

# OPUS2

Scottish Covid-19 Inquiry

Day 45

May 9, 2024

Opus 2 - Official Court Reporters

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1 Thursday, 9 May 2024  
2 (9.45 am)  
3 THE CHAIR: Good morning, Mr Caskie.  
4 MR CASKIE: Good morning, my Lord. Our witness this morning  
5 is Susanne Napier.  
6 MS SUSANNE NAPIER (called)  
7 THE CHAIR: Good morning, Ms Napier.  
8 A. Good morning, my Lord.  
9 MR CASKIE: Shall I begin?  
10 THE CHAIR: Please.  
11 Questions by MR CASKIE  
12 MR CASKIE: Good morning. Would you tell the Inquiry your  
13 full name, please?  
14 A. Susanne Anderson Napier.  
15 Q. I believe in relation to the Inquiry you've provided  
16 a witness statement; is that correct?  
17 A. Yes, it is.  
18 Q. The top of the witness statement will appear on the  
19 screen. You've signed this witness statement and before  
20 you signed it, had you read through it?  
21 A. Yes.  
22 Q. And are you content that the content of the statement is  
23 true?  
24 A. Yes.  
25 Q. And do you wish to adopt all of that statement as part

1

1 of your evidence today?  
2 A. Yes, I do.  
3 Q. For our records, the witness statement number is  
4 SCI-WT0472-000001.  
5 I'll ask you this: from which organisations are you  
6 appearing this morning?  
7 A. Turning Point Scotland and Unite the Union --- it's for  
8 Unite the Union.  
9 Q. Is it correct to say that effectively you had two roles  
10 during the pandemic? One was your employment with  
11 Turning Point --- and I'll ask you to explain that in  
12 a bit of detail later --- and, secondly, for Unite the  
13 Union?  
14 A. Yes, that's correct.  
15 Q. And tell me about your role within Unite.  
16 A. My role within Unite is --- I'm a workplace rep. I'm  
17 also the treasurer and the secretary for the branch,  
18 which is SC38/415.  
19 Q. Yours is an organisation which loves acronyms as well.  
20 In terms of Turning Point, do you know how many  
21 staff, how many employees, it had?  
22 A. Yes, it's approximately 1,600.  
23 Q. Okay. And over what range of roles does that  
24 organisation operate?  
25 A. Do you mean in terms of the individuals they support or

2

1 do you mean ---  
2 Q. No, what do they do?  
3 A. What do they do? They support vulnerable individuals in  
4 society.  
5 Q. And your role, what was it you specifically did?  
6 A. My role as lead practitioner means that I supported  
7 individuals in the service --- known as  
8 "Time Out/218 Service" --- it was to support individuals  
9 in the criminal justice system, women who had offending  
10 behaviour.  
11 Q. And in what venue did you provide that support?  
12 A. That was 218 Bath Street, the service known as  
13 "Time Out" or "218", as it's --- you know, more people  
14 know it as the "218 Service" in criminal justice.  
15 Q. I understand that that service no longer operates; is  
16 that correct?  
17 A. Yes.  
18 Q. Okay, I'll ask you about how it came to an end, if I can  
19 put it that way. But whilst it was operating, what  
20 function did you carry out? You said you were a lead  
21 practitioner. When did you work?  
22 A. When I first started there, for about a year I worked in  
23 the day service, the dayshift team, and quite quickly ---  
24 it was about a year in. That would be about 2014 ---  
25 I started working nightshifts. So I was the lead

3

1 practitioner on nightshift. There were two staff on  
2 nightshift, myself and a support worker, and basically  
3 it was to, you know, support the women throughout the  
4 night.  
5 It was a 24-hour service ---  
6 Q. Was it a residential service?  
7 A. It was a residential service at that particular point.  
8 There would be 12 beds, so there would be 12 women --- we  
9 were generally pretty often full --- there would be  
10 12 women with --- as I say, they had offending behaviour,  
11 offending histories, but most of them --- and I would say  
12 90%+plus --- also had issues with substance misuse, both  
13 alcohol and other substances. So when they came in,  
14 they would be undergoing detox and at night I would be  
15 supporting individuals through that process; you know,  
16 emotional support, homely remedies. We had nurses on  
17 board, but not throughout the night. Really all aspects  
18 of supporting folks emotionally and physically.  
19 Q. And was Turning Point viewed as an alternative to  
20 custody?  
21 A. Yes. This service in particular came about as a result  
22 of an increase in suicides in Cornton Vale Prison and,  
23 following a review, it was decided that we needed  
24 something different, we needed a more holistic approach,  
25 something that was less punitive. So 218 was, you know,

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1 basically conceptualised to do that, providing, you  
 2 know, holistic support, counselling, cognitive behaviour  
 3 therapy, detox from alcohol and other substances, group  
 4 work, emotional support — just a more holistic and just  
 5 a better way of supporting folks because most of the  
 6 women there were really victims and had been since, you  
 7 know, their younger years.

8 Q. Okay. Are you able to tell us what the budget for the  
 9 218 was when it was up and running?

10 A. Yes, prior to COVID, it was 2 million, was actually the  
 11 budget. Shortly after COVID they reduced that by —  
 12 I think — at that point I think they reduced it by  
 13 200,000 and that took away the day service.

14 In addition to the residential service, the  
 15 12-bedded unit, we had a day service that supported  
 16 around 60 women in the community from Glasgow and  
 17 Greater Glasgow, but that budget at that point was  
 18 slashed. And the reason for that was that we weren't  
 19 getting the same footfall. However, considering we had  
 20 just gone through COVID, which had an impact on who was  
 21 presenting at the service, that's why that budget at  
 22 that point was reduced to 18 — 1.8 million.

23 Q. We've heard from a number of different sources that  
 24 third sector organisations often have to bid for funding  
 25 from Government agencies, health and social care

5

1 partnerships or from Scottish Government. Did 218 go  
 2 through a requirement to bid?

3 A. They did just last year, rather — no, this year. Prior  
 4 to that, no, our funding was — came from a different  
 5 budget. I think it was from the justice budget, central  
 6 Government. We didn't need to put out tender. The  
 7 money was there pretty consistently until this year,  
 8 when, you know, we had to put it out to tender.

9 Q. Having said the budget previously was £2 million, how  
 10 much would the bid have paid a successful bidder?

11 A. How much did — how much were they — I'm not quite sure  
 12 what you mean by that, but if I could — what I will say  
 13 is what happened was there was a review of services  
 14 carried out in — I can't remember the exact date.  
 15 There was a review of services carried out and we were  
 16 asked to put in a bid for it.

17 Q. Can I take you to paragraph 7 —

18 A. Yeah, please do.

19 Q. — in your witness statement.

20 A. Yeah, right. Okay.

21 Q. You say there about the cut in funding and then:  
 22 "The decision is very controversial ... Funding for  
 23 the facility was put out to tender with the outrageously  
 24 low budget of 600,000 ..."

25 A. Yes, that's right.

6

1 Q. Having put it out to tender with that as the budget, did  
 2 anybody bid?

3 A. No, no, and as I've said in the statement — I sort of  
 4 had to backtrack on that there — it was — they  
 5 originally said our budget would be — I think they were  
 6 saying it was going to be 12 and then just immediately  
 7 they came out and slashed it to 600,000, which is  
 8 a completely unworkable sum. When you consider it had  
 9 been 2 million reduced to 1,800 [sic], so that's when we  
 10 took away the day service — so 1,800 [sic] was the  
 11 amount of money we required to run the 12-bedded unit,  
 12 and when you consider that the tender that was offered  
 13 was 600,000, it's completely unworkable. You know, it  
 14 was one-third of the money that we had after the initial  
 15 cut back in 2020.

16 Q. And what was the impact of that on the service?

17 A. Well, the service had to close because nobody bid.  
 18 Turning Point knew that they could not even dream of  
 19 running that service on that amount of money. It  
 20 would — actually, if they'd run it on 600,000, it would  
 21 have been a hostel with no support. They wouldn't have  
 22 had all the support. I mean, we had doctors, nurses —

23 Q. But that decision was taken, and was that decision taken  
 24 independently of COVID or did COVID impact on that?

25 A. Well, I suppose that's a matter of conjecture, isn't it,

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1 because, you know, we have different ideas why they were  
 2 trying to claw back finance. A lot of people might have  
 3 said that, because funds were so long following COVID —  
 4 the costs of COVID, they were trying to get money back  
 5 in whatever way they —

6 Q. And now that 218 has closed —

7 A. It's gone.

8 Q. — what are you doing?

9 A. At this point in time I'm just in between jobs, although  
 10 I still work as what's known as a "companion" for Unite.  
 11 I'm due to start another job shortly but at this point  
 12 in time I was made officially redundant on 31 March.

13 Q. And what's your new job?

14 A. I'm a stand-down officer with Unite the Union.

15 Q. So a full-time official?

16 A. Well, a part-time full-time official.

17 Q. A part-time full-time official, okay.

18 Now, at the start of COVID, the lockdowns,  
 19 I understand you were off work; is that correct?

20 A. Yeah.

21 Q. And I understand the reason for that is because you  
 22 personally suffered two bereavements in quick  
 23 succession.

24 A. Yes.

25 Q. I don't want to go into the details of those, but the

8

1 consequence of that was that you were off work, as  
 2 I understand it, until — when did you go back?  
 3 A. August — beginning of August —  
 4 Q. Okay.  
 5 A. — 2020.  
 6 Q. Right. So you were unable to work. Did you carry on  
 7 any duties or functions in your capacity as a union rep?  
 8 A. Yes, I did. I continued to take calls from colleagues.  
 9 Q. And what did you do with those calls when you were  
 10 receiving them?  
 11 A. Some of the calls I was able to just deal with at source  
 12 by allaying people's anxieties or, you know, point them  
 13 in the direction of policies that had been put out by  
 14 Turning Point Scotland. I was privy to them still —  
 15 Q. I also understand that you would refer quite a lot of  
 16 people on to a particular individual —  
 17 A. Yes.  
 18 Q. — within the organisation. Now, please don't name that  
 19 person, but can you tell me what their role was?  
 20 A. The health and safety officer for Turning Point  
 21 Scotland.  
 22 Q. And how were they dealing with enquiries they were  
 23 receiving?  
 24 A. It's my understanding they would be gleaning the  
 25 information from the same — you know, from what

9

1 Government was putting out and they would then be  
 2 passing that information back on to their, you know,  
 3 colleagues, people that they were supporting.  
 4 Q. Right. Can I take you to paragraph 17? You talk there  
 5 about what the calls were about and you indicate they  
 6 weren't really about PPE.  
 7 A. Hmm—hmm.  
 8 Q. Was that because, within the organisation, PPE was  
 9 pretty widely available?  
 10 A. Yes, it was.  
 11 Q. Then at 18 you talk about most calls from people working  
 12 in the learning disabilities sector. Can you tell me  
 13 about that?  
 14 A. Yeah. Really, as I said, most of the calls I received  
 15 was from that particular sector because they had less —  
 16 they felt they had less control over the hygiene and who  
 17 was coming in next to the project or who was leaving,  
 18 whether they had cleaned it properly. Also there would  
 19 be at times relatives visiting. You know, I know that  
 20 there had been a restriction on that, but their  
 21 anxieties were around people coming in, maybe not social  
 22 distancing, maybe the place was not as clean as they  
 23 would like it to be — just a general anxiety around  
 24 transmission. But most of the enquiries came from that  
 25 particular area.

10

1 Q. And at 19 in the witness statement you talk about people  
 2 being concerned about going off sick —  
 3 A. Yes.  
 4 Q. — and people approaching you as a union officer in  
 5 relation to that. Can you tell us about that?  
 6 A. Yeah. As I said, folks were concerned that, if they  
 7 were off sick, would that be a trigger point, would that  
 8 then mean it would result in formal absence disciplinary  
 9 procedures, and I was able to tell them that, no, that  
 10 we had come to an agreement that that would — that, you  
 11 know, any COVID sickness absence, although they would  
 12 receive support to see how they were and whether they  
 13 were fit to return to work, it wouldn't result in  
 14 disciplinary action at that particular point in time;  
 15 that they would be supported and also paid.  
 16 Q. You move on at paragraph 20 to talk about changes to the  
 17 guidance happening all the time. Tell us about that and  
 18 what impact that had.  
 19 A. I suppose that's quite an anxious period of time because  
 20 there was so much stuff to try and read through to keep  
 21 abreast with what the current procedures were. You  
 22 know, it just felt as if there was information just  
 23 cascading from everywhere, from the union, from  
 24 Turning Point Scotland, from the Government — you know,  
 25 a bit of a whirlwind going on really to try and keep

11

1 abreast with the information that then I would have to  
 2 pass on to others.  
 3 Q. Now, you have a heading just before paragraph 22 in the  
 4 witness statement which is "Daily Routine within the  
 5 Facility". What you're talking about there is the  
 6 normal practice prior to COVID happening within the  
 7 facility and how 218 engaged with residents in  
 8 particular. I don't need to take you through that kind  
 9 of daily routine, but you, at 29, talk about having to  
 10 incorporate social distancing into the daily routine.  
 11 Just tell us about that, please.  
 12 A. Well, it meant changes to the staff team. We had quite  
 13 a healthy staff team, and healthy in terms of numbers,  
 14 and that had to be reduced to ensure that, you know, we  
 15 were not — there's a narrow corridor. You know, you'd  
 16 be sliding along the walls to try and maintain social  
 17 distancing. And also for — you know, when the shifts  
 18 changed, there was also a change to that, where the  
 19 handovers were different, and also how we engaged with  
 20 like nursing staff. Normally, I would go in with the  
 21 nursing staff and — with the women and sit and chat.  
 22 That no longer happened. We were just given, you know,  
 23 handover by one person in a room, isolate — you know,  
 24 socially distance.  
 25 It was difficult because people would forget —

12

1 especially the women that were using the service, they  
 2 would forget and come right up to you and ask you  
 3 things, and you were trying to say, you know, "Please,  
 4 can you maintain a distance?". It was just a very,  
 5 very, very difficult time. Everybody was so anxious  
 6 about transmission.

7 Q. You indicate — and I don't need to take you to  
 8 particular bits of it, but from 22 to 28 — the  
 9 activities that would normally be involved for women.  
 10 Tell me about the activities for women residents when  
 11 COVID happened.

