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Scottish Covid-19 Inquiry

Day 59

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(10.00 am)

MR STEPHEN: Good morning, my Lord.

THE CHAIR: Good morning, Mr Stephen.

MR STEPHEN: We have one witness this morning.

THE CHAIR: Good morning. Thank you for coming. When you're ready, Mr Stephen.

MR STEPHEN: I am obliged.

MS KELLY MUNRO (called)

Questions by MR STEPHEN

Q. Could you confirm your full name, please?

A. Kelly Marie Munro.

Q. Thank you, and you have already helpfully provided a written statement to the Inquiry; is that correct?

A. Yes.

Q. Thank you. For the Inquiry's record, the reference number for that witness statement is SCI—WT0221—000001. Just to reiterate at the outset, Ms Munro, that everything you have said in that written statement will be taken into account by the Inquiry, even if we don't touch on every single aspect of it in oral evidence today.

A. Okay.

Q. Just a gentle reminder that the hearing is being transcribed, and there will be stenographers taking

notes, and no doubt his Lordship will be too, so just a reminder to speak at an appropriate pace and I will do the same. Thank you. Now, you're here today to give evidence on behalf of the charity, Carers Trust Scotland; is that right?

A. That's correct.

Q. How would you describe in headline terms the main purpose or aims of Carers Trust Scotland?

A. We are one of the national carer organisations in Scotland. We are an organisation that works with local young carer services. We —— in my role, I work across strategic organisations, so COSLA, Scottish Government, local authorities, local young carers' services; and I get to work with young carers as well, advocating for their rights and listening to challenges that they have.

Q. Thank you, and I was going to come on to, what is your job role, your title within the organisation?

A. My title is education officer primary and secondary, so a lot of my work is raising awareness of young carers throughout education and the challenges that they have.

Q. And how long have you held that role for?

A. Over five years now, 2019 I started, so June 2019, so over five years.

Q. I think the main focus of your written statement, and no doubt evidence today, is unpaid carers and specifically

young carers. How many unpaid carers are there roughly in Scotland?

A. So there's —— the number that we identify would be 66,000, but of that, young carers, there's —— recognised there's at least 30,000 young carers in Scotland.

Q. When we're talking about young carers, what age or ages are we talking about?

A. There's no definition in the legislation that states a young carer is someone under the age of 18. Our services that we work with, our local young carer organisations, tend to support from ages 4 or 5, and up to 18, and then you have like young adult carers which are 18 to 25.

Q. So potentially very young then. I think the legislation you're referring to, you refer to this in your statement at paragraph 69, this is the Carers (Scotland) Act 2016?

A. Yes, that's correct.

Q. Thank you. How would you describe in high level terms the range of responsibilities that young carers have, the things that they are typically asked or undertake?

A. It can range anywhere from helping with housework, looking after brothers and sisters, providing communication, right up to personal care. They can help with —— helping a member of family or the person they care for get dressed. They can deal with budgeting for

the household, they can deal with shopping for the household, collecting and providing medication. They can accompany the cared—for person to appointments. It ranges from everything they can do an hour or two caring a week, right up to 90 hours or more a week.

Q. I was going to ask, I mean, is that typically then quite a large part of their time spent on that role?

A. Yes, it will vary. Every young carer is different, but it will vary. A lot of young carers, it will impact their day—to—day life, so everything from education to their own health and wellbeing, to even spending time with friends or engaging in hobbies and other extracurricular activities.

Q. You touched on it there, but is there a reality or expectation on young carers, then, that they have to balance or juggle those responsibilities perhaps with other things like education or employment perhaps?

A. Definitely. Young carers that we have worked with in young carer services will report that actually they often find tasks difficult, so perhaps in school, they may find homework difficult if they're carrying out caring responsibilities when they get home. They often report that they can't take part in extracurricular activities, so hobbies after school, football clubs, perhaps a drama club, because they need to get home due

to caring responsibilities . Perhaps the same at weekends.

They also sometimes take time off school if they need to accompany a cared—for person to a medical appointment, or if somebody is coming into the house and they need to translate, or perhaps they just need to support that person.

Q. To be clear, are you saying that will be the case even without the pandemic, and the pandemic is obviously something the Inquiry is interested in ——

A. Yes.

Q. —— and we will come on to in a moment. That's the reality for them even outwith that?

A. Yes.

Q. Thank you. Against that background, I want to turn and discuss with you the pandemic.

A. Okay.

Q. I thought to start firstly with the closure of schools, if I may, and lockdown. At paragraph 12 of your statement, you say that even in relevance advance of lockdown in March 2020, that your organisation was learning that a lot of young carers were already starting to get worried about going into school. What was the cause or causes of their anxiety at that stage?

A. So I think that the media had obviously been reporting,

I think we had all seen that, but what we were hearing from young carer services and other young carers is they care for someone who would be potentially shielding, so they may have a terminal illness, they may be immuno—compromised, and they were worried about being in school and getting the virus and taking it home to that person; because with that they were saying there may be guilt, that they were passing that onus on, so they were really concerned about going into school, because there was large numbers of people congregating, and they didn't want to pass that back home to person they cared for, or other people in the house, but particularly the person they cared for, in any case they would be —— I think it was going to be admitted to hospital, or if they had —— there was real fear around getting the virus, and they didn't know outcomes of the virus at that point.

Q. Thank you. At paragraph 13 of your statement, you say that your organisation had not yet conducted any studies, so how were you being made aware of these concerns at that time?

A. So we work with local young carer organisations in every local authority in Scotland, and we were reaching out to them just to say: do you need any support, we understand it's uncertain times. Our young carers were reporting

anything —— they need additional support, and this is what the workers on the ground that were interacting with young carers daily, this is information that they were being given and reported back to us.

Q. Thank you. At paragraph 14 of your statement, you say that anecdotally, you became aware that young carers stopped attending school, university and respite services, and again, this is in advance of lockdown itself . Again, what were you being told or were you hearing was the reason for that, that they were stopping going altogether?

A. The fear of getting the virus. They had heard at that point that perhaps somebody they knew or someone they knew had contracted the virus, and the fear was real, so they were withdrawn from school, didn't want to go in again. This was information coming through from our young carer services. They were also stopping going to their young carer services that often offered respite groups. They had withdrawn from those groups as well, from real fear of contracting the virus and taking it home.

Q. When you say in advance of lockdown, do you know, again, it might be roughly, how far in advance we are talking about, weeks, months ——

A. I think it was weeks. I don't think it was months.

I think it was probably about three or four weeks before lockdown.

Q. Okay, and that was having a chilling effect, perhaps, on their attendance in an education setting?

A. Yes.

Q. Thank you. Now, if we turn then to when schools did indeed close, at paragraph 16 of your statement, you say that young carers really struggled with the closure of schools, and in that context, you cite one of the surveys that was carried out by Carers Trust Scotland in June 2020, I think published then in July 2020. For the Inquiry record, the reference for that is SCI—CTSxxx—000003. I won't take you in detail to that document itself, but I do want to ask you a few questions about it. This is the "2020 Vision: Hear Me, See Me, Support Me And Don't Forget Me". That's the document that I'm referring to. First things first, was the aim of that survey then to understand the experience of young carers during the pandemic?

A. Yes. We wanted to hear from young carers and what challenges they were facing if any. We wanted to hear about their lived experience during the pandemic, and also to find out what more they needed support with, if there was gaps in areas that we weren't providing.

Q. Do you know what the survey sample was that was taken at

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

not have been at an age where —— or been able to get a lift, because it would have been someone outwith the family, or they had to walk a few miles. It wouldn't be their local supermarket that the voucher was provided for. It might be one, two or three miles across town where they would have to walk to and then walk back.

Q. Thank you. I want to move on then. With the closure of schools, delivery of education then moves online. At paragraph 18 of your statement, you say that a lot of young carers reported struggling with online learning. We'll come on to digital inclusion more broadly in a moment, but I wanted to start by asking, in your experience, was the home environment for young carers, many young carers, was that suitable for online learning?

A. The feedback that we received from young carers and young carers' organisations was that it was difficult for them to engage in online learning. We held a focus group with young carers, and during that time, a few of the young carers disclosed that if they had a sibling that had a learning disability, was neurodivergent, even a physical disability, was keen to be in the same room, be on the Google Classroom with them, there was constant interruptions for them, and they wouldn't have had this interruption had they been in a physical classroom in

the school. So they found it really difficult to engage in online learning. Sometimes they just wouldn't go to the class if they thought it was going to be too chaotic, or they would have too many interruptions, because they couldn't focus on their learning.

