN: I think the pandemic amplified issues
 24 that were already there around the inclusion of deaf
 25 children and education. There has been a general move

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1 towards a generic approach to provision, so almost
 2 thinking that rather than having bespoke support, the
 3 move should be towards a kind of generic provision, that
 4 the pandemic highlighted the failings of such an
 5 approach, you know, switching off cameras, the lack of
 6 understanding that deafness is not about an inability to
 7 hear, it's about access to communication, it's about
 8 making sure that school buildings are accessible by
 9 making sure that we have good acoustics, that we have
 10 assistive technology within — integrated into school
 11 buildings so, you know, I think in conception, in design
 12 and implementation, there needs to be a recalibration of
 13 the support that deaf children require, so that whenever
 14 another crisis occurs, there is better understanding of
 15 the needs of deaf children so that when the policymakers
 16 are making difficult decisions, they're being mindful
 17 that, you know, as I said, deaf children cannot get
 18 those years back if it happens in the first four or five
 19 years of life. If you're a parent that's had a newly
 20 identified baby, then the ability to attend groups where
 21 you can meet other parents of deaf children and interact
 22 and allow your children to communicate, we are, you
 23 know, from my — from the clinics that I attended, the
 24 number of children that are coming through with
 25 communication difficulties, you know, communication

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1 difficulties primarily because like I said language is
 2 "caught, not taught", the ability to interact. All of
 3 this, the ability to make sure that there's a way in
 4 managing what was clearly a crisis that we have realised
 5 that we're not creating future crises going forward.
 6 Q. Thank you. And, Mrs McCann, do you have anything to add
 7 to this from the perspective of those for visually
 8 impaired and teachers and learning?
 9 ELIZABETH McCANN: Yes, I think we know that visual
 10 impairment is a low incidence disability, there are —
 11 the numbers are small, but I think again, and it is
 12 similar to what Dr Shannan was saying, because our
 13 numbers are small, we almost completely fell off the
 14 radar and there wasn't enough consideration given. And
 15 a similar point, this move towards, you know, generic
 16 support for learning is not good, the move away from
 17 having managers who are not qualified in visual
 18 impairment. In order for that voice to be amplified,
 19 you know, in higher managerial structures within local
 20 authorities is really important and we're not seeing
 21 that now, that there's not — the teachers of visual
 22 impairment often don't have a manager who's qualified in
 23 any form of sensory impairment and being able to take
 24 that message and having it heard up the tree is really,
 25 really important, and I think as well, it's also

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1 highlighted that need for really specialist pieces of
 2 equipment and sadly what I hear now is that because of
 3 shortage of money that young people are not getting that
 4 equipment. If we were to have a lockdown tomorrow,
 5 would we be in a better place or would we actually be
 6 worse? And I think that is also something that has to
 7 be kept in mind that, you know, access to equipment and
 8 technology for learners with visual impairment is really
 9 so important because with the right access, whether that
 10 be through technology, through support from the right
 11 people with the right qualifications, children who have
 12 got visual impairment can learn and be successful
 13 learners and equally as successfully as their sighted
 14 peers.

15 MS STEWART: Thank you very much and thank you also to,
 16 Dr Shannan.

17 My Lord, I don't have any further questions for the
 18 witness.

19 THE CHAIR: Thank you very much, Ms Stewart. And thank you
 20 very much, Dr Shannan, and Mrs McCann, I'm very grateful
 21 for your evidence. And that brings proceedings for
 22 today to an end. I think we're later tomorrow morning,
 23 aren't we? It's 11 o'clock, or something like that, is
 24 that right?

25 MS STEWART: I think it's 11.15.

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1 THE CHAIR: 11.15, I do beg your pardon. Very good, that's
 2 all, thank you.
 3 (The hearing was adjourned to 11.15 am on Wednesday 13
 4 November 2024)

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