12 A. Some women chose to self-isolate and they would be in  
 13 their rooms for most of the time. We had a lounge area,  
 14 a pretty big lounge area, which folks could access only  
 15 two at a time and socially distance. Really the main  
 16 thing that they did was probably watch TV. They had  
 17 access to — more access to laptops to allow them to  
 18 engage with family. Prior to COVID, families would  
 19 visit regularly, you know, a supported visit with staff  
 20 there, but they would visit regularly. Folks had  
 21 children, you know, women who used the service had  
 22 children, they would visit. They could no longer see  
 23 their children so they did that through, you know,  
 24 FaceTime, that sort of thing. They were incredibly  
 25 bored. That's what I'll say, you know, and isolated.

13

1 Part of the thing they needed most was support from  
 2 other people and really that couldn't be provided in the  
 3 way it had been prior to COVID.

4 Q. Okay. Now, you talk about, at 31, the COVID outbreak  
 5 and lockdown and then you provide personal information  
 6 as to why it was that you had to take time off work and,  
 7 as I've said, we don't need to go into that. But at 33  
 8 you talk about the facility also doing work in the  
 9 community. Can you tell us about that, firstly  
 10 pre-pandemic?

11 A. Do you mean my role or just the service —

12 Q. The facility.

13 A. Oh, the facility, as I said, had a day service which  
 14 supported women in the community, so it ran groups — it  
 15 ran group work, a group work programme, you know,  
 16 about — the group work programme would be about  
 17 offending, about addiction, mental well-being. There  
 18 would be craft groups. There was acupuncture offered  
 19 daily, Acu-Detox. All of that ceased, all of that  
 20 stopped.

21 Q. Then we know that you had a period of absence  
 22 until August 2020 and you talk about that at  
 23 paragraph 35. You talk about some of the changes that  
 24 you've already made reference to. Is there anything in  
 25 paragraph 35, particularly the final four or five lines,

14

1 that you want to talk about? You're talking about women  
 2 suffering a relapse whilst they were in. How was that  
 3 dealt with during the lockdown periods?

4 A. Some women would just leave the service and that would  
 5 be that. They would just go back out on to — you know,  
 6 some folks had nowhere to go. They would be back out on  
 7 to the street. But I think just the pressure of being  
 8 isolated and not really — although they were still  
 9 receiving a degree of support, it was not the support —  
 10 nothing like the support that they received prior to the  
 11 pandemic. You know, not only did they not have support  
 12 from staff, they didn't have the support from their  
 13 fellow residents. It was no longer available.

14 And part of the recovery process is building  
 15 community support, as in the community of 218. That was  
 16 no longer available to folks. So for some folks that  
 17 relapsed. It just seemed that the only way that they  
 18 could cope with their mounting anxiety was to go out and  
 19 possibly use substances, drink alcohol. It was a very,  
 20 very difficult time. Very difficult.

21 Q. How did Turning Point respond to that?

22 A. There's really not that much that Turning Point could  
 23 do. We could try and find people once they left — you  
 24 know, we always had contact details, mobile numbers.  
 25 Some folks had no address to go to. But what we would

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1 do is we would contact the police and tell them that  
 2 such and such individual had left the service or, if  
 3 someone had been sent there with a court order, you  
 4 know, through their lawyer, then obviously we would  
 5 contact the relevant individuals and let them know that,  
 6 you know, someone had just sort of left. We would hear  
 7 an alarm sometimes. Folks would just leave in the  
 8 middle of the night, down the back stairs, gone. It was  
 9 really difficult because there was nothing out there for  
 10 folks.

11 Q. At 37 you talk about health and safety and again you  
 12 make reference to the health and safety officer and also  
 13 the chief executive but you also give an indication  
 14 about another anxiety that staff had in relation to  
 15 transport.

16 A. Yeah.

17 Q. And you would hear — did you hear about that through  
 18 your role as a union official or was that something you  
 19 just picked up?

20 A. Probably both. People would talk about that in the  
 21 context of, you know, other calls, in addition to, "This  
 22 is how I feel about ... I have to travel to work". In  
 23 fact it was something actually I had to do myself so  
 24 I can personally relate to that fear of transmission  
 25 when you were on public transport. You know,

16

1 I travelled over an hour to work and an hour back, so  
 2 sometimes you were in closer proximity than you would  
 3 have wished to be. So I would say both. Folks were  
 4 just talking about it generally, staff, and then other  
 5 folks would be mentioning it as well as, you know,  
 6 difficulties around their work-related stuff.  
 7 Q. You've spoken about the necessary support within the  
 8 218 community, if I can put it that way. As a worker,  
 9 were you also getting support from the wider  
 10 Turning Point staff? Was there any communication, staff  
 11 communication, across the organisation?  
 12 A. Not that much.  
 13 Q. And what about in terms of dealing with guidance? When  
 14 new guidance came out, how were you, as a staff member  
 15 and quite a significant staff member, effectively  
 16 running a shelter during the night — how were you  
 17 provided with information regarding updates to guidance?  
 18 A. Regular — very regular contact through email from both  
 19 the chief executive and the health and safety officer.  
 20 We were — they were cascading information very often  
 21 and, if need be, I could pick up the phone at any point  
 22 and call the health and safety officer.  
 23 Q. Was that guidance always consistent with itself, if  
 24 I can put it that way? You know, did it change  
 25 significantly over time?

17

1 A. Oh, yeah, yeah, and that's why there were regular  
 2 updates.  
 3 Q. One of the complaints that we've heard from other  
 4 sources is that the guidance that was being issued was  
 5 too frequent and too — and not always consistent with  
 6 previous guidance. Was that your experience?  
 7 A. Yes, there was really a plethora of information and it  
 8 was pretty hard to keep up with it. And, yes, it was  
 9 changing often. You know, people were saying, "I've  
 10 just read such and such but now they're saying this",  
 11 and it was just a very, very difficult time. It was  
 12 a pure upheaval to not only our personal lives, lives at  
 13 home, but in the workplace — yeah, a very difficult  
 14 time.  
 15 Q. Okay. I'm going to go back — I just want to clarify  
 16 something. The funding that you received, was that from  
 17 the Criminal Justice System within Scottish Government?  
 18 A. Yes.  
 19 Q. It was?  
 20 A. But there was also a ringfenced amount that we had, and  
 21 I think it might have been £300,000. There was  
 22 a ringfenced amount that came from the city council  
 23 which was withdrawn. They said they could no longer  
 24 afford to do that. That ringfenced amount had been in  
 25 situ since — well, that would be — when did that open?

18

1 It would be 20 years this year, so it would have been in  
 2 2004 that that amount was available and then it was just  
 3 withdrawn.  
 4 Q. Gone. At 45 you talk about the process for women who —  
 5 going through the process, so how women came to end  
 6 their time at 218. How long typically would a woman be  
 7 within 218, typically?  
 8 A. Well, prior to COVID it would be six months. After  
 9 COVID and towards the end of the service it was whittled  
 10 right down to 16 weeks, which is not nearly enough time.  
 11 Q. And tell me about the transition. What happened at the  
 12 end of the period that a woman would be with 218?  
 13 A. Towards the end of the period the women would go through  
 14 a process called "graded exposure". What that would  
 15 mean is they would be — there would be a plan, a risk  
 16 assessment plan, put in place to start the gradual  
 17 process of people moving back into the community. So  
 18 that would be in terms of them dealing with how they  
 19 felt emotionally, being outside the safe environment of  
 20 the building.  
 21 So, as I said, a plan would be put in place and  
 22 initially we would support individuals to go out, you  
 23 know, maybe just have a coffee, whatever, return to the  
 24 service, and that would gradually improve until someone  
 25 had a plan of action that they would follow; you're

19

1 going here, you'll have a coffee here, you've chosen to  
 2 maybe go to two different shops, you'll go to this  
 3 shop — you know, it was quite prescriptive. You stuck  
 4 to the plan just to enable folks to gently return to  
 5 society without just saying, "There you go, you're back  
 6 in Sauchiehall Street" and —  
 7 Q. Was that a supported process?  
 8 A. Yes.  
 9 Q. Who was it that was providing the support?  
 10 A. The day service staff, the staff that worked the  
 11 dayshift. Not the day service, rather — the dayshift  
 12 staff would provide the support, carry out the risk  
 13 assessment, formulate the plan in an agreement with the  
 14 women.  
 15 Q. And at 48 you talk about referrals and how the process  
 16 for referrals changed over time —  
 17 A. Hmm—hmm.  
 18 Q. — in that the geographic area was reduced.  
 19 A. That's right.  
 20 Q. Can you tell us about that?  
 21 A. Prior to COVID and possibly some time — I can't  
 22 remember exactly when it changed, some time between  
 23 COVID and now — we used to be able — our catchment  
 24 would have been Greater Glasgow, Scotland. We'd have  
 25 women from all over. And then that was reduced down to

20

1 City, Glasgow City. So we couldn't take referrals from  
 2 South Lanarkshire, North Lanarkshire, you know,  
 3 Renfrewshire, et cetera.  
 4 Q. Which you had been taking previously?  
 5 A. Oh, absolutely, absolutely.  
 6 Q. And was the service that you were providing highly  
 7 regarded by the users?  
 8 A. Absolutely.  
 9 Q. Yes?  
 10 A. Absolutely.  
 11 Q. You talk about that and you talk about something quite  
 12 surprising in relation to that at paragraph 48, about  
 13 halfway down, where you say that the criteria for entry  
 14 was to have a conviction. Tell me about that.  
 15 A. Previously we had supported women who were at risk of  
 16 offending behaviour — you know, of offending behaviour  
 17 and also at risk of getting a criminal conviction, so we  
 18 would support individuals to see where their behaviour  
 19 was leading them. And then afterwards what we had to do  
 20 was take women only who had an existing criminal justice  
 21 history, you know, they already had convictions. And  
 22 I think I said that some women had actually said that  
 23 they'd gone out and committed crimes so as that they  
 24 could get into the service because they knew, if they  
 25 hadn't actually — if they hadn't been charged with

21

1 something, they didn't have a chance of getting in the  
 2 service. And I found that was — you know, we had been  
 3 proactive and then afterwards it was a reactive service.  
 4 You know, we were supporting women who had actually  
 5 a criminal justice history as opposed to be at risk of  
 6 offending, which is a much better way of dealing with  
 7 things in my sense.  
 8 Q. At paragraph 51 you talk about the number of calls that  
 9 you received. Presumably these would be calls from  
 10 furloughed trade union members. Can you just tell us  
 11 about how that varied over the period of COVID?  
 12 A. You've said it would — yeah. It was not only from  
 13 trade union members. It would also have been just  
 14 from — probably from Turning Point Scotland staff as  
 15 well, people who — I was supporting people who weren't  
 16 members. I'm not going to say to — I just wasn't going  
 17 to say to someone, "No, I'm not supporting you, you're  
 18 not a member". So I was taking calls really from the  
 19 whole staff team at that point.  
 20 Q. And you explain to some extent what the calls were  
 21 about. Can you tell us about that?  
 22 A. Again asking about — just trying to allay their  
 23 anxieties around sickness absence, about — I've already  
 24 spoken about the learning difficulties service, where it  
 25 was around the hygiene and it was about transmission,

22

1 about folks coming out of — you know, people who had —  
 2 I did say earlier in the statement that Turning Point  
 3 Scotland doesn't support elderly people but we support  
 4 elderly people who have learning difficulties.  
 5 So they would be in and out of — they would be more  
 6 vulnerable through age and also having, you know,  
 7 Down's syndrome, whatever learning ... it meant that  
 8 they did get a lot of hospital treatment and may have  
 9 been in hospital. And quite a few calls were around  
 10 someone getting out of hospital and coming back into the  
 11 community to share a house with maybe three other  
 12 individuals and workers. So folks were at their wits'  
 13 end, saying, "The hospitals are full of COVID. What  
 14 happens when they come out? Do they have COVID? Do we  
 15 test?". There was a lot of anxiety around that.  
 16 Q. Did Turning Point take steps to allay those fears?  
 17 A. Yes.  
 18 Q. Why were people coming to the union rather than to their  
 19 employers?  
 20 A. Probably just because they thought maybe they had  
 21 more — not confidence but — just maybe I'm more  
 22 approachable or they felt I was more approachable, there  
 23 to ...  
 24 Q. At paragraph 53 — I'm not going to ask you to read it  
 25 out — but you identify that there were particular

23

1 problems at particular facilities.  
 2 A. Yes.  
 3 Q. Again, without going into the specifics of what you  
 4 refer to at paragraph 53, what was different about the  
 5 venues from which you were receiving a large number of  
 6 calls?  
 7 A. Those would have been the services which were in  
 8 people's own homes. So what there would be is maybe  
 9 a four-apartment house supporting three individuals  
 10 living in their own home, shared accommodation, and that  
 11 would have been, as I said previously, about maybe folks  
 12 being in hospital, coming out, back into the service and  
 13 also the amount of staff that were going in. So you  
 14 would have maybe two staff in the morning, two staff in  
 15 the evening, you might have six staff supporting those  
 16 three individuals over a 24-hour period. So it was just  
 17 about the footfall, the amount of people social  
 18 distancing. They were definitely in much more close  
 19 proximity so the anxieties were just around  
 20 transmission.  
 21 Q. And you refer at paragraph 55 to you being involved in  
 22 communication with managers about people going off with  
 23 COVID. Again, why would you be involved in that rather  
 24 than someone just going directly to their line manager?  
 25 A. Because at times the line managers appeared not to be

24

1 aware that there had been an agreement made that folks  
2 wouldn't be penalised for it and the letters that were  
3 being sent out to individuals who had been off sick with  
4 COVID — the letters at that point still had headings  
5 like "Formal absence meeting", and people were saying,  
6 "Why is this a formal absence meeting? I've had COVID.  
7 It shouldn't be like that". So I was then going back to  
8 managers and saying, "Look, can I refer you back to  
9 probably the communication that you've had from X, Y  
10 and Z because it's clearly saying this shouldn't be  
11 a formal — this is not a formal absence meeting. It  
12 might be a supportive meeting. So you need to ..." —  
13 and they did eventually change the wording on that. And  
14 that created a lot of anxiety around folks, you know,  
15 this formal absence. People thought, "Oh, we'll lose  
16 our jobs, we won't get paid", blah blah blah.  
17 Q. At 55 you talk about workers who were off several times  
18 with COVID in close succession. Did that link to  
19 particular anxieties?  
20 A. Sorry, which paragraph are you referring to?  
21 Q. 55.  
22 A. Oh, 55 again. Yeah, of course, there was an anxiety  
23 around it. But although those procedures did change,  
24 I know more recently the COVID — anyone who is off with  
25 COVID, it is now just as in sickness absence; at that