Q. And is that a lesson learned, do you think?

A. Yes, I definitely would say it was a lesson learned particularly for young carers, I think, that they had no other choice. I don't think they were able to take a laptop and go to a different room. I think that scenario would still work out the same, I think, but if they had access to school hubs, then it would make life easier for them, not to say that every young carer would have went to a hub, but the opportunity would have been there for them to get a break and been able to engage in online learning.

Q. We'll come back to hub schools, but moving more to digital inclusion more generally, at paragraph 30 of your statement you say that numerous young carers and young adult carers were isolated, due to being digitally excluded.

Now, I understand at paragraph 27, that was an issue that was highlighted to the Scottish ministers in a letter of 11 June 2020. For the Inquiry's record that document is SCI—CTSxxx—000005. For completeness, at

paragraph 28, you say that your organisation received a response to that letter in July of 2020, and again for the Inquiry record, that reference is SCI—CTSxxx—000007. I don't want to go into the detail of that exchange because the Inquiry will move on to implementation and decision—making phases in due course. But what I do want to ask you is are there any particular examples of digital inclusion or exclusion that you would like to highlight to the Inquiry. I think you cover a couple of these in your statement, but it would be helpful to hear those?

A. We heard from some young carers. One young carer had to use her mother's mobile phone to access education, online classrooms, because they had no other device in the house. They also didn't have wi—fi, so they were using mobile data, and she found this really difficult because some —— certain apps weren't supported on it, so the young person couldn't use that —— within there —— there was another young person who was missing some online classrooms because the family only had one device. His mother was a full—time university student, and they were also trying to use that device for the cared—for person's hospital appointments. Despite asking the school for further —— and the local young carers' organisation also asked for help with devices,

the school had said that these devices had been passed to other vulnerable children, and unfortunately there was nothing else available for them. They repeatedly asked for printed copies of schoolwork, and this was never delivered.

Q. And to sum up then, what was the consequence for them being able to undertake their education at that time?

A. They were digitally excluded. They weren't able to access online education, or if they were, it was very limited, being able to access, so therefore they didn't have the same —— the same access as their peers that would have laptops or mobile phones, or —— so it had an impact on their education. They felt that they didn't get exam results that they wanted or access to study that they needed, so they felt that that had a big impact on their education and further education.

Q. And just to be clear, these examples that you have given, these were highlighted to the Scottish Government; is that right?

A. Yes, in the letters we sent to them.

Q. Thank you. In your experience then, was there a consistent approach by local authorities to digital inclusion for young carers in Scotland?

A. No. Every local authority was different, and every young carer had a different experience. One of the ones

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

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

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

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

authorities?

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

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

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

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

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

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

A. I would say definitely in the future that infrastructure

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

around ventilation.

Q. Did all young carers return to school?

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

Q. I think at paragraph 66 of your statement, you say that:

"Some of our young people lost their way in education and did not return..."

A. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

Then at paragraph 24, you also talk about how young

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

umbrella, but the young carer workers reported getting some, like, very detailed information for them because it was maybe the only person they had seen all week, and they were being really honest about their caring role. So the young carer worker would often just take notes on their phone, because it was quite hard, when they were walking round the park, to try and get notes, and they noticed a massive change in this from only being able to talk for one to two minutes online or on the phone, to actually -- these young carers being able to express themselves and any challenges they were facing.

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

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

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

of that survey?

A. So some of the key findings were that young carers were reporting that their mental health was worse than before the pandemic. One in four young carers were unable to take any break from their caring role. I think it's 74% young carers felt less connected to others since the pandemic, and 69% of young carers reported that they felt more stressed. One quote from a young carer says:

"It's hard to care for someone when I can't care for myself."

That's within the survey.

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

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

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

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

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

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

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

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

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

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

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

communication difficulties.
Q. Thank you. At paragraph 11, specifically you refer to the fact that:
"If a child has a communication difficulty, then that is likely to affect their ability to learn and access the curriculum, their ability to interact with peers; and to manage and navigate the playground. The impact is wide reaching, and it is important to prevent harm."
Would you care to elaborate a little bit on that, please?
A. Yes, I think it's important to know how important spoken language is for learning within that context, so it's the foundation on which learning is built. Much of teaching and learning is predicated on language of some degree, whether that's spoken or written language, and therefore children who struggle to communicate in any forms I have described will find navigating the school and the curriculum very challenging. Communication is a dynamic skill. It's one of the most complex skills that humans learn, and therefore being able to make friends and navigate friendships, navigate the challenges of the playground and understanding what's said and what's not said can be quite difficult for children with communication needs.

Q. Thank you. You've already touched on it in your explanation about the consequences of it, but mental health in paragraph 18, you say:
"... is closely linked with communication skills ... also a connection between spoken language abilities and behaviour. All behaviour is a form of communication, and we know when children have communication difficulties, they can become distressed and will find different ways to convey that their needs aren't being met."
You say that this is manifest:
"... in low mood, disengagement with learning, or in more disruptive behaviours."
We'll come on to discuss some of the studies that were undertaken during and just after the pandemic, but is there anything more that you would like to elaborate on on this link between communication skills and mental health?
A. I think the nature of communication difficulties is lots of children can go under the radar, particularly if they're not making -- acting out in school or at home, and their mood is quite low, and they just get by and go under the radar. I think the challenge of behaviour is that it can mask a lot of difficulties, so if a child has particularly challenging behaviours, then that's

what the focus is on, rather than the cause of behaviour, rather than how they're feeling about the lack of contact and connection within the home or school environment.
Q. Thank you. I would then like to move on to ask you about the role of speech and language therapy and educational contexts pre-pandemic. If I could ask you first to please explain some of the different types of speech and language communication difficulties that speech and language therapists work with, with children in particular?
A. Yes, so in terms of education settings, whether that's nursery or school, there's very wide range of difficulties that can present. So with the... I mentioned speech sound difficulties, some children can be quite unintelligible, and find it difficult to get their point across, which can lead to high levels of frustration and anger. Interestingly, with the speech sounds, that's very closely linked with the ability to read and write, because it's about phonemes and sounds, and so their ability to distinguish between sounds, to process what's being said, and anything that happens within spoken language is translated into written language.
There are children with issues such as developmental

language disorder. I think people understand dyslexia far better than developmental language disorder. Dyslexia is obviously a specific difficulty in reading and writing, whereas developmental language disorder is a specific difficulty in the ability to express and understand spoken language, but it also has an impact on written language. These children, some of them are very good non-verbally, they're good socially, and they're good at copying their peers.
So sometimes right up to P3, their difficulties aren't apparent because they get by by navigating the environment, being hypervigilant about what's going on and anticipating what they should do. However, when the attainment levels increase and the demands on them increase, then that's when it starts to become much more difficult for them.
So the speech and language therapist will seek to observe children in the context of education, identify what strategy they're using, what strategies would be helpful to navigate the educational context, and also to assess their communication and understand what -- the range of vocabulary that they have, their ability to understand what's being said, can they follow complex instructions or not, and do they understand the nuance of social communication.

Q. You talk about the types of speech and language difficulties and communication difficulties you work with in paragraph 25, and specifically, you talk about you're assisting children with delayed spoken language skills who present as much younger than they are when they come to school or nursery. You say that there are quite a lot of environmental factors that play a part in that. Would you care to elaborate on that, please?
A. Yes, so our members and educators are saying there's a large number of children coming to school with inadequate spoken language skills for learning. That can be presented in lots of different ways, but the reasons for that are complex. I suppose it's important to understand the different types of needs that they can present with. They can present with specific difficulties or difficulties that you might expect a younger child to present with.

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

words or enough high quality words.
Q. Thank you, and you also say that you assist children with specific speech and language difficulties where there is a genetic element, and they are born with those needs. What type of needs –– could you give us some examples of what those look like?
A. Yes, so there are children who are born with risk factors, whether that's genetic, biomedical, neurodevelopmental. Those children –– sometimes described as disordered, so atypical communication needs, whether that is children on the autism spectrum, attention deficit disorder, speech and language –– sorry, speech disorders, language disorders, voice challenges, disfluency, a huge range of needs.
Q. You also say that you work with children who have very high complex need levels –– high level needs where you might have to use augmented and alternative communication. Could you please elaborate a bit on that as well?
A. Yes, that's right. There's children who have complex needs, whether that's physical and learning disabilities who are perhaps nonverbal, or who have very limited verbal communication. Speech and language therapists will seek to facilitate their communication to a range of means; that could be low–tech aids which could be

pictures, it could be high–tech aids where children utilise eye–gaze devices, where they can look towards a particular picture and the device will say the word, and high–tech aids where there can be lots of complex programmes on ipads, where children can access through switches or accessing with their finger to touch a range of pictures to get –– communicate their point and their needs and their wants.
Q. Thank you. Just continuing in relation to the role of speech and language in educational contexts pre–pandemic, you note at paragraph 7 of your witness statement that speech and language therapists are primarily employed by the NHS, but that most local authorities –– sorry, I'll wait until we get there. You say that they are primarily employed by the NHS, but that most local authorities have a service level agreement to provide SALT services within educational contexts.