25

1 particular point in time it wasn't. So I was again just  
2 saying to them, "Don't worry about it. Do not worry  
3 about your absence through COVID. If you can prove that  
4 you had COVID, you'll be supported through that, you'll  
5 receive your wage, you won't be penalised, you'll get  
6 a supportive meeting, but it's not a formal absence  
7 meeting. It should just be a supportive meeting". And  
8 it's really down to, I would say, the ineptitude of some  
9 of the managers, who maybe weren't reading — you know,  
10 are not getting properly briefed on what they should be  
11 doing.  
12 Q. At paragraph 59 you talk about a longer-term impact  
13 within not just Turning Point but the health and social  
14 care sector in general. Can you tell me about that,  
15 please?  
16 A. Yeah, and you see in the first kind of statement in  
17 that, I would say a lot of people who were — definitely  
18 worked harder, had more anxiety around their own health  
19 and providing support for others with wages that didn't  
20 reflect what they were doing, just thought, "We've had  
21 enough. We're out, we're out. We're leaving this  
22 sector", and we're still feeling the impact of that now.  
23 Q. So did you view that as quite a significant number of  
24 people who simply said, "No more"?  
25 A. Yes, yes. And we know in Scotland that there is now —

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1 you know, the social care sector is on its knees  
2 basically. There have been so many people that left and  
3 just said, "No, we've had enough", and I know it's  
4 probably similar in the NHS. It was such a stressful  
5 time for people and they just don't feel they were —  
6 you know, although people were out clapping in the  
7 streets, you know, they weren't financially remunerated.  
8 They didn't feel — they felt after it was all sort of  
9 dying out that they just went back to being kind of  
10 dogs' bodies really. That's what the people would say.  
11 Q. At 62 you talk about what you view as a difficulty that  
12 arose from wearing masks.  
13 A. Yeah, without a doubt. I've never in my life ever had  
14 sinusitis before and I had it really, really badly and  
15 still at times suffer for it because I had to wear  
16 a mask — wear a mask on the bus two hours, wear a mask  
17 for a 12-hour shift unless I was sitting on my own.  
18 Yeah, I feel that had a real detrimental effect to  
19 myself and I know that there are — even people within  
20 my family are suffering from it, regular sinusitis now,  
21 and that's what they — I suppose having a mask on and  
22 having the fibres had an impact. My daughter is a nurse  
23 and her face would be red raw literally with wearing  
24 a mask in a heated environment.  
25 Q. At paragraph 63 you talk about your attitude to the

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1 vaccine. I'll give you the opportunity to explain that.  
2 A. Yeah. I do believe I have long COVID and whether —  
3 I mean, I'm not a microbiologist, I haven't studied it  
4 in depth, but I do know and I do feel that the vaccine  
5 came out so quickly, and although, of course, there  
6 are — you know, they've done various studies prior to  
7 it, you know, COVID-19, on the one hand, they were  
8 saying it's so unique, it's so different from other  
9 virus — to think that in jig time they could have  
10 managed to get a vaccine that was somehow going to have  
11 that impact, you know, to prevent you having it or for  
12 it to be less of an impact, I don't know. I'm very  
13 sceptical about it.  
14 I know people who have not had the vaccine and have  
15 had COVID and it's been slight, and they've had  
16 conditions like diabetes or whatever, and I know people  
17 who have had all the vaccines and have had COVID which  
18 has hit them like a tonne of bricks. Who knows?  
19 I certainly — as I said, I took two vaccines, I wish  
20 I had never taken it at all and, if I was offered it  
21 again, I wouldn't do it. I think there was an awful lot  
22 of pressure. Although I don't believe it was mandatory,  
23 certainly there was that feeling of, "Will you be taking  
24 the vaccine or you'll no going here or you'll no be  
25 going there and you'll no be flying?". There could be

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1 an element of you losing your job. All of this was an  
 2 undercurrent going on. It's kind of veiled threats  
 3 towards what would happen if you don't take the vaccine.  
 4 Q. That was the next thing I was going to ask you about  
 5 because you make reference to that at paragraph 66.  
 6 I think — I don't need to ask you to repeat what's in  
 7 paragraph 66.  
 8 Those are all the questions I have for you, unless  
 9 there's anything important that you think I haven't  
 10 covered.  
 11 A. No.  
 12 MR CASKIE: Ms Napier, thank you very much.  
 13 A. Thank you.  
 14 THE CHAIR: Yes, thank you, Ms Napier. Thank you,  
 15 Mr Caskie.  
 16 Mr Caskie, we've finished early again, which is —  
 17 this is not a criticism. It's relatively common.  
 18 I don't know if the next witness is here actually.  
 19 MR CASKIE: Nor do I but I'm sure the usual channels will be  
 20 in touch, if I can put it that way.  
 21 THE CHAIR: Yes, if it's possible to start early, we can  
 22 start at about 10 to or something like that, but, if  
 23 not, we'll start at 11 o'clock. Thank you very much.  
 24 MR CASKIE: And I will see you this afternoon.  
 25 THE CHAIR: So I believe. Thanks.

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1 (10.33 am)  
 2 (A short break)  
 3 (11.17 am)  
 4 THE CHAIR: Good morning, Ms Bahrami.  
 5 MS BAHRAMI: Good morning, my Lord. Our next witness this  
 6 morning is Maurice Hickey, who is Scotland head of  
 7 policy at the Pharmacists' Defence Association, and his  
 8 statement reference number for the record is  
 9 SCI-WT0333-000001.  
 10 MR MAURICE HICKEY (called)  
 11 THE CHAIR: Thank you. Good morning, Mr Hickey.  
 12 A. Good morning, my Lord.  
 13 THE CHAIR: Right. If we're all ready, Ms Bahrami will have  
 14 some questions for you.  
 15 MS BAHRAMI: Thank you, my Lord.  
 16 Questions by MS BAHRAMI  
 17 MS BAHRAMI: Mr Hickey, please could you tell us briefly  
 18 about your own background and about the  
 19 Pharmacists' Defence Association, please?  
 20 A. My own background is that I'm a pharmacist. I've been  
 21 a pharmacist for 42 years and over that period I've  
 22 worked in all the sectors of pharmacy and I've worked as  
 23 an employee, I've worked as a contractor pharmacist and  
 24 currently I work as a locum for the trade union. I've  
 25 also been active in pharmacy politics over most of that

30

1 time and basically have sat on every board at some time  
 2 that you can get elected to, including the board of the  
 3 Royal Pharmaceutical Society of Great Britain.  
 4 I work for the PDA partly because of COVID. I just  
 5 got — by 2021 I got to a point where I'd had enough  
 6 basically and wanted out to a certain extent and the PDA  
 7 had started to restructure as a result of COVID and were  
 8 sort of changing the way they operated in Scotland.  
 9 The PDA is the largest representative body for  
 10 pharmacists. There's roughly 65,000 registered  
 11 pharmacists and we represent, as members, 38,000 of them  
 12 and we're the largest such body in the British Isles at  
 13 the moment. Roughly 10% of our members are in Scotland  
 14 and PDA is a trade union, it's also a professional  
 15 indemnifier and it's a membership organisation. So we  
 16 try and look after them, and it is only for pharmacists.  
 17 It's not for other pharmacy staff.  
 18 You know, we challenge employers, regulators and  
 19 Government on behalf of the members and we look after  
 20 the students from the day they start at university. We  
 21 offer them free membership. That's it basically.  
 22 Q. Thank you. Now, when the pandemic restrictions were put  
 23 in place, many pharmacies saw a surge in workload while  
 24 some saw a significant decline in patients and  
 25 customers. Would you tell us the reasons for this,

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1 please?  
 2 A. The reason was because of the lockdown. If you worked  
 3 in a city centre pharmacy — a lot of cities are not  
 4 like Edinburgh in the sense that they have a lot of  
 5 people living in the centre. A lot of cities have  
 6 business areas or whatever and all these people vanished  
 7 to home workers as a result of the lockdown. I was  
 8 doing the odd day very close to here and what we found  
 9 was our patients changed overnight. It was all the ones  
 10 that lived nearby that we started seeing where  
 11 previously they would have gone to pharmacies near where  
 12 they worked during the day.  
 13 I think some of the pharmacies were around railway  
 14 stations, for example, and in the more  
 15 business-orientated areas their clientele vanished  
 16 overnight, and it took a number of the companies that  
 17 controlled these pharmacies — they were mainly chains,  
 18 but they — I think it took them several months to sort  
 19 of adapt to that.  
 20 The other side of the coin was that in the more  
 21 outlying areas these pharmacies became busy because of  
 22 that, but they became much busier as a result of the  
 23 general lockdown. But this change between city and  
 24 perhaps the suburbs was quite profound.  
 25 Q. Thank you. And that led the busy pharmacies to

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1 implement a one-in/one-out queuing system. Did that  
 2 lead to issues with some patients, particularly in the  
 3 winter months?  
 4 A. It led to issues with some patients from the word "go",  
 5 but by and large people accepted it, certainly during  
 6 the first lockdown. You have to remember that  
 7 a pharmacy — when you go into a pharmacy, the patients  
 8 going to it — it can be quite a big area and there's  
 9 a bit behind that the patients are excluded from, and  
 10 it's much smaller. And in many cases we had to sort of  
 11 move forward in the shop, and to have two people queuing  
 12 in the shop, that caused problems and you were —  
 13 everything had to be done at the counter, so, for  
 14 example, if we were dealing with people that wanted to  
 15 come in for a urinary tract infection or to get the  
 16 daily supervised methadone, we couldn't take them into  
 17 our consultation rooms. That had to be done at the  
 18 counter and these are quite tricky interactions to  
 19 manage if there's a queue in the shop.  
 20 So very quickly it had to be one-in/one-out. So  
 21 when the patient came in, it was just them and whoever  
 22 was there, which led to a lot of people thinking that  
 23 not much happened in pharmacies because they're used to  
 24 them being quite bustling places, but in actual fact  
 25 there was a lot going on and, if there would be things

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1 going wrong, patients wouldn't be aware of that.  
 2 Q. Thank you. In paragraph 19 you state that:  
 3 "A number of GP surgeries were doubling  
 4 prescriptions to ensure customers/patients would not run  
 5 out. For example, instead of 4 weeks' worth of  
 6 prescription, they were issuing prescriptions for 8 or  
 7 12 weeks at a time. This also contributed to subsequent  
 8 shortages of medications, particularly for devices like  
 9 asthma inhalers."  
 10 And later in your statement you also speak about  
 11 people stockpiling over-the-counter medication, such as  
 12 paracetamol, which also led to a shortage of that  
 13 medication, and in time people stockpiling lateral flow  
 14 tests. Firstly, did that ever result in medication  
 15 expiring before it could be used and so leading to  
 16 waste?  
 17 A. I don't think anyone could say for certain if it would  
 18 have. Generally in a pharmacy if you pick up  
 19 a prescription and it's longer than the expiry, you're  
 20 given enough until the expiry date and then you're asked  
 21 to come back. That in itself was — particularly for  
 22 some of the COPD inhalers was one of the sort of issues  
 23 that caused patients to become, shall we say, agitated  
 24 because they weren't sure if they would get the second  
 25 one and they were always aware that there were shortages

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1 because it was widely publicised.

2 In terms of the — I think the idea of issuing  
 3 four-week prescriptions, there's quite a lot of evidence  
 4 that suggests that, if you eight instead of four, there  
 5 is more wastage, so — you know, it means more work for  
 6 some people, but now it's all computerised it's not so  
 7 difficult. But a 12-week prescription there's  
 8 considerably more wastage because people don't always  
 9 need it and people were ordering things they didn't  
 10 necessarily need because they might need them. You  
 11 know, that would be medicines for stomach problems and  
 12 what—not where — depending how they eat or, you know,  
 13 different factors. They would not necessarily need  
 14 a month's worth for a month, but they were coming in,  
 15 getting as much as they could, and you felt it was  
 16 always because it was, "What if we run out of things?".  
 17 So that was an issue.

18 In terms of the overall waste, I don't think anyone  
 19 has documented it. But something I've discussed with  
 20 colleagues and we noticed was that we gave out huge  
 21 amounts in — particularly in the first lockdown. This  
 22 didn't occur in the other ones because the health boards  
 23 leaned on the doctors to go back to normal prescribing  
 24 and everything settled down. But in the first lockdown  
 25 we discussed that with colleagues and we would say,

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1 "Well, that means they don't need it the next time — in  
 2 two months' time or three months' time when they're —  
 3 because they've had it when it's due", but they would  
 4 still come in and if — I looked at a few records myself  
 5 and I know others did, and it would seem that a lot of  
 6 that must have gone to waste.  
 7 Q. Thank you. It might be that GPs were pressured by  
 8 patients to double and triple prescriptions, but do you  
 9 believe that there would have been the same level of  
 10 shortages if GPs hadn't prescribed in that way and if  
 11 individuals hadn't chosen to stockpile over-the-counter  
 12 medications?  
 13 A. I mean, sadly shortages are with us all the time. It's  
 14 a major part of my job — a major part of any  
 15 pharmacist's job. But I do think that there was  
 16 a shortage of paracetamol, for example, and there was  
 17 a shortage of COPD — you know, drugs that had an effect  
 18 on breathing, inhalers and the like. And I think the  
 19 fact that people were overprescribed probably for about  
 20 six weeks from the onset of the lockdown, that  
 21 contributed to it and it took the supply chain several  
 22 months to settle back down.  
 23 Certainly, once we got into the second lockdown and  
 24 the third lockdown, I would say, yes, there were  
 25 shortages but not really significantly more than I would

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1 expect at any other time. I mean, if it happens to you,  
2 if you're the patient, it's not good news. And the  
3 shortages are very often drugs — you can't say to  
4 a diabetic, "Well, I'm sorry, we can't get your  
5 insulin". That involves changing the therapy, that  
6 involves other practitioners. There's all sorts of  
7 things to reinforce it. But generally the shortages  
8 that we hear about are the shortages of painkillers,  
9 shortages of insulin, shortages of drugs for people that  
10 have difficulty breathing, and these are all worrying  
11 for patients.

12 Q. If a patient with diabetes or COPD, health issues like  
13 that, wasn't able to get their medication, would there  
14 be a risk of them having to be admitted to hospital to  
15 be managed in a different way?

16 A. There's always a risk with every patient. Medicine is  
17 not a risk-free supply function. There were  
18 difficulties then certainly with communications with the  
19 surgeries. We would refer them to minor injuries, minor  
20 ailments or to casualty if we thought fit, but generally  
21 we would try and get them to make contact with the  
22 doctors, and we would contact the doctors and say,  
23 "Look, there's a problem with this". There's a process,  
24 it's not perfect, but I don't think that particularly  
25 failed. I think some patients got quite close — or

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1 quite stressed by the situation and, you know, I think,  
2 if they were admitted to hospital, it was because there  
3 really was nothing else that could be done. If it could  
4 be managed at home, they were managed at home.

5 Q. Did the PDA ever try to raise the issue of prescriptions  
6 with double and triple the amount of medication or  
7 issues of stockpiling by individuals with the  
8 Scottish Government?

9 A. I don't think we raised it in particular but I'm pretty  
10 sure some of the other bodies did. It was well known.  
11 As soon as it happened, I think a lot of pharmacists  
12 complained to the health boards and said, "Look, we  
13 can't manage this situation".

14 Q. Was there a view that either the Government directly or  
15 the health boards should have stepped in sooner to  
16 prevent this becoming an issue?

17 A. I don't really know what they could have done because,  
18 to be perfectly honest, it happened so quickly and they  
19 did act. I mean, perhaps they didn't act as quick as  
20 I would have liked or as the working pharmacists would  
21 have liked, but they did act. Having said that, there  
22 are professionals that will do as and what they please.  
23 I mean, that's true for all the professions, not just  
24 the medical ones. But, generally, once the health  
25 boards sort of were alert to it, I think things

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1 started — we went back to having normal shortages.

2 Q. Yes. In paragraph 21 you mention that pharmacists also  
3 took on a triaging role during the pandemic.

4 A. Aha.

5 Q. Would you tell us about that, please?

6 A. Well, that was partly because the doctors — it was very  
7 difficult to see a GP. Having said that, some surgeries  
8 were better than others. The very worst, I think, would  
9 be that the receptionist and not the doctors were just  
10 telling everybody — if you phoned the doctor, you were  
11 told go to the pharmacy and we would see them the next  
12 day or the same day and basically we had to triage them.  
13 A lot of them we could treat, it has to be said, but  
14 a lot of them we couldn't. We had to — you know, there  
15 had to be local mechanisms in place to refer them back.  
16 Some surgeries were good at handling it and some were  
17 bad.

18 Q. And that also increased your workload further?

19 A. Oh, it hugely increased our workload because you've got  
20 your normal workload that you do — and we're very busy  
21 as a rule. I suppose the best thing about a pharmacy in  
22 a sense is that there's no appointment system, anybody  
23 can walk in, anybody can access — you know, ask to  
24 speak to the pharmacist. If anything, the queuing  
25 helped in one way, but in the other, a lot of the people

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1 we were seeing — we saw — all sorts of people would  
2 just come in and I — you know, you almost thought they  
3 wanted out the house if it — you know, it was an excuse  
4 to get out the house, and I wouldn't blame them.  
5 I didn't know what it was like to be banged up for six  
6 months because I had the opposite problem, not being  
7 able to be.

8 But I think the triage system, in some surgeries the  
9 receptionists just were told to send everybody to  
10 a pharmacy and that considerably sort of increased our  
11 workload on top of what was already a huge workload.  
12 Many of us — our surveys, the PDA surveys, the  
13 Safer Pharmacies Surveys, were showing in 2017, 2018 and  
14 2019 that there was — in parts of pharmacies there were  
15 instances of burnout in the 80% range and COVID just  
16 blew that out the water. Everybody struggled.

17 THE CHAIR: Can I ask, please, this increase in the use of  
18 pharmacies for triage purposes, did that cease, go away,  
19 go back to what it was pre-pandemic when the pandemic  
20 abated or went away?

21 A. Well, no. We have a — you'll have heard of the  
22 "Pharmacy First system", where we can supply counter  
23 medicines and we get paid — the consultation — we get  
24 paid three ways. It's the same payment that you get,  
25 but we can give the patient advice, we can supply

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1 medicines or we can refer them to the GP surgery. And  
 2 Pharmacy First was relaunched in 2020. It was meant to  
 3 be relaunched in April and they postponed it to end  
 4 of July/beginning of August, which increased the  
 5 education burden on pharmacists in the midst of the  
 6 first lockdown. But the Pharmacy First system in many  
 7 ways is a triage system. So you have three choices, one  
 8 of which is to send the patient to the doctor.

9 I think the usage of the system was 2 million  
 10 patients used it in the first 15 months or so. It was  
 11 widely popular and it continues to be the same. If  
 12 anything it's busier as more and more people are aware  
 13 of it. So that triage system was in place, was heavily  
 14 used and is still heavily used, but it's structured  
 15 differently now. It's one of the positives.

16 THE CHAIR: Thank you.

17 MS BAHRAMI: Thank you. We've heard from a number of other  
 18 professionals that there were great feelings of stress,  
 19 under-appreciation, mental health was severely impacted  
 20 and there was a lot of burnout and people were leaving  
 21 their professions early; there was a sense that they  
 22 were seen as separate to the NHS and not appreciated  
 23 like NHS staff. Were those range of feelings and  
 24 actions also true for pharmacists?

25 A. Widespread, widespread. I -- when I read through the

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1 union -- the PDA did a lot of surveys, including the  
 2 Safer Pharmacy Survey, and when you read that it just --  
 3 it just comes out the page in neon that everybody felt  
 4 like that. And pharmacies -- a community pharmacy  
 5 particularly is a bit different in that it's not -- it  
 6 is part of the NHS and we deliver NHS services, but the  
 7 pharmacists, the work they're in -- the locums have no  
 8 access to the NHS pension, they're not on NHS  
 9 pay scales, they don't have the career structure that  
 10 you have with band 5, 6, 7, 8 and 9 in the NHS, so  
 11 everybody feels slightly divorced. I think,  
 12 particularly in the case of that group, the feeling of  
 13 being isolated and excluded was -- and there was other  
 14 things happened, but that feeling was magnified, if  
 15 anything.

16 I remember at the beginning of the thing we got --  
 17 we were told to stay open and there was a letter coming  
 18 round, saying, "If you get ill, contact Public Health  
 19 and they'll tell you if you can go to work". I knew one  
 20 pharmacist who worked in a pharmacy who -- they were in  
 21 an area of Edinburgh that had a lot of tourists and  
 22 there'd been lots of the rugby players come to that  
 23 area, and he got ill with what in retrospect was  
 24 obviously COVID, but when he phoned the Public Health,  
 25 they said, "You've got the wrong symptoms, go to work".

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1 You know, you have to say, on the other hand, I don't  
 2 think they knew how it was developing, but there was  
 3 more than one instance like that. It was always  
 4 a problem.

5 And then, I think initially, there were difficulties  
 6 with many of the pharmacists getting the communications  
 7 that were coming from the Government and coming from the  
 8 contractors' body, Community Pharmacy Scotland. Both  
 9 sets of communication was very good but, because of the  
 10 sort of position as employees of contractors, as  
 11 subcontractors to contractors, a lot of them didn't see  
 12 the information coming out initially.

13 That was made worse by the fact that they changed  
 14 the operating platform that the NHS email system works  
 15 on and a lot of people, like myself, who had an old --  
 16 I'd had an old nhs.net email since about 2005 and all of  
 17 a sudden they changed it to nhs.scot, and I couldn't get  
 18 one because they had problems that meant you had to be  
 19 fully integrated into the NHS to get one, and they would  
 20 allow one person in a shop, I think, to have the email  
 21 initially.

22 They've got that sorted out now but I know that  
 23 was -- having spoken to Government officials, that that  
 24 was a problem also for some of the other professions.  
 25 Locum dentists, locum optometrists and people who were

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1 peripatetic all had difficulty getting the emails and  
 2 accessing information.

3 Q. There was also an issue regarding low-paid pharmacy  
 4 staff moving to other -- leaving their jobs and moving  
 5 to other roles that were deemed less stressful; is that  
 6 right?

7 A. That's always been an issue. The pharmacy support  
 8 staff -- I mean, at the moment the Government or the  
 9 DHSC in England have put through national protocols to  
 10 allow technicians to take on some of the work in  
 11 community pharmacy under PCDs, but the employers aren't  
 12 training as many staff as they can because they pay them  
 13 so poorly that, as soon as they get them trained,  
 14 they'll go into the NHS because they can earn a third to  
 15 half as much and they have a career structure and they  
 16 get the pension and they have to work less hours and  
 17 they don't have the stresses that they get in community  
 18 pharmacies.

19 That's always an issue. All of us in community  
 20 would work with support staff who are trained, the  
 21 technicians, they're regulated, who would leave and get  
 22 more money stacking shelves or sitting on the till at  
 23 Lidl. That's something -- that doesn't affect the  
 24 pharmacist other than in the sense that we don't have  
 25 properly trained support staff around about, but,

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1 I mean, you can't blame anyone for leaving, especially  
 2 the way we were getting treated by patients, by  
 3 management, the way we all felt ignored. I would have  
 4 done the same.  
 5 Q. In paragraph 27 you state that, when people became ill  
 6 with COVID-19, while larger pharmacies could move staff  
 7 around, smaller pharmacies at times had to suddenly  
 8 close the whole pharmacy. In those areas with the  
 9 smaller pharmacies, did that lead to patients not being  
 10 able to access medication that they needed?  
 11 A. I think there was odd instances, but I don't think that  
 12 was particularly a big problem. I think initially the  
 13 larger chains were reluctant to move staff about and  
 14 then did. I think the case of the smaller chains, there  
 15 was probably a problem in the sense that, if somebody in  
 16 a particular pharmacy contracted COVID, then they all  
 17 had to isolate and that meant there was maybe one or two  
 18 staff that were normally there who hadn't been exposed  
 19 who could go back to work. So they would have to move  
 20 staff from other shops and that would spread COVID  
 21 around the group. I know a few of them were affected by  
 22 that.  
 23 The single-handed independents, which are  
 24 vanishingly rare these days, to be perfectly honest,  
 25 I think they had -- you know, they all had -- everybody

1 had problems, but it was just dealt with at the time and  
 2 I think there was a lot of thinking on the foot and  
 3 maybe minor breaking of the rules because it was the  
 4 only way we could work.  
 5 Q. Thank you. In paragraph 30 you tell us that pharmacy  
 6 owners in Scotland were paid specific funds to provide  
 7 training to their staff. Was this payment made by the  
 8 Scottish Government?  
 9 A. Every payment that the pharmacists get is paid for by  
 10 the Scottish Government. I mean, the average  
 11 pharmacy -- one or two of the big chains who have large  
 12 shops might be different -- but the average pharmacy,  
 13 the split is 90% of the funds or their payments come  
 14 from the NHS and from the Government, therefore, the  
 15 other 5% is just counter sales, and it's a diminishing  
 16 amount, especially with Pharmacy First, when people  
 17 know, "Well, why would you go and pay for something when  
 18 you can actually endure a two-minute consultation and  
 19 get it for nothing and save a tenner?". You would be  
 20 mad not to.  
 21 So all their money comes from the Government.  
 22 Within that money is included -- the current terms, they  
 23 get paid for staff training. That's not just for  
 24 pharmacists. A lot of it is -- it's for all the staff  
 25 and it's to cover things like Pharmacy First, new PG --

1 PGDs, that sort of thing.  
 2 The Government -- the civil servants tell me that  
 3 the spirit of it is that that should be spent on the  
 4 staff, but as a union we survey our members and say,  
 5 "Do you get protected learning time? Do you get time  
 6 off?", and the truth is most of them -- and I don't mean  
 7 like 80% -- but a very high percentage of them do not  
 8 and they have to do it in their own time.  
 9 Now, that was a major problem in 2020, when the  
 10 Pharmacy First -- the Minor Ailments Scheme was changed  
 11 to Pharmacy First and there was a lot of training to do  
 12 with that and there was a subsequent train of PGDs where  
 13 we would supply antibiotics for skin infections, we  
 14 could treat herpes, a number of things -- shingles is  
 15 the word I was looking for -- they all had to be done  
 16 and people had to do them at the time. And this was at  
 17 a time when they were going into work and, although we  
 18 were working less hours as far as the public could see  
 19 because we wouldn't open till 10, we'd close for lunch  
 20 and we'd close at 4.30 -- and that would be for  
 21 cleaning -- most people were just trying to catch up  
 22 with the day-to-day work. Many people were working  
 23 longer hours unpaid and then they would have been  
 24 expected to sort of undertake this burden of training in  
 25 their own time, often at weekends, and that should have

1 been family time. The employers by and large did not  
 2 pass that money on to the staff.  
 3 Q. Do you think the organisation that paid each pharmacy  
 4 should have held them to greater account for the  
 5 purpose -- to find out what they were spending the money  
 6 on? So rather than just releasing it, expected them to  
 7 account for what it had been spent on?  
 8 A. I think there could be better audit of how the money is  
 9 spent and where it goes. The simple truth is, if all  
 10 the staff do it in their own time, then the contractors  
 11 can say to the Government, "Everybody has done it so the  
 12 system works". But the system is working at the expense  
 13 of the staff and burnout. That's true for all the  
 14 staff. I mean, that's -- something I would like to see  
 15 would be better audit. I think there are different ways  
 16 of doing things, perhaps directing that to the staff,  
 17 and I think you could see that in COVID it became  
 18 a particular burden.  
 19 Q. Thank you. Now, we've heard from a number of other  
 20 professionals as well that they couldn't access furlough  
 21 funds but also couldn't sustain themselves on statutory  
 22 sick pay so had to work even when they were ill and in  
 23 some cases professionals were self-employed and so  
 24 didn't even receive sick pay. Was this also true for  
 25 pharmacists and pharmacy staff and did this contribute

1 to people leaving the profession?  
 2 A. It must have contributed. It was a major problem.  
 3 I don't think people necessarily left during COVID but  
 4 I think there have been quite a lot of people left  
 5 since, and I think that's a significant issue. If you  
 6 were a locum, a locum pharmacist, if you didn't work,  
 7 you don't get paid and they were classed as  
 8 self-employed business people. They didn't get any  
 9 furlough and they don't qualify for statutory pay. And  
 10 I do know pharmacists that worked longer than they  
 11 should have and --- especially now we know about things  
 12 like long COVID, and that's acknowledged. People did go  
 13 back to work sooner --- you know, sooner than they really  
 14 should have. At the end of the day, people have to feed  
 15 their kids, they have to pay their mortgages and you  
 16 can't really blame them for that.  
 17 In terms of the staff, I think that's --- I knew  
 18 pharmacy staff that had been furloughed and they were  
 19 people that had particular health issues, but the bulk  
 20 of pharmacy staff did go to work, and for staff who were  
 21 employees and took ill, they only got statutory sick pay  
 22 and a lot of employers within the sector don't actually  
 23 add any more on that; you get it? Now, I couldn't live  
 24 on £80 a week or whatever it is. They had colleagues  
 25 who were furloughed right through the lockdowns and the