Could you please just describe how speech and language therapy services are traditionally provided outwith educational settings?
A. The traditional model of speech and language therapists would be within community clinic settings, where the families attend the clinic in a central position, and it would be one–to–one therapy where the therapist works

alongside the parent or a therapy partner with that child to identify and support and provide therapy for their particular needs.
Q. Could you please then explain how and to what extent speech and language therapy services were integrated into educational settings in Scotland prior to the pandemic?
A. This was variable across Scotland and does depend on the level of funding that the local authorities provide, so it's quite patchy. I would say that the majority of local authorities in Scotland do have a service level agreement with the NHS to provide those services, to provide speech and language therapy in mainstream schools or in more complex special schools. Funding for speech and language therapy is reducing from local authorities and from health boards, actually, which is impacting their ability to provide some of these services in an educational context, and has been reducing for a number of years. So that will affect how consistent or how much speech and language therapy can provide in that context. Sometimes if the threshold resource is not sufficient, then they have to centralise and provide speech and language therapy within a community clinic for instance.
Q. Please could you explain what speech and language

therapists do in educational settings, and the different levels of speech and language therapy support that is provided within those settings, and specifically prior to the pandemic, and I think you refer to universal, targeted and individualised therapy. If you could please explain a bit about each of those?

A. So we described the traditional form of speech and language therapy. Evidence and practice has moved on from then to show the importance of providing support and approaches for children in the context in which they function, whether that is in the home or nursery or school. That is to acknowledge how key communication is for learning and wellbeing, which -- the key outcome for education, but also to acknowledge that the biggest impact sometimes happens within the education context, so by that, I mean the dynamic and varied environment which children function in, we have to ensure our approaches and our aims are relevant for that child, and that we are working on what's most important for them. What are the barriers to them learning, what are the barriers to them interacting and then participating in an education context.

The model which we have described as -- what we should expect is high quality provisions at universal, targeted and individualised. The traditional model is

that whenever there was a concern, it would go straight to the individualised, but what we know from research is how important it is to have the whole environment supported around the child.

So universal offers, we know, for instance, if you improve children's vocabulary, you improve their attainment, whether they have communication needs or not. In the context of an early years setting, you would hope that adults are interacting with children in a way that will promote their language development, and not get in the way of that.

So that could be universal offer where speech and language therapists can work with early years practitioners to support and promote behaviour change and how they're interacting, and that could be about getting down to the child's level, commenting on what the child is doing, repeating back what the child is saying and adding language to it and avoiding lots of questions.

Q. Could I ask you just to pause there, so practically what is the role of the speech and language therapist, compared to the early learning and childcare practitioner, for example? How do they interact to deliver this universal support?

A. So in that context, the speech and language therapist is

a facilitator, where they're functioning within the environment. We know how important it is for them to develop relationships and trust to make it feel safe for those practitioners to change their practice, so they will there -- in a coaching and modeling role. We sometimes use video feedback. We video the interactions of the practitioner with the child, and then we spend time dissecting that and discussing ways in which to facilitate communication. So in that context, a speech and language therapist is there to facilitate and promote and develop the skills of the practitioner.

Q. Then if you could move on to explain a bit more about targeted, what sort of children would require targeted interventions, and what do those look like in practice?

A. So what we would hope is we can meet the needs of quite a lot of children at the universal level. If that's not adequate, then it would move up to targeted level, and that's about giving a bit more concentrated support for a group of kids, perhaps, who require a bit more additional input. Sometimes that can be working with a practitioner to give advice about how to promote the needs of these children.

Practically speaking, that could be facilitating group interventions around developing vocabulary, having fun with words, improving their ability to tell stories.

The therapist, again, it's always about building the skill of the people who are there all the time with the child, rather than a therapist who could be coming in once a week or once every three weeks, and if that's not adequate at a targeted level --

Q. Before you move on to the individualised, could you please just describe some of the communication, speech and language issues that would require targeted intervention?

A. So the type of difficulties you may come across are children who have got a very limited vocabulary. They have got -- they use perhaps very general words rather than specific words to get their point across. The use of verbs is very important. That's the core of a sentence. So if they're using very general purpose word verbs like "doing", it makes it very difficult for them to get their point across. So it's about expanding their vocabulary of nouns, but also verbs, and being able to help them structure a story in such a way that they can communicate it in a well and complex way, which will then support their reading and writing in later years.

Q. That targeted -- that type of targeted support, would that be for a group of children?

A. Typically, it's a group of children who require more

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

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

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

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

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

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

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

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

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

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

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

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

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

consistency pre—pandemic?

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

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

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

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

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

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

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

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

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

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

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

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

You say:

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

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

You go on:

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

children have to play catch up."

Was that pre-pandemic?

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

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

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

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

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

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

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

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

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

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

communication needs are critical.

So if you don't get that development and improvement, then they will find it very difficult to interact with others, to engage in nursery or school, and be able to —— ultimately, I think there's sometimes a thinking that if we close the gap at a certain point, that gap will stay closed. However, the research does demonstrate that you need to keep engaging with those children to maintain improved communication throughout their school career in order to achieve positive outcomes.

Q. So you have identified the importance of health workers —— health visitors, but what if any role are you learning that childcare practitioners and teachers play in identifying and referring issues in relation to older children?

A. Yes, I think we get a lot of requests for assistance, and they see these children very often, and will refer them to speech and language therapy. They get to see them in context, they get to see how they're functioning with their peers, and whether they're able to interact with adults otherwise, and they are therefore also very important in identifying need early.

Q. Thank you. Mr Carter, I would like to move on now to discuss the impact of pandemic restriction measures,

including the closure of early learning and childcare settings and schools on the provision of SALT services. We've just touched on health visitors, but could you please, if you can, give an indication of to what extent disruptions to health visitor assessments and newborn hearing screening impacted on early identification of speech and language difficulties during the pandemic?

A. We know the health visitors struggled to access families during the pandemic. They will have had fewer appointments. They had to move to remote offers, telehealth offers, which led to fewer appointments and incomplete data. Therefore, as the first port of call, the fact that they didn't have access to families meant that we weren't identifying children early, and there was a significant dip in requests for assistance at one point during the pandemic because of that.

Q. In relation to health visitors, you note in paragraph 22 of your statement that they noted a significant spike in around 27 to 30—month mark that was concerning and that this was also observed in Public Health Scotland data. Could you please explain in a bit more detail what was observed and why it's concerning?

A. Public Health Scotland produced a few excellent reports on this. They monitor health visitor data. Health visitors engage with children across their development,

including 13 to 15 months and 27 to 30 months. They noticed a significant peak in concerns about communication. Now, health visitors monitor many areas of child development. It's important to know that pre—pandemic, communications was the highest area of concern anyway, sitting about 10% of that 27 to 30 month. From January 2021, Public Health Scotland noticed a significant increase compared to pre—pandemic levels. This peaked in August 2021 and actually has remained above pre—pandemic levels until now.

This is particularly concerning because the area —— the time that these children are being assessed, this is a critical time for children's language development, and so Public Health Scotland noticed it, and were flagging it up as a concern, and health visitors were saying they were seeing far more of these children. The area where —— the most concern was communication.

Interestingly, you can differentiate between children in the highest areas of deprivation versus the most affluent areas. For those in the highest areas of deprivation it was sitting about 20% plus along that timeline, and for more affluent areas it was sitting about 7 or 8 or 9%. So there's a significant different between the two.

Q. And again, what were some of the reasons for the spike

and that differential again?

A. So the reasons are complex. I suppose if we go back to the different types of children that we have, we've got the children who were born with risk factors, with communication needs; we've got the other children who have socioeconomic disadvantage. The first children with specific communication difficulties what we've noticed is that having come to services, speech and language therapists and educators, they're noting far more complexity of need, and they are noting that these children have experienced more harm, struggling with their mental health, struggling to engage with education, and that will have been because of the lack of access to the services.

The other children with socioeconomic disadvantage, the research seems to be showing that the reasons for that peak was because of seeing fewer —— their world has become much smaller, they were seeing fewer of their family members and friends, and therefore interacting far less. They also weren't experiencing the world. Learning language is a dynamic process where you need to experience different parts of the world. Going out to see stuff, seeing animals etc helps develop vocabulary and also lack of access to education. I think the very significant point here is that stress has had a

significant impact and points to why we saw the spike.