1 whole period who were getting 80% of their wages.  
 2 The people --- we heard from --- I heard it myself ---  
 3 staff saying, "I'm not testing myself for the pure and  
 4 simple reason I can't afford to be ill". If staff had  
 5 got ill --- because we were very exposed to COVID,  
 6 everybody got ill at some point. If we'd been able to  
 7 get equity with people who were furloughed when we were  
 8 ill, which I think would have been only fair, I think  
 9 that would have gone a long way to decreasing the sort  
 10 of incidences of long COVID and people wouldn't be so  
 11 burned out, wouldn't have been so ill at the time and it  
 12 probably would have reduced the spread within the shops,  
 13 because I think people went to work when they knew they  
 14 had COVID and people certainly went back to work earlier  
 15 than they should.  
 16 Q. Thank you. We've heard from care homes that UK-wide  
 17 chains, UK-wide care home chains, often attempted to  
 18 apply English guidance in Scotland and I see from your  
 19 statement that this was also an issue for pharmacists.  
 20 You give an example of that, in paragraph 41, as staff  
 21 being able to go to work if they had COVID  
 22 asymptotically in England but in Scotland that wasn't  
 23 permitted. But UK-wide pharmacy chains were requiring  
 24 Scottish staff to be at work in accordance with English  
 25 rules and, when the PDA contacted them about this, they

1 refused to change anything until Humza Yousaf spoke to  
 2 them. Did you find a regular need for the PDA to  
 3 intervene in these situations?  
 4 A. Yes, there was --- you know, at certain periods. I mean,  
 5 the issue of mixed messaging, where the media were  
 6 reporting things as being in Britain --- and this was  
 7 more of a problem I think in the first pandemic.  
 8 Everybody got wise to it and would counteract it when it  
 9 happened later on --- but the mixed messaging that was  
 10 coming out --- and that affected patients, not just  
 11 pharmacy staff. I mean, some of our staff were confused  
 12 because the higher management, particularly in the  
 13 chains, were telling them one thing and they were  
 14 phoning us up and saying, "Is this right?", and we'd say  
 15 "No, no, that's England only" or "That's England and  
 16 Wales. This is what you have to do. So we would put  
 17 out press releases and say "In Scotland ..." or qualify  
 18 it and say, "This is the situation in England", and then  
 19 underneath, "and in Scotland and Wales it's different".  
 20 The incident you're referring to is one of the  
 21 larger chains and I think it was in April 2022 the  
 22 superintendent issued a statement to all his shops,  
 23 saying, "If you feel well enough --- if you've got COVID  
 24 but you feel well enough to go to work, go to work".  
 25 And that didn't apply in Scotland, it only applied in

1 England. We wrote to them within 24 hours of them  
 2 releasing it because, as soon as they'd emailed it to  
 3 the staff, we had people phoning us up and sending us  
 4 WhatsApps of the actual letter and saying, "Isn't this  
 5 wrong?". We contacted the company and they just said,  
 6 "We don't care. You know, we just treat all of Britain  
 7 the same", and we continued to put pressure on them.  
 8 So in the end I contacted the Medicines Division in  
 9 St Andrew's House and it was escalated to Humza Yousaf's  
 10 office, and he made a statement saying "It's different"  
 11 and they had to retract it in Scotland. So it was  
 12 always an issue that affects pharmacy. They quite often  
 13 though --- the chains --- and you can't really blame them  
 14 in a sense. You know, 90% of their pharmacies, this is  
 15 the model, and then Scotland is 10% and it's a slightly  
 16 different model, and they work on a one-size-fits-all or  
 17 they try to work on a one-size-fits-all model. It  
 18 wouldn't be a problem with the Scottish chains or  
 19 anything. It was specific to the UK-wide chains.  
 20 Q. So essentially the mixed messaging is a result of  
 21 management making a decision to ignore Scottish guidance  
 22 and apply English guidance where it shouldn't be  
 23 applied?  
 24 A. I don't think they ignored it. I don't think they were  
 25 aware. You know, they just --- they look at it from

1 an Anglo-centric point of view.  
 2 Q. Do you think they had the resources to be aware of the  
 3 different ---  
 4 A. Oh, they had the resources. I mean, they've got much  
 5 more resources than we have as a member --- a non-profit  
 6 organisation which relies on our members to give us  
 7 their income to represent them, and we could cope with  
 8 it easily. We had all sorts of checks in place so  
 9 that --- you know, we knew --- so if something happened in  
 10 Scotland, I told everybody. My equivalent in Wales did  
 11 the same. I knew what was going on in Northern Ireland,  
 12 Wales, Scotland. Sometimes I would see something happen  
 13 in Wales and I'd be going to --- lobbying the Government  
 14 and saying, "You should look at this, this works". So  
 15 if I can do it in three days a week, I'm pretty sure  
 16 that a large multi-national with, you know, their kind  
 17 of money could do that, and their staffing levels, they  
 18 could have done it. They weren't interested.  
 19 Q. Thank you. Another significant cause of concern for  
 20 pharmacists and pharmacy staff was the inability to  
 21 socially distance in smaller pharmacies, and that was  
 22 exacerbated by a lack of availability of PPE. Were  
 23 pharmacies being provided PPE by the NHS or were owners  
 24 purchasing their own PPE?  
 25 A. Three stages, I suppose. I mean, the crammed conditions

1 in pharmacy, that's something I'd like to go back to,  
 2 but the problem with PPE, I think there was three  
 3 stages, possibly four.  
 4 Some pharmacies had PPE really just because it  
 5 provided certain services or because they had a client  
 6 base that asked for it. I wouldn't say it was  
 7 widespread, but I certainly worked in one shop who had  
 8 PPE and it all disappeared overnight in late January ---  
 9 and we all laughed about all these Chinese people, for  
 10 want of a better description, coming in and buying all  
 11 the masks --- and it was because COVID was happening at  
 12 home and they responded to that, and very quickly we ran  
 13 out of them, much to our shock, and tried reordering it  
 14 and couldn't get it.  
 15 The first main stage, it was being supplied through  
 16 the Health Service, the health board, and we just didn't  
 17 get it or, if we did, it was very, very limited. Some  
 18 pharmacy owners did obtain it because they were quick  
 19 off the mark, but they didn't, I think, get very much,  
 20 and very quickly nobody had any. So we were left sort  
 21 of out there, hence the fact that in a lot of shops  
 22 people put screens up as quick as they could --- not all,  
 23 it has to be said.  
 24 So it was coming from the health board and there was  
 25 very much a feeling amongst our members that we were

1 last in the queue. That could be --- in the case of  
 2 community pharmacy, that could be because we were not  
 3 seen as part of the NHS or a full part of the NHS, but  
 4 we also had hospital pharmacies reporting to us that  
 5 they weren't getting as much and they certainly weren't  
 6 getting, you know, the better PPE. They were just  
 7 getting the simple mask, if they got anything at all.  
 8 That was resolved when the supply --- the Government  
 9 managed to put the supply through the pharmacy health ---  
 10 through the pharmacy wholesalers and we were able to  
 11 order it from them and by the end of the year it was  
 12 pretty widely available. You didn't always get it. You  
 13 had to order it every day, so you would order --- you  
 14 might need a box for a day, so you would order ten,  
 15 constantly trying to keep ahead because there were --- at  
 16 times we just couldn't get it even then. And it sort  
 17 of --- into 2021 it became normal.  
 18 But there were three stages. The employers --- some  
 19 of them tried to supply it, then it went through the  
 20 health boards and it was very sort of --- you couldn't  
 21 predict that you would get it, and then it went through  
 22 the drug wholesalers, so it came with our daily drug  
 23 deliveries and that solved the problem. I think that's  
 24 a lesson that was learned quite quickly and I think ---  
 25 if we were ever in that position again, I can't see that

1 they would do anything differently.  
 2 In terms of PPE, though --- and again this is in the  
 3 first lockdown --- there was so little in the place.  
 4 A lot of people would wear throw-away PPE. The  
 5 Government was saying --- I'd hear on the radio  
 6 John Swinney or Humza Yousaf or Jeane Freeman said,  
 7 "There's loads. Everybody's got it. We've got it in  
 8 place", and I'd be thinking, "I haven't seen any", and  
 9 there would be people phoning up on Radio Scotland and  
 10 saying, "I'm phoning from a surgery and we don't have  
 11 any", and so forth.  
 12 People had to reuse it and the guidance was that, if  
 13 you used it and took it off, you should use another one,  
 14 a clean piece. I saw drug delivery drivers who were  
 15 going out into the community and driving round patients  
 16 and they were using one piece for two weeks. You could  
 17 tell how long they were wearing it because it bobbles  
 18 and it looks dirty. People were making home-made covers  
 19 to put over them, and you would be saying to people,  
 20 "You really shouldn't be wearing that", you know. It  
 21 was a non-ideal situation, but I think we were where we  
 22 were at the beginning and I think by the end it was ---  
 23 all the problems were ironed out, but it was badly  
 24 handled.  
 25 Q. Yes. And in paragraph 50 you state that, even when PPE

1 was available, some pharmacy owners discouraged or  
 2 prevented staff from wearing PPE because, you say, it  
 3 set the wrong sort of image and was not attractive.  
 4 A. Yes, yes. We had people ---  
 5 Q. What was the PDA's views about that?  
 6 A. Well, we were so concerned about some of the things we  
 7 were hearing and some of the things that were being said  
 8 that --- because it's a retail business, I think there  
 9 was a feeling that some pharmacy owners put commercial  
 10 imperatives before, if you say, clinical imperatives.  
 11 That had several impacts. But at the beginning there  
 12 was --- a lot of them were reluctant to put up screens,  
 13 a lot of them were reluctant to have their staff put  
 14 masks on, because they thought it presented the wrong  
 15 image. It may be that some of the managers making these  
 16 decisions were not medical staff or medically trained in  
 17 any way and it may be that they just hadn't quite  
 18 grasped the seriousness of the condition, but that  
 19 happened in several places.  
 20 We issued --- we produced a risk management book ---  
 21 I refer to it in the report --- and we sent that out to  
 22 all our members and said, "This is what your pharmacy  
 23 should be doing", and they could work through it. And  
 24 that enabled them to go to employers, but there was  
 25 nothing came from the Government or --- there was

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1 a certain amount came from the contractors' body,  
 2 Community Pharmacy Scotland, but nobody, I think, other  
 3 than us produced a proper risk management tool, so you  
 4 could say, "If this is happening, you're in danger".  
 5 I mean, some of the risks you couldn't eliminate  
 6 because of the size of pharmacies. I would say in more  
 7 than half of them, to actually socially distance was  
 8 impossible. I mean, you're in a small space, small  
 9 room, and you're having to move around all the time and  
 10 everybody is moving around. We all joke that at some  
 11 point in the day everybody in the pharmacy will be  
 12 standing in the same 1-metre square, you're bumping into  
 13 people, people are coughing, people are ill. Nobody saw  
 14 that because they were on the other side of the counter  
 15 and they didn't see --- necessarily see into the pharmacy  
 16 space where we were working, and that was a problem.  
 17 Q. Did the PDA try to contact pharmacy owners that wouldn't  
 18 allow their staff to wear PPE?  
 19 A. Oh, we do that routinely. You know, people phone us up  
 20 with --- it could be, "I didn't get paid for my locum",  
 21 and we would just phone up the office and say, "We're  
 22 the PDA", and it gets solved very quick. The same  
 23 goes --- we did that with the large chain that was giving  
 24 the English guidance in Scotland. We were straight on  
 25 the phone to them. We do that as a matter of routine.

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1 If a member phones up and they've got that sort of  
 2 query, we've got people who just get on the phone and  
 3 say, "Is this right? And if it is, don't do it". And  
 4 if they don't do it, we pursue them.  
 5 Q. In respect of preventing staff from wearing PPE, was  
 6 there a view that the regulator or NHS Scotland should  
 7 have stepped in to enforce the requirement to wear  
 8 a mask or other PPE?  
 9 A. I think the regulator would take the view that they  
 10 couldn't enforce it because it's not within their remit  
 11 and I think the Government would probably say the same  
 12 because they can't actually force people to do something  
 13 unless it's in legislation. It's the same for the  
 14 regulator and ---  
 15 Q. So do you think the Government should have enacted  
 16 legislation preventing employers from preventing their  
 17 employees from wearing PPE?  
 18 A. It would have to have been emergency legislation and  
 19 part of the problem was everything that came out was  
 20 guidance and some people --- and it happens all the  
 21 time --- some people would push the envelope, as they  
 22 say, and ignore the guidance, and this was a case.  
 23 I also think in many cases it was just people who  
 24 weren't medically trained, who were in charge of medical  
 25 functions, completely misunderstanding what they were

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1 having to manage. It does beg the question that are  
 2 these the most appropriate people to manage health  
 3 professionals, health functions and things that impact  
 4 on patients.  
 5 Q. We've heard from some professionals that they suffered  
 6 higher levels of verbal and physical abuse. Was this  
 7 also the case for pharmacists and pharmacy staff at  
 8 times of shortages and queuing and the like?  
 9 A. Absolutely, categorically. It was horrendous.  
 10 Everyone, if they didn't experience abuse themselves,  
 11 witnessed it first-hand. I think we did a survey and we  
 12 found that something like 60/70% had actually  
 13 experienced it --- that could be verbal --- but 90% ---  
 14 nearly 100% of our members, when they were surveyed,  
 15 said that they had witnessed or suffered some abuse.  
 16 Now, that could be --- that could range from just  
 17 people being sarcastic and just generally shitty, for  
 18 want of a better word, right up to full-scale assault,  
 19 and that happened; people picking up things in the shop  
 20 and throwing them around and what-not. The problem with  
 21 that, from a public perception, was nobody was aware  
 22 that this sort of thing was going on and it happened all  
 23 the time.  
 24 It's not --- with most patients it didn't because  
 25 of --- if you say 95% of patients are wonderful, it's

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1 the 5% that cause you all the bother that stick in your  
2 mind and affect your mood at the end of the day because  
3 it — you know, your adrenaline gets going, you're in  
4 that sort of situation with a confrontation. It's not  
5 good to experience.

6 To get it day on, day out, was particularly bad in  
7 terms of everybody's mental health and so forth. You  
8 used to dread going to certain places because you knew  
9 what they were like. It was just constant. I mean,  
10 we've got one of our senior reps, she was held up at  
11 knife point. We've also got a lot of members who are  
12 black minority ethnic community pharmacists and they  
13 suffered a lot of targeted racist abuse, you know. And  
14 it can be things as simple as, "We've had to order that  
15 in for you especially and it will be here tomorrow", and  
16 you're just standing there and there's somebody acting  
17 like it's the Texas Chainsaw Massacre and — you know,  
18 and it goes like that [clicks fingers]. That was what  
19 I think most people struggled with. You never knew who  
20 was going to do it and you never knew when it was going  
21 to happen, but it did.