For families during the pandemic they were experiencing much higher levels of stress, they were struggling with home schooling, home working. They found it stressful to manage all the demands, particularly around economic demands. We know that more people went into poverty, and when you consider even at a baby level, what you're hoping to see is a mother or father being responsive to the babies. The baby makes a noise, babbles, smiles, and it's called serve and return, where you try and have good quality interactions.

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

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

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

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

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

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

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

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

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

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

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

therapy, and challenges experienced by families, although some of the challenges and issues you have already described in relation to ——

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

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

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

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

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

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

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

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

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

access to IT equipment. Now, some areas in Scotland for speech and language therapy services, they didn't have access for a very, very long time, which obviously impacted their ability to provide telehealth, which basically is the family on one side, you on the other side, and you can do a bit of assessment with the child if they're of an age. You can observe the child, you can promote, you can coach and model —— well, you can coach the parent.

So the therapists were —— very quickly adapted to that, provided lots of high quality —— as high quality as they could approaches and interventions remotely, if they had the IT equipment. The challenge would be on the other side as well, whether the families had access to wi—fi or the adequate IT equipment to facilitate that, and that wasn't always the case.

So telehealth was an offer which we rapidly moved on. We also relied on phoning all staff —— all the people on the case loads to talk to the parents and give advice and strategies and reassurance, but also we had —— typically a lot of the services had good social media presence, and the demand for that increased significantly during the pandemic with the parents keen to access high quality advice and strategies for their child, to be signposted to good resources online, and

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

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

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

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

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

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

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

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

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

When the parent is anxious and has poor mental

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

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

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

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

Again, all tied presumably to the loss of speech and

language therapy?

A. That's right.

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

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

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

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

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

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

lockdown on children and young people with communication needs. So was this asking similar questions but of your membership of the practitioners?
A. That's right.
Q. You say:
"The respondents to this survey noted deteriorating mental health and an increase in challenging behaviours."
So again, similar to what were being reported by the parents and children and young people themselves?
A. That's right, yes.
Q. You also mention:
"The respondents also raised concerns about barriers to accessing services; about the deterioration of communication skills and swallowing needs; and an increase in safeguarding concerns."
What were those specific concerns in relation to safeguarding, if you can remember?
A. Yes, I think this -- I am assuming this relates to isolation of families, where there's safeguarding concerns. It's a general reflection on the concern of what would be happening with children who were not able to get access to public services or schools or education, but I don't know specifically about the detail of that.

Q. If we could then move on to discuss the issues around schools reopening and operating with restrictions. When education settings reopened with restrictions, what access did speech and language therapists have to children, and -- probably thinking more about the ones where the services were embedded in schools and then separately ones where they weren't.
A. So again this was variable across Scotland. Different local authorities interpreted the guidance differently and interestingly it would seem that those services who were more embedded pre-pandemic and had a close relationship and were viewed as a core member of the team got access to education far quicker than those who were seen as an external agency who were kept away from education settings. So for services where there's established relationships they got on very, very fast, or reasonably fast, and then for those who weren't or didn't have as close a relationship, then it could be many, many months before they got anywhere near an educational placement and that was a concern for us.
Q. And just in terms of the concern, was that in relation to impacts of children not being able to access those services?
A. Yes, that was in relation to knowing how important partnership working is in a multidisciplinary approach

to meet the needs of children and to ensure that children are accessing the highest quality services and overcoming barriers and so it's about the connection and how important communication is for children to access educational establishments and deliver on the outcomes that you would hope them to achieve in the education setting.
Q. In terms of some of the practical challenges, you discuss at paragraph 42 challenges that the use of personal protective equipment had for speech and language therapists and their ability to do their job and you also outlined some of the difficulties or tensions that arose in relation to guidance and different guidance for health practitioners and educators, if you could please just elaborate a little bit more on some of those concerns and challenges?
A. Yes, obviously there was different guidance for health professionals versus education and so what our members found was that as a health professional you had to follow guidance which is far stricter, which you might expect, but that given that they were working in an education context, that meant that they were going in with full uniform, sometimes full PPE, apron, mask, gloves, compared with their education colleagues who may be wearing a mask, for instance. So this actually

caused some tension and anxiety on both sides where educators were wondering why the health staff were wearing so much PPE and they weren't and also from the health staff feeling, this felt like a barrier to the job they were trying to do. In part it was reassuring to educators that our members were supporting education, to explain that we were being careful, we weren't visiting too many places or one if at all before coming to their educational placement but the fact that there was different guidance and speech and language therapy in this position where they straddle health and education, it became a barrier and got in the way of our partnership working when we did manage to get back into education.
Q. And were there any discussions around that at the time?
A. Locally there was, as far as I can tell, and having engaged with lots of speech and language therapy leads, they had local negotiations. Some of the local authorities took a harder stance and others negotiated, so it was about trying to come up with a pragmatic solution. But also you're trying to manage the anxiety of staff on both sides so that was a tricky situation to be in but, yes, I would say there was quite a lot of local negotiations on that.
Q. Thank you. I think if we could then turn to look at

some of the ongoing impacts and you mentioned specifically at paragraphs 43 to 47 increased waiting times for speech and language therapy post pandemic. Could you please explain a little bit more about that and in particular what the current waiting times are for speech and language therapy for children in Scotland?

A. We started to hear anecdotally that the waiting times for speech and language therapists were very high and so therefore in May 2023 we sent a comprehensive freedom of information request to all services in Scotland. At that point the information came back demonstrating that there were 6,503 children waiting for speech and language therapy. The average wait at that point —— the average longest wait for the initial contact with a therapist if they needed it was one year, one month; the average longest wait at that point if they needed therapy was one year, five months. Now, that —— we also asked for data across the last five years which allowed us to demonstrate the increased wait during that period so we were able to show that the wait over the last five years for initial contact for speech and language therapy had deteriorated significantly and had decreased by eight months in those last five years. For wait for therapy it increased significantly and the average longest wait had increased by ten months over those last

five years. So the wait was very significant and we refreshed some of that, that data in May 2024. There are more children waiting for speech and language therapy now, 6,727, and —— the waits are variable though so in some areas they could wait for 12 weeks, in some areas it's more than 3 years, but for the data we have most recently, the longest wait was over six months for 50% of the health boards in Scotland. And the reason that is very significant, which I alluded to earlier, is that for children's development that level of wait it's like a lifetime because they're doing so much development during that period compared with an adult waiting for something similar so that is a particular concern because they're not getting the support they need and they're developing or should be developing rapidly during that period.

Q. Thank you. And just you've touched on it, or some of the reasons, but what is contributed to this increase in waiting time?

A. I think what's contributed to the wait is that services were paused, for some services that was a significant wait, speech and language therapists were deployed, it was harder to get to children face—to—face so actually progress for children and therefore throughput, if you like, was delayed and restricted. In addition to that,

we have got recent freedom of information requests to show —— to give us insight into the capacity in the system for Scotland to deal with this number of children, so we know that the increase in speech and language therapist headcount in the last five years has increased by 2% in Scotland, but compared with the rest of the UK, the rest of the UK have increased the headcount of speech and language therapists on average by 15%, so the capacity in Scotland is a concern and shows, we're able to highlight, that also will be affecting how quickly we can get to children and meet their needs.

Q. And again you've touched on this already but given what you have already told us about the impact of the pandemic on restrictions on children's communication and language skills that have already been observed and how important early intervention is, how concerning are these waiting times for the profession in terms of outcomes for the children and more generally?

A. I think our members speech and language therapists know this better than most, they don't want children to have to wait a long time because they know how urgent it is to see some of these children and trying to express to those people in the system why this wait is far too long and they are trying to do that, as are we. I think it's

been described as a Public Health crisis. I think, as I have expressed before, there was a concern pre—pandemic, the pandemic has worsened this and we're concerned that we don't have the resources in Scotland. We do need to do the transformation in Scotland to support new ways of working but you need a threshold resource to deliver that. And these are real children we are talking about, real children who are experiencing harm, and therefore there is an urgency about supporting the children who have experienced this and supporting the improved needs but also other children who are coming through so the outcomes are clear, research is demonstrating how important it is and we need to take it seriously and address it as soon as possible.

Q. Thank you, Mr Carter, I'm going to come on just finally to some of the lessons to be learned but one moment, please. Mr Carter, then finally you have from paragraphs 51 onwards to the end of your statement, you identify some potential lessons to be learned. If I could just ask you to go through those and just elaborate where appropriate on any particular ones that you would like to draw to the Inquiry's attention.

A. There's the general one about the eating and drinking and swallowing about protective equipment for members. I think for a while for a period during the pandemic we

were making the case that coughing is an aerosol—generating procedure and therefore our members needed to be protected against that because when they're dealing with people with eating and drinking needs, they're getting very close. When you choke or cough, if you have a problem with your swallowing, you're more likely to cough and we were seeking the highest level of protection FP3 masks, so that's a key lesson, I would say.

Q. Just pausing on that, you spoke about difficulties of wearing PPE when trying to do the job of providing therapy. Were these special masks the transparent masks, face coverings?

A. Well, for speech and language therapists working with children or adults with dysphagia, ie the eating and drinking difficulties, the transparent mask was less important because they just needed to be able to get close to them to be able to touch their neck, to feel the swallow and to assess that adequately. For children with communication needs and indeed particularly speech sound difficulties, transparent masks are critical so the child can actually see what you're doing with your lips, your tongue, and so therapists did get access to transparent masks, it was quite a long way into the pandemic before we got that but that is a key —— a key

learning for if this was to happen again.

Q. And then I think the next one you have relates to the redeployment issue. You say that.

"... after that initial lockdown period, it would have been useful to have had a period of reflection. The best use of the workforce should have been reconsidered and staff should have been returned to services where their skills should have been of most value."

Do you care to elaborate on that? I assume that relates to the redeployment issue?

A. Yes, I think that once the pandemic was understood and it became obvious what was happening, we would want to avoid deprioritisation of children's services to ensure the harm didn't occur and so our strong recommendation is that children's services are protected and that speech and language therapists stay in their core role to be able to meet the needs of these children.

Q. And then you have got at paragraph 54, you again refer to maintaining children's services and more importantly, maintaining a level of integrated teams around children.

Do you care to elaborate on that potential lesson?

A. I think the interesting thing about the pandemic is it shone a light on how important it is to be fully integrated, to be close to each other, and so a rigid

view as a health—only service got in the way of that in terms of guidance and our ability to engage in an integrated manner and services who recovered more quickly and who saw improved access were those who are more integrated prior to the pandemic so this is a key lesson about the importance of speech and language therapists being embedded within educational placements.

Q. And then at 55, I'm not sure how related this is to the previous one, but you talk about therapy services that remained most effective had adopted a preventative approach pre—pandemic. Could you please elaborate a little bit on that?

A. Yes, so services who had delivered transformation pre—pandemic and who were working that whole system approach which I described around universal targeted and individualised observed that even when they weren't able to get into an educational context that some of that work could continue even if they weren't there and that was the whole point of being able to prevent harm and continue work and support and provide a sustainable approach to some of these needs so that was the point that we were trying to make there.

Q. And was that work ongoing being delivered by educators, by teachers and ...

A. That's right, educators, early years practitioners, and

because they had the skills and the approaches and the knowledge of particular interventions, then that would have continued even as a whole class offer or a small group or even individual.

Q. You've made the point very clearly in your evidence about how critical children's spoken language skills are in respect of their outcomes. Is there anything you would want to add to that lesson that you have got in paragraph 56?

A. I think it's been the awareness in the general public and in the system of how important communication is, is relatively low. The pandemic clearly showed the exacerbated need. It highlighted how urgent it is to address children's spoken language and that this is a public health crisis and we need adequate levels of speech and language therapy to serve these children in an integrated manner and I would hope the lessons learned are how critical communication is for children's learning and how it can be promoted and also what gets in the way of it.

Q. Thank you, and then just finally, you say it's important:

"We need to learn the lessons and develop a nationwide approach to meet the needs of children with communication needs."

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

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

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

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

Scottish Sensory Centre, and again, I had a dual role there, so very similar to Dr Shannan, I was organising courses for teachers of visual impairment, so professional learning, and not just for teachers but also for a range of other professionals as well and third sector.

I also teach on the postgraduate diploma in visual impairment. This is a mandatory qualification for teachers to gain the qualification to become qualified teachers of visual impairment.

Q. Thank you, and that was something I wanted to come on to ask you about, was the qualifications for teachers of the visually impaired; what additional skills and qualifications do they have? Do they do the postgraduate diploma in education in the usual way and then additional training?

ELIZABETH McCANN: Yes. So they do their teacher training as per normal. They would go and work in a mainstream school, and then they would generally be appointed in the role of teacher of visual impairment, and they would come to Edinburgh University. We are the only provider of the qualification in Scotland, and they come on on blocks and undertake the postgraduate diploma which is at Masters level 11. It generally takes around two—and—a—half to three years to complete.

Q. Thank you, and do these teachers, specialist teachers tend to be employed by a local authority or a charity or ...

ELIZABETH McCANN: They are —— in the main they are employed by a local authority, the only exception being if the teacher was working in a grant—aided school, but that's the only real exception. I should also add, just for context as well, that while I mostly teach teachers who are gaining the qualification, I also have some students who are there on a full—time basis who may undertake a course in visual impairment as part of the MSc on inclusive education.

Q. Following qualification, are these teachers based typically within a single school, or are they peripatetic?

ELIZABETH McCANN: So it can vary. They will either be in a service, so they would be peripatetic in nature, covering really from birth up until the age of 18, and working —— going into schools, visiting these learners in school and at home, and again across all types of schools and early years provision, or they may be based in one school if they are employed by a grant—aided school.

Q. Thank you. In relation to the qualifications for the teachers of the deaf, Dr Shannan, can you explain a

little bit to us about their additional qualifications and skills?

DR BRIAN SHANNAN: So in many ways it follows a similar format to the one that's just been described. The primary difference is that the teachers also require to have a specific training level in British Sign Language, but it's exactly the same. They're employed by the local authority. The course is delivered at the university. I just should have added one additional point to my role during the pandemic that just came to mind, I was also working, as well as managing the service in Fife, I ran weekly clinics at the audiology department with my colleagues from NHS Fife. So we ran joint audiology education clinics throughout the pandemic.

Q. Thank you, that's helpful. That's something I will come on to, to speak about the link between education and health in a short while. Dr Shannan, can you explain for us just in high level terms a bit about the Scottish Sensory Centre's work, its aims and objectives?

DR BRIAN SHANNAN: Sure. So the Scottish Sensory Centre is there to try to promote and provide skills and training for —— for professionals working within the field, specifically deaf education, and visual impairment. The —— as I said, it will engage with different

government organisations and bodies such as third sector organisations to try to work and promote work that will enhance the profession as well as providing training, specific courses for professionals.

Q. Thank you. We're interested to learn from you today about the impacts on —— on learners who are blind and deaf as they go through their various stages of education, principally in early years and school education. Staying with you, just now, Dr Shannan, in terms of how those identified as being deaf are referred to the correct organisations prior to entering formal education, can you tell us a bit about how that operates?

DR BRIAN SHANNAN: Yes, so it's important probably to try and look at the origins of deafness for a child, so for a percentage of the children, they are born, have congenital deafness, and that deafness is permanent. It's primarily identified through the newborn hearing screening programme. For another percentage of deaf children, they will acquire permanent deafness later in life at some point during their childhood. Those two groups of children will generally be referred by an audiology department, or in some areas by an ear, nose and throat department to a central education system.

However, there are another group of children that

primarily have a temporary or transient form of deafness. It normally affects the middle ear, and it's quite commonly been referred to as "glue ear". So this condition, there's a high percentage of children, around 80% of the population will at some point suffer that glue ear, especially in the very early years, and so that is usually managed by the ear, nose and throat department and that will generally have either a surgical procedure to remove the blockage in the ear or have hearing aids, because it's important to put deafness as not being an inability to, say, to hear, but deafness is a challenge accessing communication.

For some children, they will have a form of deafness which means that accessing speech, even in a quiet environment, can be challenging; but for children that have got a permanent form of deafness, they find it —— listening in noise accessing communication a challenge. But we also have deaf children that, you know, require British Sign Language because it's important to see deafness not as a medical condition, but as a sense of identity about who you are.

Therefore parents, when they find out their child is deaf, need to make decisions about communication because all children require language and communication, and it's important to state that children develop their

language and communication within really the first four years of life, so it's not —— it's not as if, you know, for a few years as happened potentially in the pandemic where, you know, things were put on hold, the children only have a very narrow window to develop those communication skills, and families have a time to make decisions and informed choices about the communication, whether that be BSL or spoken communication.

Q. Thank you. That provides us with a helpful context when we come on to look at the impacts. Can you tell us how it is that these children are made known to education services?