22 Q. Thank you. You touched on it there, but in  
23 paragraphs 84 to 91 you talk about issues for BAME  
24 workers and other disproportionate impacts. In  
25 paragraph 85 you're referring to BAME and female

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1 pharmacists and you state:

2 "Both groups were shown to be worse affected in  
3 a number of ways during the pandemic."

4 Can you tell us what some of those issues were and  
5 whether you consider anything could have been done,  
6 particularly by the Scottish Government, to alleviate  
7 those issues?

8 A. I think we weren't the only people to raise it. The UK  
9 Black Pharmacist Association and I think at other times  
10 the Royal Pharmaceutical Society raised it as an issue.  
11 The factors that affected female pharmacists were —  
12 there's more female pharmacists than male pharmacists  
13 and there is a very high proportion of our workforce  
14 that is BAME. They had problems at home with their  
15 families and so forth and their communities, but in  
16 terms of just being at work, they were an easy target  
17 for people that were stressed. Somebody that is just  
18 freaking out generally, they would be the person they'd  
19 pick in the room to unload on because, if they did it to  
20 me, I would give them it back. But they would think  
21 that, "The little girl in the corner, she's not going to  
22 talk back to me", and there was a lot of bullying. It  
23 was just sort of — it just became endemic and constant  
24 and it particularly affected them.

25 And, as a group, the Government was producing — the

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1 English Government or the Westminster Government,  
2 rather, was producing evidence to sort of say that quite  
3 early these groups were actually more prone to — maybe  
4 because of the way — their living conditions or where  
5 they lived in cities — they were more prone to getting  
6 COVID. I think that preyed on their minds as well. You  
7 know, you don't need to go into work and then be picked  
8 on forever when the disease seems to be picking on you.

9 We certainly raised the issue very quickly with —  
10 I think it was Christine McKelvie MSP who was — I think  
11 it was the Equalities Committee or something like that  
12 that she was convenor of, and we followed it up. It was  
13 just something that was there. It applied to all  
14 pharmacists with protected characteristics. There was  
15 a lot of abuse towards all pharmacists.

16 I mean, myself, I have a hearing disability as  
17 a result of a car crash many years ago and I would get  
18 it off patients. They would be saying things to you  
19 like, "Are you deaf?" and I'd pull out my hearing aid  
20 and say, "Yes, can you speak up?", and then they'd start  
21 shouting their head off at you. All the screens, that  
22 made the situation worse for lots of people. It made it  
23 worse for a lot of patients with similar disabilities.  
24 But in terms of the BAME pharmacists, I think our  
25 surveys and the UK Black Pharmacist Association surveys

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1 would appear to say that they got more of it or they  
2 were more likely to get it —  
3 Q. Okay, thank you.

4 A. — and more of them are female, if that answers your  
5 question.

6 Q. Thank you. In paragraph 111 you state that while  
7 usually a pharmacy can't dispense medication when the  
8 pharmacist is absent, "the regulator permitted [us] ...  
9 a specific time-limited dispensation when no penalty  
10 would be applied if, in specific circumstances, ready  
11 assembled medicines were being collected by patients in  
12 the physical absence of a pharmacist", but there was  
13 a requirement for a pharmacist to be available by  
14 telephone during that short period.

15 A. Hmm—hmm.

16 Q. You say, however, that almost immediately corporate  
17 pharmacy owners started taking advantage of that  
18 relaxation and in paragraph 113 you state that, "These  
19 companies attempted to run some pharmacies with no  
20 pharmacist present at all", while requiring locums to  
21 have to manage multiple pharmacies by telephone. What  
22 issues did that create, the lack of a pharmacist being  
23 there and locums having to spread their attention across  
24 multiple stores?

25 A. Well, the first factor that increases when the

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1 pharmacist is not there is there is an increased danger  
2 to the patient because there is no pharmacist to  
3 consult. That by its very nature is the primary danger.  
4 This issue arose partly — and I think the dispensation  
5 from the GPhC, the General Pharmaceutical Council, who  
6 are the regulator — I think the situation arose because  
7 you did have situations where a pharmacy would have to  
8 close and there would be medicines there that were  
9 bagged up and ready to go. So it was really to ensure  
10 the patients still got their medicines while — in this  
11 space while the pharmacy got sorted out and got cleaned  
12 and got re-opened and so forth. So there was that.

13 But very quickly what we found the employers were  
14 doing was they were saying to their staff, "Would you be  
15 able to cover two shops?". You can only have one  
16 responsible pharmacist per pharmacy. You can't be  
17 responsible for another one geographically distant, even  
18 if it's 30 yards up the street. What these particular  
19 companies were saying was — they would say to the  
20 staff, "Can you cover that other shop? We don't have  
21 a pharmacist there". They would say, "There's  
22 a shortage of pharmacists", or they would book a locum  
23 and say, "But we want you to cover two shops". Now,  
24 saving on the pharmacist's salary is a significant  
25 salary, if you can do that. That was a commercial

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1 decision because there was in fact no shortage of  
2 pharmacists.

3 The reason I can say that is that in the lockdown  
4 people didn't take holidays because who would take  
5 a holiday and sit looking at four walls at home when you  
6 can at least get out? By and large people just worked,  
7 particularly in the lockdowns, and then had their  
8 holidays after. So we got — we had complaints from  
9 members who were locums, who were saying, "I'm having  
10 all my bookings cancelled", and then we were finding out  
11 they were cancelling bookings and the shop wouldn't open  
12 and they would operate differently, and they would  
13 say — the companies would say, "There's a shortage of  
14 pharmacists". Well, there was this pool of locums who  
15 were no longer able to work because their bookings were  
16 cancelled and there was also the fact that — I think  
17 they took 3,000 retired pharmacists on to the register.  
18 So instantly there was a pool of thousands of  
19 pharmacists who could work in all sectors and there was  
20 no shortage and these companies were trying to run  
21 pharmacies — two pharmacies on one pharmacist.

22 So we very quickly — the union very quickly lobbied  
23 the health departments — they didn't seem so  
24 interested, it has to be said — and the regulator, and  
25 the regulator issued a statement, saying, "You can't do

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1 this". I mean, it affected our members, but the major  
2 reason was the most dangerous thing you can do with  
3 a pharmacy is run it without the pharmacist; all those  
4 checks are not there, which is when the patient comes in  
5 and you speak to them.

6 The numbers of times you say, "Have you got any  
7 questions?", or they'll come in and present and you look  
8 at them and you know something's wrong — take that  
9 away — or there's nobody to explain how you take your  
10 medicine — they always say in our profession, "If you  
11 really want to scare yourself, tell a patient something  
12 and then ask them what you've just told them". It is  
13 scary.

14 Q. When the regulator issued that statement, did that put  
15 an end to the practice or did some continue?

16 A. It put an end to that practice, although I mean even to  
17 the current day we see instances of it, and again it  
18 occurs with the chains, where on a Saturday they'll try  
19 and get somebody to cover two pharmacies and they'll  
20 cite the fact that they can't get a locum. We have  
21 instances then where we've recorded the closed  
22 pharmacies and locums had offered to work at reasonable  
23 rates and they said, "No, no, we just decided to close",  
24 and they still get paid.

25 Q. Yes, I wanted to ask you about that actually. In

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1 paragraphs 124 and 126 you speak about that, that  
2 corporate pharmacies chose to close temporarily rather  
3 than pay for locum pharmacists and that they were still  
4 reimbursed by the Scottish Government for services they  
5 were either unable or unwilling to provide. You  
6 contrast that with the situation in Wales, where they  
7 would not be reimbursed in that situation.

8 A. Hmm—hmm.

9 Q. Is it the view of the PDA that the Scottish Government  
10 should consider the Welsh position and consider  
11 declining to pay in that situation in the hope that it  
12 would lead to a decline in the rate of closure?

13 A. If I can explain it, the way they get paid — they  
14 negotiate every number of years a different contractual  
15 framework for the pharmacies to get paid, pharmacy  
16 owners to get paid, and they get paid all sorts of  
17 different kinds of payments which loosely can be split  
18 into two: activity payments and non-activity payments.  
19 An activity payment would be one that you wouldn't get  
20 paid for if you're not open. That's  
21 dispensing/supplying medicines. But if you close for  
22 one day in six, generally you'll displace them into the  
23 other five days, so you have five days where you're  
24 busier and you get all the activity payments.

25 The other ones were they get paid for supplying

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1 services, like Public Health services or whatever,  
 2 but — and it also includes things like the education  
 3 payments that we were talking about earlier. There's  
 4 a whole variety of them. But they get paid them  
 5 irregardless of whether they don't open and we've  
 6 estimated they could be worth between £400 and £700  
 7 a day. So there's a significant saving that can be made  
 8 by not opening the pharmacy and displacing the activity  
 9 work into their other hours.

10 We have lobbied the Government, the  
 11 Scottish Government, and been told that it would require  
 12 legislation to change that and that can only be done  
 13 when the new — the next contractual framework is  
 14 negotiated, which will be in a few years, probably for  
 15 2026, so we would hope that we can get something put in  
 16 place.

17 The Welsh situation was that, when they negotiated  
 18 the contract, the Government of Wales slipped it in  
 19 that, "If you don't open, you won't get paid", and  
 20 I don't think the contractors thought very much about it  
 21 at the time because, if they could prove there was  
 22 a good reason — your shop had been flooded or you were  
 23 in a rural area and somebody couldn't — you had  
 24 a period when you couldn't open because somebody got ill  
 25 or whatever, these were fairly rare and you never

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1 thought about it, and then of course COVID happened and  
 2 there was this knock—on from the contractors or the big  
 3 chains where they closed.

4 We were monitoring the situation and finding there  
 5 was increasing numbers of — they were abusing the  
 6 situation in all three mainland British countries, and  
 7 the Welsh Government turned round and said, "You can't  
 8 do that, you know. If you do that and you haven't got  
 9 good reason, we'll not pay you. We'll take the money  
 10 back. We'll recover the money". And the upshot of it  
 11 was we had pharmacists from Scotland and England phoning  
 12 up and saying, "I'm being phoned up by so—and—so and  
 13 they're saying, 'Can you go and work in Wales?'" So it  
 14 does work, and it can't work in Scotland because it's on  
 15 the basis of an already—negotiated contract that's in  
 16 legislation and to change it they would actually have to  
 17 bring in legislation in the current Parliament —  
 18 emergency legislation — and I don't think there's  
 19 a willingness to do that.

20 Q. Thank you.

21 THE CHAIR: You're into your last ten minutes, Ms Bahrami.  
 22 MS BAHRAMI: Thank you, my Lord.

23 In paragraphs 130 to 135 you talk about pharmacists'  
 24 involvement in vaccine sessions and that pharmacists  
 25 took steps to prepare to contribute to the vaccine

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1 roll —out in anticipation of the vaccine programme  
 2 commencing but they were subsequently excluded or given  
 3 much lower rates of pay than previously agreed while  
 4 pharmacy owners were still paid the higher rates for  
 5 supplying their employees for the roll —out. Would you  
 6 please tell us about that, including the perceived role  
 7 of the CPS in that outcome and the effect on the rate of  
 8 vaccination in the community?

9 A. Well, first of all, I don't think it actually affected  
 10 the rate of vaccination. It was a technical thing and  
 11 it was something that we felt was very unfair. They  
 12 asked for people to go and become vaccinators and they  
 13 were offering a rate of pay of £70 an hour — I think it  
 14 was a three—hour session that you did — and they made  
 15 it open to dentistry — dentists, optometrists and  
 16 pharmacists.

17 Now, in the case of pharmacy, a lot of pharmacists  
 18 are very accomplished vaccinators. I learned to — I've  
 19 been doing vaccinations since 2005 so I have a lot of  
 20 experience in it. I'm not untypical. And what happened  
 21 was they offered this and lots of pharmacists  
 22 immediately signed up, particularly the locums, who, you  
 23 know, were able to do it, had done the training and  
 24 couldn't get work because contractors weren't employing  
 25 them. Very quickly, they turned round and said, "No,

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1 pharmacists couldn't do it".

2 Now, bear in mind pharmacists were more experienced  
 3 than the other groups, so when they started working,  
 4 they were helping train the others, they'd done  
 5 additional training in their own time, which costs  
 6 money, and they had to take out additional insurance  
 7 because they were doing COVID vaccinations and so forth.  
 8 So they laid out this money to be able to do it and then  
 9 all of a sudden they were told that pharmacists would no  
 10 longer be able to apply for it unless they are — and  
 11 they will be paid at the same rate as a band 5 nurse,  
 12 which is — I don't know what it is, but it's about £18  
 13 an hour.

14 Q. Yes, I think in your statement you say that the initial  
 15 rate offered was £69 per hour —

16 A. 69.

17 Q. — and that was reduced to 14.50 per hour.

18 A. 14.50 at the time, yeah, that would be correct. But  
 19 what they had agreed with — I don't think it was  
 20 Community Pharmacy Scotland, the higher level, it was at  
 21 the local level, and this affected in particular  
 22 Greater Glasgow. What the agreement they'd come to with  
 23 them was that the pharmacy contractors could send  
 24 a member of staff, and the member of staff, they would  
 25 get paid 14.50 for the member — they would get paid 69.

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1 If a locum went, he got paid 14.50. If the owner sent  
 2 a member of his staff, he would get paid 69 and he could  
 3 book a locum at a lot less than that and they made  
 4 a profit on it.  
 5 We complained to the Government, we complained to  
 6 Greater Glasgow, and Greater Glasgow sent a letter to  
 7 us, which you've got a copy, saying that they had to  
 8 take account of commercial imperatives and they didn't  
 9 want to increase the shortage of pharmacists. And they  
 10 were worried that if all the locums, many of whom  
 11 couldn't work because they weren't being employed, took  
 12 on this work, there would be no pharmacists to work in  
 13 the shops. And you think, this doesn't square up. So  
 14 it was an abuse of a sort of position and really it was  
 15 something that was undertaken by people at the health  
 16 board, I think, who were probably gaslighted in some  
 17 way, to help — the contractors made money out of it and  
 18 our members lost a lot of money out of it.  
 19 Q. Thank you.  
 20 Now, we have your statement, I'm just conscious of  
 21 the time as well, and we will consider it in its  
 22 entirety alongside your oral evidence today. We just  
 23 have a couple of moments left. Is there anything you  
 24 would like to highlight at this point that we haven't  
 25 covered?