DR BRIAN SHANNAN: So for the permanent form of deaf children, they will be referred generally by an audiology department to a central education service. For the children that have got a temporary form of deafness, unfortunately, there is —— currently within Scotland, there is no national referral pathway for those children, and therefore some children will go to audiology services, and they might, depending, be referred on a central service, but for some, they might just be referred back to the local school. And for some children with glue ear, they might be managed on a "wait and see" basis by a GP, so they're unknown to a whole group of people that need to have an intervention, and

their language and communication will be compromised without it.

Q. Thank you. Staying with teaching of the deaf, Dr Shannan, it will be helpful if you could —— I understand there's those who use BSL and there are those who use spoken communication. Could you provide a bit of context for us in terms of telling us how and where these two groups of children are educated by and large, those who use BSL and those who are deaf but able to speak?

DR BRIAN SHANNAN: So for deaf children, the vast majority of deaf children are now educated in a mainstream school. That would be true whether children are using spoken communication or British Sign Language. For a percentage of children, they will go to an enhanced provision which would generally be a resource base for the deaf, or sometimes are called schools for the deaf. They are places within —— normally within a mainstream school that have specific staff and acoustic conditions that will be —— enhance their ability to access communication.

So for BSL children, they would require access to a communication support worker or a support staff member that ideally should have a high level of British Sign Language skills, to be able to allow them to access the

communication, and for children, whether it be in a resource base or in a mainstream provision, they would require additional devices and support to make the curriculum accessible. A hearing aid has a range of about 1 to 1.5 metres, some of them maybe more —— 2 metres. After that you're relying on the sounds reflecting in the room.

So if the acoustics in the room are not good for speech, therefore they can make speech more difficult to hear, and therefore you require a device where the teacher or the person speaking would wear a transmitter that would communicate directly to a receiver that attaches either to a hearing aid; or for some children, they have an implantable hearing aid called a cochlear implant, and it would communicate and therefore by increasing what's called the ability to have direct speech being communicated to the device and therefore to the hearing mechanism, you could try to mitigate to some extent the challenges of poor acoustics or distance.

Q. Thank you, I want to ask you in a short while about the assistive devices that are used, but before I do, just staying just now with the individual professionals who work alongside these children to provide their education, what is the role of other professionals beyond the teacher or the teacher for the deaf?

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

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

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

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

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

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

DR BRIAN SHANNAN: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

of equipment that would allow them to access their work.

Q. Thank you. I want to just go back to something you mentioned a short while ago, which is the redeployment of specialist teachers, and I notice from your Rule 8 response, you talk also about the furlough of certain specialists. What was the incidence of that redeployment or furloughing, and what was the impact of that?

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

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

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

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

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

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

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

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

Q. And were these devices available to the children who

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

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

the second lockdown, and I wasn't working for a local authority, but my understanding is that teachers of visual impairment did go in to local —— into the hub schools if there was a child, a young person there, who was a braille user, yes.
Q. Thank you. I want to turn now to you, Dr Shannan, to ask you very similar questions in relation to deaf learners. You set out in the Rule 8 response that at the first lockdown, not all pupils had the devices they needed to learn from home. Can you tell us a bit about the devices that deaf students, first of all, the BSL users might require to have?
DR BRIAN SHANNAN: So it's important to put in context that 90% plus of children that are deaf are born into hearing families, so for the BSL users, in a sense fall into two groups. There are BSL users whose first language in the home are deaf parents that are using BSL, so —— and in those cases, the children will be exposed to BSL and they will develop language in a similar way to a hearing child through exposure to a language.
However, for deaf children that were born into a hearing family, they were at a significant advantage, because to develop —— basically you need to develop a language and you develop a language through exposure. The old saying is: language is caught, not taught. So

you need to be able to have exposure to people that are proficient with that language. That was not happening across Scotland. So (inaudible) there's a limited number of skilled staff pre—pandemic, but within the pandemic situation, not all those —— the cameras, as we've already heard, on Teams were switched off, so you need to physically see somebody, you need somebody —— for family members who have a deaf child, they need to be able to access sight tutors to develop their skills so that they can communicate with their child.
It's quite an emotional wrench to be able to have a deaf child that you cannot communicate with, and all the support networks that you require have been removed. So, you know, deaf children, the parents were at home trying to support their deaf children as best that they could but without access physically to a BSL user. So in some areas they would try to access alternative video communication systems, but the blanket switch—off of the screen system basically, you know, denied deaf children their education, because you couldn't access communication. For —— I interrupted myself so I'll stop there.
Q. That's fine, and I understand from those who perhaps rely on lip reading, also, that would have been an impact?

DR BRIAN SHANNAN: Correct, because communication, every -- although we talk about BSL and spoken language, we call that multimodal communication, namely every language, spoken language involves looking at people's body language, looks at lip reading, all of those different things. So we all use different -- we all use visual and auditory parts to communication, so a BSL user or a deaf user that's using spoken language, the switching off of a screen basically switched off education.

Q. You've set out in your Rule 8 that learners struggled to access laptops or computers where two-way communication was available. Is that what you mean, that there was a screen and cameras in both directions?

DR BRIAN SHANNAN: Correct, so in some situations for some families where they had maybe multiple children in the family, there might have only been a single laptop. So some children were accessing their education through online learning that might have been on a phone or a tablet or a laptop or a shared device. So you -- not only did the technology -- the technology had full capacity but significant restrictions were imposed on that functionality. That disadvantaged children especially with an additional support need, and deaf children -- as I said, deafness is not a learning disability. Deaf children can achieve the same as

hearing children if they have access to communication. What we did by removing that is we took away communication.

Q. You say in your Rule 8 that there was limited input from teachers of the deaf, and this is something that Mrs McCann has touched on in relation to those who are visually impaired. Can you tell us a bit about why that was the case?

DR BRIAN SHANNAN: So again, there was a variety of reasons. Some of those were, as Mrs McCann has said, that, you know, decision-makers within the local authorities were prioritising, you know, potentially support into hub schools because maybe staff members were absent, and they were looking to source staffing for those -- the hubs, but in some cases there was just a lack of priority given to deaf children. In some cases, we had unions telling staff members not to support children online, because they felt there were safety concerns, but again, all of these competing interests were happening, but at the heart of this was a deaf child; and as I said you can't -- if what is happening is occurring during the time when your window of opportunity to develop a language is happening, to remove that, you're taking away somebody's right to a language, to communication, to participation, and it has

a lifelong effect. You can't come back after a year or two and say: we'll pick up your language. A human being has that window of opportunity.

Q. Thank you. You mention your Rule 8 response, and, indeed, the parents you surveyed say that there was ineffective classroom management, and this was a barrier, and this brings us back to the helpful explanation you gave us before about the impact of noise, or noise coming from more than one source. Can you explain a bit to us about how the classroom management was ineffective?

DR BRIAN SHANNAN: So in an ideal situation, a deaf student would have their assistive device, which they would be able to attach to a laptop, which would then mean that what was being was transmitted from the laptop would go straight into the receiver of the hearing aid, and therefore into the hearing mechanism. As I have described, those systems were not routinely available.

You then had an online learning platform. As I said, in many cases there was no access to a visual reinforcement. So you were then having somebody, the class teacher, on an online list having, not muting all the microphones, for instance on the computer, and so -- it's understandable, people were in busy households, so sometimes you have televisions on, or other things going

on with the family, which was then polluting the learning environment.

You then also had -- in a classroom, you would generally not expect to see everyone just shouting out the answers, but, you know, there wasn't -- there's a hand up option on Teams. That wasn't always being utilised. So really, for a lot of, you know, parents and certainly in the research we carried out, parents were saying, you know: basically, the kids were just becoming deflated and disengaged, because this was not a learning environment that was accessible to them, and so the pandemic in a sense amplified already issues around how deaf children access mainstream provision.

I think it's important that policymakers have a greater understanding of the needs of deaf children so that -- those were not firmly established because if they were, then the online learning would have been more -- managed more organised, but, you know, mainstream teachers were thrown into suddenly learning online. So they were learning technology, technology that had been restricted, and there was no real communication with professionals in the field to say: we're doing this, you know, is there a way that we can make this better, or we can mitigate the effects.

Q. In terms of the assistive devices, you have explained

very powerfully for us that the absence of the face—to—face with the speaker or the speakers is important, but had that not been the case, did the child have access to the device needed to amplify the sound, for example?

DR BRIAN SHANNAN: No, so in a sense if we think about hearing devices for deaf children that use them, there's either a hearing aid or a cochlear implant. Then, like I said, there's an assistive device that attaches a receiver to that, and a microphone. So for the hearing device, the hearing aid to work, you need to have ear moulds that are properly fitted. Because of the pandemic, there was a delay for some children being able to get access to new ear moulds. A lot of the health boards were going to scanned moulds that had been taken previously, and the manufacturers were adding on a millimetre here across the board to try to get a mould that fitted.