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1 A. I think one other thing, very briefly, that we didn't  
 2 cover was the £500 bonus payment and this goes back to  
 3 the fact that pharmacies or pharmacists in community  
 4 aren't really seen as a proper part of the NHS. There's  
 5 a sort of snobbery about it. First of all, some of the  
 6 employers weren't willing to pass the payment on to  
 7 pharmacies, they weren't willing to make the claim for  
 8 the locums and even, in one case, for their staff  
 9 because they didn't — you know, couldn't be bothered.  
 10 It was in Scotland and they were a national chain, they  
 11 don't — you know, they weren't going to take that  
 12 focus.  
 13 We had set up a helpline for all the people that  
 14 couldn't claim the payment. When it was finally agreed,  
 15 after we'd lobbied the Government, that it should apply  
 16 to pharmacists delivering NHS services, most people got  
 17 the notification that they could claim later than they  
 18 could make the claim. And in some cases they had — if  
 19 you had three days at most, if the employer had already  
 20 made the claim, they couldn't make the claim on behalf  
 21 of you. So we had to set up a helpline and get all  
 22 these people sort of listed. And it took up to  
 23 eight months after they paid the bonus to everybody else  
 24 to get it for all staff, including people that were  
 25 missed out because they were on maternity leave.

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1 And when they set up a portal — the Government set  
 2 up a portal to enable us to get in, they set it up and  
 3 not everybody could get in because they had to give  
 4 a contractor number where they had worked, which is  
 5 a four-figure number, and they were checking that you'd  
 6 worked in all the places you'd claimed, to make sure you  
 7 weren't making an illegal claim. And if you worked in  
 8 the health boards or you worked for a hospital or for  
 9 a GP practice, you couldn't make the claim. So we had  
 10 to go back, and it went on.  
 11 It was a classic example of how, you know, we as  
 12 a group felt that we were in some way not felt to be  
 13 part of the NHS and yet we were the group that were open  
 14 all the time. If there's anything I think I would like  
 15 to see come out of this, it's maybe that all pharmacists  
 16 should be employed by the NHS and the NHS can set  
 17 health-based priorities for them.  
 18 It's a bit like The Divine Comedy and Dante arrives  
 19 outside the gates of hell and he meets Virgil, and  
 20 Virgil is standing there, he's got all this knowledge  
 21 and he's the great philosopher and he's got lots to  
 22 offer. He can't get into hell and he can't get into  
 23 heaven, he's stuck in the middle. That's a bit how  
 24 I feel we were, out in purgatory.  
 25 MS BAHRAMI: Thank you very much.

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1 A. Thank you.  
 2 THE CHAIR: Yes. Thank you, Mr Hickey. Good. 1.30.  
 3 (12.31 pm)  
 4 (The short adjournment)  
 5 (1.30 pm)  
 6 THE CHAIR: Good afternoon, Mr Caskie.  
 7 MR CASKIE: Good afternoon, my Lord. Our witness this  
 8 afternoon is Neil Mathers.  
 9 MR NEIL MATHERS (called)  
 10 THE CHAIR: Very good. Good afternoon, Mr Mathers.  
 11 A. Good afternoon, my Lord.  
 12 THE CHAIR: Right, when you're ready, Mr Caskie.  
 13 MR CASKIE: Thank you, my Lord.  
 14 Questions by MR CASKIE  
 15 MR CASKIE: Would you tell the Inquiry your full name?  
 16 A. My name is Neil Mathers.  
 17 Q. You've provided helpfully a witness statement for the  
 18 assistance of the Inquiry. I think the witness  
 19 statement has just appeared on the screen.  
 20 A. It has.  
 21 Q. Do you recognise that?  
 22 A. I do.  
 23 Q. I think you've signed the witness statement at the end.  
 24 Before you signed it, had you read it?  
 25 A. Yes.

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1 Q. And are you content that the content of the witness  
 2 statement is true?  
 3 A. I am.  
 4 Q. And do you want the Inquiry to take account of all of  
 5 the witness statement as part of your evidence to it  
 6 today?  
 7 A. Yes, please do.  
 8 Q. For the purposes of our records, the witness statement  
 9 has a reference number which you don't need to concern  
 10 yourself with, but it's SCI-WT0481-000001.  
 11 Which organisation are you here from? Samaritans?  
 12 A. I work at Samaritans. My job role is executive director  
 13 for Scotland.  
 14 Q. Can you tell us a bit about the Samaritans? We probably  
 15 know what it is but it is probably better to hear it  
 16 from you.  
 17 A. Yes, Samaritans is a suicide prevention and crisis  
 18 support charity. We've been working in the UK and  
 19 Ireland for the last 70 years. Our vision is to ensure  
 20 fewer lives are lost to suicide and we do that by  
 21 tackling inequality and the risk factors that make it  
 22 more likely that people might take their lives.  
 23 Q. Okay. In terms of your own role as the executive  
 24 director for operations for Scotland — you say  
 25 something about your role in paragraph 7 of the witness

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1 statement and you indicate there what it is that you do,  
 2 but if you could just tell us what it is that you do?  
 3 A. Yeah, I'm responsible for our operations across  
 4 Scotland, so that includes research, public policy,  
 5 influencing campaigns, marketing, communications,  
 6 service programming and partnership development.  
 7 Q. And from paragraph 9 of the witness statement I see that  
 8 you are a UK-wide charity.  
 9 A. Yeah, we work across the UK, Republic of Ireland,  
 10 Channel Isles and Isle of Man.  
 11 Q. Don't forget the Isle of Man!  
 12 How does the organisation structure itself in terms  
 13 of the different nations or regions that it's involved  
 14 with?  
 15 A. So the organisation is led by a chief executive and  
 16 governed by a board of trustees. In Scotland we have  
 17 a sub-committee of the board of trustees, which is  
 18 called the "Scotland Committee", and that's made up of  
 19 some existing listening volunteers within our  
 20 organisation and some co-opted independent experts that  
 21 support us with our work. The Scotland Committee is  
 22 responsible for overseeing and having devolved  
 23 decision-making for public policy, partnership  
 24 development and influencing within the wider Samaritans  
 25 strategy.

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1 Q. At paragraph 11 you say something about the breadth or  
 2 the geographic spread of the Samaritans in Scotland.  
 3 Can I just ask you to explain about that and the  
 4 difference between charities and affiliate branches —  
 5 sorry, branches and affiliate branches?  
 6 A. Yes, so across the UK and the Republic of Ireland we've  
 7 got around 200 branches which support the work that we  
 8 do. Some of those are what we call "central charity  
 9 branches", so they belong to the main charity of  
 10 Samaritans, and some are what we call "affiliate  
 11 charities" which — affiliate branches — which are  
 12 charities in their own right and operate under an  
 13 agreement with our Samaritans central charity.  
 14 So in Scotland we have 19 branches. Seven of those  
 15 are within the central charity and the remaining are  
 16 part of — are affiliate branches and they manage their  
 17 own affairs and fundraise for their own operational  
 18 costs.  
 19 Q. Okay. Does the organisation have full-time equivalent  
 20 employees?  
 21 A. Yes. So we have 300 — just over 300 members of staff  
 22 across the UK and the Republic of Ireland. In Scotland  
 23 we've got ten members of staff.  
 24 Q. Right. Now, having been through the statement, it seems  
 25 to me that many of the statistics and information that

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1 you provide are UK-wide rather than Scotland-specific,  
 2 and we're obviously a Scotland-specific inquiry. Is it  
 3 not possible to disaggregate Scotland out or are you so  
 4 inextricably linked?  
 5 A. Unfortunately it's difficult for us to do that. The  
 6 main service that we provide is a helpline, which is  
 7 offered 24/7 all year round and it's serviced by our  
 8 volunteers, 23,000 volunteers, across UK and Ireland.  
 9 That service is managed across the broad spectrum of all  
 10 five nations, so if someone phones the helpline, they  
 11 could be speaking to any of our trained volunteers  
 12 anywhere in the country. It's a confidential, anonymous  
 13 helpline, so we don't record calls, we don't ask people  
 14 where they're from, so to disaggregate that data would  
 15 be impossible really.  
 16 Q. So people who make contact with the Samaritans from  
 17 Scotland won't necessarily be speaking to someone in  
 18 Scotland and vice versa?  
 19 A. That's right.  
 20 Q. I know that you have a well-known number. I think it's  
 21 116 123. Does that — how is it decided where that  
 22 telephone call is going? Once I dial that number,  
 23 what's the internal system for working out who picks up  
 24 the other end of the phone?  
 25 A. So we have a telephone infrastructure that manages all

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1 calls coming through and is able to direct callers to  
 2 the available listener, wherever they are. So every  
 3 volunteer, when they go into a branch to start a shift  
 4 with us, will log into the system, will make themselves  
 5 known in the system that they're available and then the  
 6 digital technology that we use enables callers to be  
 7 directed to the person available. That's how it works  
 8 across the whole country.

9 THE CHAIR: I suppose I'm in danger of putting my toe into  
 10 waters about which I know nothing — I apologise in  
 11 advance — but I suppose that the rationale is that the  
 12 needs — no doubt there are many different needs, but  
 13 the needs or concerns of people that contact Samaritans  
 14 through the helpline are not geographically distinct, in  
 15 other words, the same sort of needs are as likely to  
 16 occur in Dover as they are in Dundee and so forth and so  
 17 on, and therefore it doesn't really matter where the  
 18 person to whom the call is directed is located or  
 19 am I wrong in that?

20 A. No, you're right, my Lord. The way that we — the  
 21 service essentially is a listening service, so we don't  
 22 provide advice, we don't refer callers to other forms of  
 23 support, although, if asked, we do signpost callers to  
 24 support that they might need. But essentially it's  
 25 a confidential, non-judgmental listening service and

1 that's the main function.

2 MR CASKIE: When I phone the Samaritans, as it were, the  
 3 person I speak to will be a volunteer?

4 A. That's right.

5 Q. How many volunteers do you have in Scotland?

6 A. In Scotland we have around 1,000 volunteers working  
 7 across the 19 branches, and some of those are also  
 8 volunteers working within our prison Listener scheme.

9 Q. Okay, I'll come on to the prisoners' listening scheme  
 10 shortly. Can you tell me what the Scottish budget is  
 11 for Samaritans?

12 A. So to deliver the work that we do across the listening  
 13 service and through our central charity branches as well  
 14 as the Scottish operation, I estimate it's about  
 15 £1.1 million that it costs each year to run that. It is  
 16 an estimate because, as I've said previously, the  
 17 listening service is funded and supported across the UK  
 18 and the Republic of Ireland, so there's a proportionate  
 19 cost that's included within that figure that I've given  
 20 you for Scotland.

21 Q. And how many branches do you have in Scotland?

22 A. We've got 19 branches.

23 Q. 19. We know in some detail about the impact on many of  
 24 lockdown. Tell me about the impact of lockdown on the  
 25 Samaritans.

1 A. So for Samaritans, like most organisations, we had to  
 2 quickly adapt and respond to the restrictions that were  
 3 brought in at the beginning of the pandemic, so our  
 4 Samaritans listening volunteers were given key worker  
 5 status, so that helped enormously in enabling them to be  
 6 able to go to their branches and provide the listening  
 7 service and support the shift patterns that we needed to  
 8 provide.

9 Obviously the pandemic also affected our volunteer  
 10 base and for some they may well have had to self-isolate  
 11 for their own protection or were unable to come into  
 12 branch, so that did have an impact on our ability to  
 13 maintain shift patterns as we normally would. We  
 14 weren't actually, although my statement — if I can make  
 15 a quick correction. I've said that all 19 branches did  
 16 remain open — actually 17 branches remained open, so  
 17 there was two branches that did have to close during the  
 18 restrictions, particularly from April 2020 through that  
 19 first year of the pandemic.

20 Q. Was that closure as a consequence of the physical size  
 21 of the premises?

22 A. It was a mixture of the physical size and also they were  
 23 two very small branches in terms of number of  
 24 volunteers, so maintaining shift patterns was very  
 25 difficult during that period.

1 Q. We've heard a lot from what might be called "third  
 2 sector organisations" about introducing systems to  
 3 facilitate people working from home. Was that something  
 4 the Samaritans did on any scale?

5 A. In Scotland we maintained the support through the  
 6 branches in the main. Outside of Scotland there was the  
 7 possibility to do that through the NHS helpline that we  
 8 ran in partnership with NHS England and Wales —

9 Q. Again that's something else —

10 A. — which we'll come back to.

11 Q. — that we'll come back to.

12 So your volunteers were physically going in to your  
 13 offices. I understand from the statement that, prior to  
 14 lockdown, you were providing a face-to-face support  
 15 service. What happened to that?

16 A. So that had to stop immediately and the impact of that  
 17 was felt long after really the restrictions were lifted.  
 18 We're really only in the last year beginning to offer  
 19 face-to-face support within our branches, but not all  
 20 branches have been able to undertake that.

21 Q. Did you increase the amount of work that you were doing  
 22 online?

23 A. We introduced —

24 Q. — during the pandemic?

25 A. We introduced an online chat service as part of our

1 wider listening service. So the listening service is  
 2 made up of our 24/7 helpline, which most people know,  
 3 which is the phone service; we have an email component  
 4 of that, so people get in touch with us by email and we  
 5 provide emotional support through written word; and we  
 6 introduced an online chat service, which — another  
 7 written word, but in real-time; and we also have  
 8 a letter service, so we have a correspondence branch  
 9 providing emotional support through the written word and  
 10 through the postal service.  
 11 Q. Is the chat function still continuing?  
 12 A. The online chat function is still continuing and that  
 13 will become a primary component of the listening service  
 14 in the future.  
 15 Q. Was that something that was introduced at the time of  
 16 the pandemic?  
 17 A. It was something we were working on before the pandemic  
 18 but for obvious reasons became vitally important it was  
 19 made available. We also received some funding from  
 20 Scottish Government to support the development of online  
 21 chat.  
 22 Q. Okay. I'm looking at paragraph 19 now, where you talk  
 23 about the fact that when the pandemic started you  
 24 weren't in post.  
 25 A. That's right.