So in some cases, the children's hearing devices were not working at an optimal level. Then on top of that, lots of services, the equipment is expensive, there is no doubt about that. However, that was not routinely made available to families. Equally, when there were problems, because you were a family being given a device, how do you connect this up, how does it

all work, the support network around that was not always available.

So, you know, it was a lack of access to universal devices, a lack of access to the hardware laptops, and also, you know, making sure that the equipment that the deaf children required to access the curriculum —— that was suitably maintained.

Q. In terms of access to hub schools, were those who are users of BSL given access to hub schools in the first lockdown, or indeed the second?

DR BRIAN SHANNAN: So in the first lockdown, there was no deaf children that I was aware of that were accessing the hub schools. In the second lockdown, some deaf children did access those schools, but again it was not universal across the country. Certainly for BSL users, there would be a strong case to be made that they required that physical person to be there to communicate with them.

Q. In connection with those who communicate with the spoken word, were they given access in the second lockdown?

DR BRIAN SHANNAN: Again, this was not always universal, and again, it comes back to this lack of understanding. There's a conceptual understanding that a deaf child, if you provide them with a hearing aid, that suddenly they become an honorary hearing person, that they can hear

and participate in society. That is not the case. A device is only as effective as the environment that it's in and the other equipment that is attached to it, and therefore making the case that deaf children required communication, they needed to learn and develop their language, and therefore were valid candidates for a hub, was not universally applied across the country.

Q. Thank you, and if you're able, can you tell us a bit about what the hub schooling of these children looked like when they did attend the hubs?

DR BRIAN SHANNAN: So I can only speak for the area that I worked in at the time, that we would send teachers of the deaf or support staff to the hub to support the young people. The hubs generally had a group of priority candidates, so children of parents that were working in the emergency services, or core services. There were children that had —— whose needs were identified as being specific, but they were always trying to maintain a manageable number within the hubs, so again, it comes down to that case being made on a case—by—case basis, and it depended on, you know, different education managers. Within authorities generally, education managers will oversee an area of a region, and so it depended upon, were those educational managers mindful to accept the case being made.

Q. And was the case made by the teaching staff or by the parent to the local authority?

DR BRIAN SHANNAN: Our authority was generally made by either the staff, the teachers of the deaf approaching myself, or myself approaching the different education managers and making that case.

Q. Thank you very much. I want to look now at another cohort and that is those who are deafblind. If I can bring you in on this, Mrs McCann. It's set out at page 6 at section 7(b) that online learning does not meet the needs of these children and young people, and you speak about a multisensory approach being required. Can you explain to us what's meant, first of all, by a multisensory approach?

ELIZABETH McCANN: So I think if I talk just very briefly, first of all, about deafblind.

Q. Of course.

ELIZABETH McCANN: So these are children who have got a dual sensory impairment, but most of those learners that we find in Scotland, but perhaps not exclusively, do have additional support needs above and beyond having a hearing loss and a visual loss. So many of those young people would be found in special schools, but —— so those young people had more access to learning during that time, but obviously if there were significant

health concerns, then some parents may have taken the option not to send them to school because of the fragility of their health.

Nonetheless, they are still entitled to education, but a multisensory approach to learning is exactly that: they need to have literacy, for example, through sensory storytelling that use simple language, but also have props and real objects, which will have a variety of touch and smell and perhaps taste as well that will enhance learning and be able to help them to understand concepts more readily.

Q. Is a multisensory approach to learning about the environment in which the child is, or is it more about the pedagogy deployed by the teacher?

ELIZABETH McCANN: Well, it's both, because as I have just really described the pedagogy, for those learners, they need to have an environment where there are few other distractions, because that can interfere with learning, so they want a low arousal environment where it is quiet, that allows them to focus on the language that is being used, and where there are a few distractions; for example, people moving around will be a distraction away from the learning, which will take the attention away, because they —— sometimes they're hearing if they're —— perhaps if their vision is quite low, then they may have

a hearing loss, but actually their hearing is a better sense, so they will tune into that and they will use that very well.

But for those children, anybody moving around will be a distraction. Also, you know, very bright rooms, light is also —— positioning of that young person within the room is really important, because often again they can stare at light and not actually take their visual attention on to the thing that they are being presented with.

Q. Is it, in your view, Mrs McCann, possible to have this multisensory education within a domestic setting?

ELIZABETH McCANN: It's very, very challenging. In a home setting where everybody was at home, everybody —— for some families, you know, their accommodation wasn't always ideal. So everybody was in the same room or in a couple of rooms. Again, as Dr Shannan has explained, about competing background information, and also something that I haven't mentioned, and I probably should have mentioned in my last question that you asked, there has been a lot of talk and discussion about the amount of input that parents need to have, or that another person needs to have with that child, whether they have a visual impairment or are deafblind.

For some families, if there are a lot of children at

home, trying to divide and split up your attention is really difficult. It's also really difficult in families where both parents worked, because they were juggling two jobs, each having a job, where they were having online meetings, and so it was very, very difficult that —— when did you squeeze in —— education had to be almost fitted around the needs of the parents first, because they had to keep hold of their job in order to have a family and a roof over their head. So that was another huge issue, but there were lots and lots of barriers, particularly for the learners who required that multisensory approach, because education for them, it's very difficult to squeeze in lessons that last an hour, because their attention and their level of fatigue is such that it needs to be short bursts throughout the day, and that's another additional challenge.

Q. Thank you. One thing I did want to ask you, but I'm not sure who's best placed to respond to this, is about the assistive devices used by those who are deafblind, and in particular the switches that they use. You've set out that not all students had access to switches when they were at home, that sharing of switches was an issue. I don't know which one of you is best placed to speak to that?

DR BRIAN SHANNAN: I'm happy, yes.

Q. Please carry on.

ELIZABETH McCANN: Yes, so for many children who are deafblind, they don't have speech, and so they may access switches. They would have been assessed by —— it might have been an occupational therapist or in terms of where is the best position for that switch to be in to allow them to physically move either an arm or a head or a leg in order to access that switch.

There are a variety of switches that are on the market, and switches that have —— require minimal movement for a young person that's got quite restricted both gross motor and fine motor skills, so these are the kind of switches that you might just put your hand on, and a slight finger movement would trigger the switch; or other switches which are larger, as I say, that can be accessed by hitting it.

So, again, in a classroom situation, those switches may be shared by a number of learners, and, indeed, for example, in a morning routine, for saying good morning to their classmates, that might be something that would be passed around a group of young people. But again, when learning moved to online learning and young people weren't accessing school, they didn't always have access to any switch, never mind one that was the most

appropriate for them.
DR BRIAN SHANNAN: Could I make just one point. It would be important also within the group that are deafblind, for some, they can be, say, born deaf, but they develop Usher Syndrome, which is where your sight becomes much narrower or narrow to the point of not being able to see at a later point. So they can become visually impaired, you know, into their early teens.
So for that group of children, especially for BSL users, they move from being able to use BSL communication to one where their world starts -- and therefore their communication is removed, and therefore they need to move to a kind of on-body signing system. So there needs to be a transition from one type of communication to another, as well as the impact being, you know, in your early teens, discovering that you're going to begin to lose your eyesight and all the implications there, and the need for all those support services to be in place.
That absolutely has to happen in person, and, you know, you can't learn these things online. So it's just to kind of put in context that for some, the ones that we've been talking about where deafblindness was at birth, and there's maybe more complex needs, but there are other deafblind individuals that -- whose

communication and learning has followed a traditional path, other than, you know, being deaf or visually impaired, and they happen not in sync, and therefore it's a process, so within that group, also just needs to be considered.
Q. Thank you. In terms of these children's access to hub schools, I understand from your Rule 8 that there may be, for those who are born deafblind, certainly some additional health needs that perhaps would make hub schooling not an attractive option, but were these children offered hub school places in the first lockdown or the second?
ELIZABETH McCANN: So my understanding is that -- that children who had complex additional support needs, including deafblindness, were offered -- some of them were offered hub places in the first lockdown, and during the second lockdown as well.
Q. Thank you, and again, you mention that they typically attend special schools. Would their schooling replicate that which they would have had pre-pandemic?
ELIZABETH McCANN: For some, there were some issues in terms of many of these young people are transported to school by taxi which is paid for by a local authority. Again, as far as I'm aware, there were some issues around transport for those young people, and, you know, again,

if they were sharing taxis and the availability of taxis to take young people to schools, so sometimes that then fell -- that burden fell on parents as well, so there were issues; and again, also around issues with staffing as well, in those schools as well, and staff who themselves were vulnerable, and therefore couldn't work in a hub school. So all of those played a -- had an impact on learning.
Q. Thank you. I want to move now on to looking at the reopening of schools and operating within the restrictions. If I can come to you first on this, Dr Shannan, at section 8(e), you say when schools reopened, family and anxiety issues meant some deaf learners remained at home.
Can you tell us a bit about what it was that led to these deaf learners not returning to school?
DR BRIAN SHANNAN: So this was certainly an experience that I witnessed in Fife where there were a number of deaf learners that had been very confident members attending school, great attendance, good attainment, and they just could not leave the house, they could not go into mainstream schools, they -- for some, they would come on kind of a restricted timetable to try to reintegrate back into school, and for others, they would maybe stay within a room within the school and not be able to feel

confident enough to go into the -- into the classroom. I was shocked by the number of children that I had -- you know, I had known most of these children since they were born, to see the impact on them and their families, and their families were certainly really worried about that and their children's future.
Q. You raised the issue of bubbles as being one aspect of the restrictions that impacted deaf pupils, insofar as it impacted the level of professional input that they might have. Can you expand on that a little for us?
DR BRIAN SHANNAN: So within a school, within a primary school, you know, the nursery could be classed as one bubble. The early years part of the school, you know, primary 1, 2 and 3 could be classed as another bubble, and then the senior school could be another bubble. So if you had a deaf student in each of those provisions, you weren't able to go and visit all of those because you would be crossing bubbles. So, you know, you were basically only able to go and see -- you were restricted to a limited number of schools per day, but you were also limited to the number of bubbles that you could go and see, and therefore as I said, going back to the previous point about if you don't have the equipment, if there's a problem with your piece of equipment, then you're not able to access the curriculum that there was

no —— that kind of flexibility to move between the bubbles just was not within any of the regulations.

Q. Thank you. And Mrs McCann, you raised similar issues in connection with the bubbles. Is that for the same reasons as outlined by Dr Shannan?

ELIZABETH McCANN: Yes, and also if you have a child, a young person in a classroom who perhaps already has a support for learning assistant, you know, you weren't able to go in as well as an additional adult into a room and then the opportunity for withdrawal which is perhaps not, you know, would be our normal way of working, we would rather be in the classroom to see what's happening, every available space was taken up, so there was no opportunity for withdrawal either, but yes, exactly as Dr Shannan mentioned, I think there was also another issue as well, particularly between the end of the first lockdown for learners who are transitioning as well. So for transition for a young person who has got a visual impairment requires a lot of thought especially if they're moving between schools, from nursery to primary, primary to secondary, and also secondary out of education, but if we think about in between stages, a lot of work again is done by habilitation specialists in order to familiarise that young person with the new environment that they are going into but obviously these

people had been furloughed and so when schools were going to open up again in the August, at the end of that first lockdown, there was a lot of scrabbling around happening in order to get people back into work and see which children were going to be transitioning and make all of the arrangements to get access to the schools, which, prior to COVID and now as well, a lot of that work would happen during the holidays because habilitation specialists don't have teachers holidays but they're all being furloughed so there was a lot of work that had to be done in a very short space of time when teachers ostensibly were on holiday so that liaison and that was just missing.

Q. One thing I wanted to ask you about in addition to what you said there is the functional visual assessments and you say it was difficult to undertake many aspects of such assessments. Can you tell us what these assessments are and how and why they're conducted?

ELIZABETH McCANN: So, generally speaking, a teacher of visual impairment would carry out functional vision assessment within the school environment to find out how well that young person is using their vision and from the results of that assessment, generally speaking, distance assessment, testing of near vision as well, colour and contrast and so on, we then make

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

to get that information in a functional sense either.

Q. What was the impact on the learner of not having that functional assessment?

ELIZABETH McCANN: So if you don't have good data to work from, then you are not really able to make —— give good advice to teachers and again you're very much relying on the learner themselves saying "Well, this is ... " —— if they've got their text on an iPad or on a computer, "This is the text that I'm using" or "This is the size that I'm using" but we don't have —— we don't have good data so we're therefore unable to make the best advice and so learning is not optimised for that pupil.

Q. Just one final question for you, Mrs McCann, in connection with this aspect. You mention that on the return to school, poor skills both in use of technology and in braille reading technique had to be unpicked and retaught.

Why was this, why had pupils picked up these poor techniques?

ELIZABETH McCANN: So there are a variety of reasons. Again the challenge of doing braille lessons remotely when there wasn't someone who knew braille sitting beside that young person, that was a difficulty and a challenge and sometimes learners didn't have braille so if they were using hard braille to read rather than using a

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

learning in order to keep up with their sighted peers. It was the quick fix, if you like, when nothing else was available to them. And then for learners, some learners who did have their devices had learned to do things, if they were further down that road of learning to access, some of them learned by trial and error on what their devices could do for them but this then had subsequent issues. So, for example, I heard of one learner who was using their braille note-taker and was accessing their work quite well because work was either emailed to them or -- and they could open the file and access it, email it back to their teacher and so on, that had become their normal way of working.

Now, on a note-taker, you would access a Word document because that's the document or the format that's most readily accessible, you can have speech, you can have braille, you can edit it and so on. When that young person then returned to school and they were still using that way of working, it had become their normal way of working. However, unfortunately due to the security of our exam system, they were not able to access the exam papers in Word format and so there was a lot of negotiation had to take place between the teacher of the local authority and SQA in order to have their paper in a format that they could access that was still

their normal way of working because what they were doing was not something that previously had been allowed due to exam security.

Q. Thank you, and you have answered what would have been my next question about SQA. And on attainment, Dr Shannan, you have set out at section 8(h) and I'm not going to go into this in any detail but just to tell you that the Inquiry has the BATOD survey that you refer to about the potentially widening attainment gap due to lack of specialist support and I understand from that that it was a lack of specialist support during the pandemic but I won't ask you further on that because I'm mindful of my time.

Just before we close, I wanted to ask both of you, perhaps Dr Shannan first of all, were the impacts you've described both in the Rule 8 and here for us today, did you make representations to the Scottish Government to make them aware of these impacts either at the time or subsequently?

DR BRIAN SHANNAN: At the time, there was no direct method that I had to make them aware of these issues for sure and subsequently obviously we have carried out the research that's already been submitted which sets out many of these issues and obviously in the submission here obviously part of that the Inquiry is to highlight

these so the submissions that we've made today and also in the Relate addresses those issues.

Q. Yes, thanks very much. And, Mrs McCann, is that a similar situation for you in the role that you had at the time of the pandemic?

ELIZABETH McCANN: Yes, although I think it's also fair to say that Scottish Sensory Centre is funded by a Scottish Government and we do provide annual reports for them so they were aware or should have been aware through that report of the work that Scottish Sensory Centre was doing in terms of trying our best to support teachers of visual impairment and indeed teachers of the deaf in order to deliver as good a service as they possibly could.

Q. Thank you very much. Just in closing, I wanted to ask you, you both, whether in addition to what you have said today and indeed, Dr Shannan, you have set out in the research paper we referred to recommendations to benefit deaf learners and mitigate some of the negative impacts but further to that, are there any other key lessons that Scottish Sensory Centre thinks should be applied to ensure these impacts are addressed and mitigated?

DR BRIAN SHANNAN: I think the pandemic amplified issues that were already there around the inclusion of deaf children and education. There has been a general move

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

difficulties primarily because like I said language is "caught, not taught", the ability to interact. All of this, the ability to make sure that there's a way in managing what was clearly a crisis that we have realised that we're not creating future crises going forward.

Q. Thank you. And, Mrs McCann, do you have anything to add to this from the perspective of those for visually impaired and teachers and learning?

ELIZABETH McCANN: Yes, I think we know that visual impairment is a low incidence disability, there are -- the numbers are small, but I think again, and it is similar to what Dr Shannan was saying, because our numbers are small, we almost completely fell off the radar and there wasn't enough consideration given. And a similar point, this move towards, you know, generic support for learning is not good, the move away from having managers who are not qualified in visual impairment. In order for that voice to be amplified, you know, in higher managerial structures within local authorities is really important and we're not seeing that now, that there's not -- the teachers of visual impairment often don't have a manager who's qualified in any form of sensory impairment and being able to take that message and having it heard up the tree is really, really important, and I think as well, it's also

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

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

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

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

MS STEWART: I think it's 11.15.

THE CHAIR: 11.15, I do beg your pardon. Very good, that's all, thank you.

(The hearing was adjourned to 11.15 am on Wednesday 13 November 2024)

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