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1 Q. When was it you started?  
 2 A. I started in post in September 2022.  
 3 Q. So at the time of the pandemic, before you were  
 4 employed, how many staff did the Samaritans have?  
 5 A. At the start of the pandemic there was two members of  
 6 staff working.  
 7 Q. So it moved from two to now ten?  
 8 A. That's right.  
 9 Q. And how many of those were recruited during the  
 10 pandemic?  
 11 A. I think most of the new members of staff were recruited  
 12 in 2022. One or two may have started in 2021.  
 13 Q. And you were recruited in 2022; is that correct?  
 14 A. That's right.  
 15 Q. Tell me about — looking back on it, reflecting back on  
 16 the recruitment process, how was that handled in terms  
 17 of employing new people, including yourself, during the  
 18 pandemic?  
 19 A. I think it's difficult to comment about how that was  
 20 handled during the pandemic. My own experience was that  
 21 it was a very positive — by that time I was able to  
 22 meet face to face with those that were recruiting me  
 23 into the role, although we have moved to more of  
 24 a hybrid recruitment model since the pandemic. So we  
 25 used online tools to be able to interview staff during

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1 the pandemic and appoint them to roles and we continue  
 2 to do that but mix it with in-person interviews as well.  
 3 Q. Okay. You said earlier that two of the branches hadn't  
 4 functioned during lockdown and you needed to correct  
 5 part of your statement. I'm looking at paragraph 20.  
 6 Is that where the correction needs to be made?  
 7 A. That's right, yeah.  
 8 Q. Okay. At 22 you talk about staff being furloughed — or  
 9 "remained working throughout the pandemic". I inserted  
 10 "furlough" so correct me if I'm wrong. What happened  
 11 there?  
 12 A. We didn't furlough any staff other than those working in  
 13 shops.  
 14 Q. And of the ten staff that you have now, how many of  
 15 those are shop workers or managers and how many are  
 16 involved in the core business of the Samaritans?  
 17 A. In Scotland, all ten are involved in the core business.  
 18 We have one Samaritans charity shop in Scotland, based  
 19 in Edinburgh, and that's run by the Edinburgh branch and  
 20 by volunteers.  
 21 Q. Volunteers, okay. In terms of staffing the organisation  
 22 and presumably — and you'll correct me if I'm wrong,  
 23 I hope — finance for staffing, the period during and  
 24 just after the pandemic is a period of significant  
 25 growth for the Samaritans as, if I can put it this way,

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1 a business rather than as front-line volunteer workers.  
 2 A. Yeah.  
 3 Q. How was that co-ordinated within the charity?  
 4 A. It was a decision before my time, that there was clear  
 5 opportunities for investment in the Scotland team to  
 6 take advantage of opportunities to work in partnership,  
 7 particularly with Government, to make suicide prevention  
 8 a priority and to increase our visibility and our voice  
 9 in our campaigning in Scotland to support and encourage  
 10 help-seeking and help-giving for those who need  
 11 emotional support.  
 12 So there was a decision prior to the pandemic to  
 13 make that investment, but that was boosted through  
 14 further work to identify areas such as the  
 15 West Highlands and Skye, where we developed a project  
 16 where there was higher risks of suicide and where we  
 17 didn't have any branch support, so to invest some  
 18 innovation in programming within that area. So we were  
 19 boosted with funding from Scottish Government through  
 20 the COVID transition and the Recovery Fund to make that  
 21 happen.  
 22 Q. That's another thing which I'll ask you about. The way  
 23 that your statement is structured is you provide general  
 24 information and then, at the end, you focus on  
 25 particular projects that the organisation does and

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1 that's basically the way that I'll do it.  
 2 A. Okay.  
 3 Q. So these are all introductory remarks and we'll come  
 4 back to the specific projects. One of the things that  
 5 one might think as a civilian, if I can put it that way,  
 6 is that calls to the Samaritans during the pandemic  
 7 might have increased quite significantly. Is that  
 8 correct or did you see something different?  
 9 A. We didn't see an increase in the volume of calls to the  
 10 listening service during the pandemic. We saw an  
 11 increase in the volume of calls at particular periods,  
 12 particularly where there was new restrictions brought in  
 13 in lockdowns, where there was an increase to the volume  
 14 of calls, particularly late night/early morning, so  
 15 (overspeaking — inaudible).  
 16 Q. You talk about that at 26 as — you talk about that  
 17 being from 2.00 am to 6.00 am —  
 18 A. Yeah.  
 19 Q. — being a particularly heavy period —  
 20 A. Yeah.  
 21 Q. — for calls. I was surprised to read that because  
 22 I thought it might just have been — it might have been  
 23 just after 6 o'clock, when the ministers had just  
 24 finished speaking to the country, as it were, as  
 25 happened almost every day, but it was the middle of the

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1 night that you saw — your organisation saw  
 2 a significant shift.  
 3 Now, in 26 you provide some interesting statistics,  
 4 12% increase in calls during that 2.00 am to 6.00 am,  
 5 and presumably that's compared to pre-pandemic?  
 6 A. Indeed, yeah.  
 7 THE CHAIR: And for the avoidance of doubt, it's like for  
 8 like, so it's 12% increase between 2.00 am and 6.00 am  
 9 compared with 2.00 am and 6.00 am periods before the  
 10 pandemic?  
 11 A. That's right, my Lord.  
 12 THE CHAIR: That is interesting.  
 13 I suppose I should ask why. Do you have any idea?  
 14 MR CASKIE: Do you know why?  
 15 A. I would be speculating, but I think that that period of  
 16 the evening or the morning is when we might receive  
 17 calls from people in extreme distress, so we're seeing  
 18 that increase during the most severest of lockdowns in  
 19 that early part of the pandemic. So it — we could make  
 20 a comparison that there was an increase in distress over  
 21 that period.  
 22 Q. Of the day?  
 23 A. Yeah.  
 24 Q. Because what you seem to be saying — and again please  
 25 correct me if I'm wrong — is that there was

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1 a significant increase in the volume of calls that you  
 2 were receiving during that period of time but there was  
 3 no overall increase. You know, you receive a certain  
 4 number of calls every day and that didn't change, it  
 5 just shifted within the day?  
 6 A. That's right. And over the first year of the pandemic,  
 7 we answered 2.5 million calls over that period.  
 8 Q. UK and Ireland—wide?  
 9 A. UK and Ireland—wide.  
 10 Q. 2.5 million?  
 11 A. Yeah. Last year, just to give you a comparison, we  
 12 answered 3.3 million calls, so the volume of calls has  
 13 gone up over the last number of years.  
 14 Q. I know you weren't working there at the time but off the  
 15 top of your head — we'll find this from other places if  
 16 we require it — what was the volume of calls in the  
 17 year before COVID kicked in?  
 18 A. That's a good question which I don't have an answer to  
 19 right now.  
 20 Q. You don't have an answer to. That's fine. One of the  
 21 places that we might be able to find an answer to that  
 22 is in the report that you refer to at paragraph 28,  
 23 where you refer to One Year On.  
 24 A. Yeah.  
 25 Q. Can you just tell us about the One Year On report —

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1 A. Sure.  
 2 Q. — without going into necessarily the content of it?  
 3 A. So we produced a report one year after the restrictions  
 4 were brought in and it was a report that did an analysis  
 5 of the existing caller data that we had, so this is  
 6 anonymous caller data. We do record some basic  
 7 information about the types of issues and concerns that  
 8 callers share with us. We supplemented that with some  
 9 primary research with our volunteer listeners to get  
 10 a better sense of what they were hearing on the calls  
 11 and with the NHS healthcare worker line also and then  
 12 did some primary research to look more broadly at the  
 13 other issues that were going on at that time. So we  
 14 compiled all of that to create the One Year On report.  
 15 Q. And you provide us with some information in relation to  
 16 that kind of information at paragraph 28 and further  
 17 down, where you integrate references to COVID into your  
 18 call or response. You said there were some types of  
 19 calls where COVID came up and other types of calls where  
 20 it didn't. Can you tell us about the differentiation?  
 21 A. Yeah, so we saw a strong association with coronavirus  
 22 concerns in relation to calls around mental ill health,  
 23 loneliness and isolation, work and study pressures,  
 24 physical health. So those are concerns that we hear  
 25 routinely on the line, but during the pandemic they were

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1 strongly associated with worries and concerns about  
2 coronavirus.  
3 Q. I'll come back to that, but at 29 you say there was a 9%  
4 increase in issues of loneliness and isolation in  
5 2020/21 compared to the previous year so --- and you've  
6 already drawn COVID in as a factor which arose commonly  
7 in calls relating to loneliness and isolation; is that  
8 correct?  
9 A. [Nods]  
10 Q. You also talk about types of calls where coronavirus  
11 didn't arise as an issue. You do that in 28. Again,  
12 can you tell us a bit about that?  
13 A. It was something that we observed through the analysis,  
14 that there was clear distinction where there was some  
15 issues, as I've mentioned, around family, relationship,  
16 work, study, health, where coronavirus was a factor, but  
17 some of the other areas that can come up in calls around  
18 substance misuse, addiction, issues around sexuality or  
19 gender concerns, that those weren't strongly associated  
20 with concerns around coronavirus at the time.  
21 Q. Okay. And at 31 you talk about a self-help app. Again,  
22 tell us about that.  
23 A. So we launched a self-help app across the UK in the  
24 early stages of the pandemic. It could be accessed  
25 through our main website or downloaded as a mobile app.

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1 The purpose of it really was to provide another  
2 accessible way to provide support to people who might  
3 have been struggling during the pandemic. So it had  
4 a range of tools, techniques and exercises that people  
5 could use to support their self-care.  
6 Q. Does that continue to be available?  
7 A. We just made a decision to withdraw the app now, just  
8 because of declining usage.  
9 Q. Right. Now, the next part through almost to the end of  
10 your --- sorry, the next part of the witness statement  
11 through to the end is really about different projects,  
12 as I describe them --- I know you don't describe them as  
13 "projects" --- and I want to ask you about those in  
14 a second.  
15 A. Okay.  
16 Q. But I also want to ask you something about --- before we  
17 do that --- about the process by which Samaritans deal  
18 with an individual. I'm not asking, you know, what  
19 techniques or training and so on that an individual  
20 volunteer will receive, but what happens when the  
21 volunteer puts the phone down, the call has ended? What  
22 follow-up is there? Because you say you don't give  
23 advice, you occasionally --- or you, when appropriate,  
24 signpost. What happens when you put the phone down?  
25 A. For the listener?

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1 Q. No, for the ---  
2 A. The caller?  
3 Q. --- volunteer.  
4 A. For the volunteer. So when the volunteer listener puts  
5 the phone down, they will record some basic information  
6 about the call that they've listened to. So we have ---  
7 on the system we've got some standard issues and  
8 concerns that will come up and will change from time to  
9 time over the course of the service running and the  
10 volunteer will mark which concerns or issues were  
11 raised. The length of the call will be recorded also  
12 and that gives us an indication of how long, obviously,  
13 a call was needed. That information goes into the  
14 system and it's formed the basis of the One Year On  
15 COVID report. So we did an analysis of that caller  
16 data.  
17 Q. And is there any follow-up for the volunteer in terms of  
18 supporting that individual?  
19 A. In terms of supporting the volunteer, every volunteer is  
20 encouraged to --- before they take another call --- so if  
21 there's any impact on them in terms of what they've  
22 listened to, they always work with a peer by their side  
23 and there is always a shift leader available. So if  
24 there's any distress caused by that, then they would  
25 have someone available to be able to listen and to

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1 support them.  
2 At the end of every shift, there's a mandatory  
3 debrief session with the two volunteers that have been  
4 on shift at that period. That's not optional and that's  
5 in order to protect our volunteers, to make sure that  
6 anything that they've heard that evening or morning has  
7 been processed and they can leave the branch not taking  
8 that home with them.  
9 Q. You talk about the volunteers at 33 and onwards and you  
10 talk about the training that volunteers get and a move  
11 to make that more online. Can you tell us about that,  
12 please?  
13 A. So we have quite extensive training in place for our  
14 listening volunteers, which includes weekly training  
15 which we call "core training", it includes mentoring  
16 with an experienced Samaritans listener and then further  
17 training before they are able to take calls themselves.  
18 It's quite extensive. Pre-pandemic that was all face to  
19 face and delivered in branch. When the pandemic came  
20 in, all of that training had to stop and it took us  
21 about a year to adapt and to provide an online  
22 alternative to that.  
23 So we set up support for branches to be able to move  
24 online and we also created a training school, which is  
25 managed across the UK, which gives us extra capacity to

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1 manage that training. So we can bring volunteers  
 2 together or prospective volunteers together from all  
 3 parts of the country and support them through that  
 4 training in that way as well as providing the  
 5 training —

6 Q. That must have been quite a big change for the  
 7 organisation because prospective volunteers in Edinburgh  
 8 would previously be trained by people in Edinburgh and  
 9 you've now moved so that they might be being trained by  
 10 someone in Aberystwyth or wherever the college is.

11 A. We maintain both versions, so, for example, the  
 12 Edinburgh branch continued to provide training online  
 13 after that initial pause of a year, but we added to that  
 14 an additional capacity managed from the centre to be  
 15 able to support those branches that maybe struggle to  
 16 provide that online training. So in Scotland we do have  
 17 a number of smaller branches with lower numbers of  
 18 volunteers. That means it's more difficult to find  
 19 volunteer leaders to take on that training role, so this  
 20 is an additional support to branches who may be in that  
 21 position.

22 Q. Okay. At paragraph 32 you talk about one of the  
 23 specific services that you provide, which is a service,  
 24 as I understand it, for NHS workers.

25 A. Yeah.

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1 Q. Can you tell us about that?

2 A. So in England and Wales we built a partnership with them  
 3 to offer a listening service for health and social care  
 4 workers across the NHS, so that was also staffed by our  
 5 listening volunteers. Some of those volunteers  
 6 delivered that service remotely from home and indeed  
 7 some of our volunteers in Scotland contributed to the  
 8 delivery of that service in England and Wales. So  
 9 I mentioned earlier in our discussion that some of our  
 10 Scotland volunteers were unable to go into branch for  
 11 their own health concerns but we were able to provide an  
 12 opportunity for some to be able to contribute  
 13 remotely — unfortunately, only for England and Wales  
 14 healthcare workers.

15 Q. One of the things that we've heard on a number of  
 16 occasions from volunteer organisations is that the  
 17 number of volunteers increased during lockdowns. Was  
 18 that also true for the Samaritans?

19 A. We had a lot of interest at the beginning of the  
 20 pandemic and throughout of people who wanted to  
 21 volunteer and lend support. Due to some of the issues  
 22 and challenges that I've already mentioned in that first  
 23 year, it meant we weren't able to capitalise on that  
 24 flood of interest and support that people wanted to  
 25 give, primarily because we couldn't train them

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1 immediately. So we've been, since then, working through  
 2 those people who still want to volunteer with us and try  
 3 to bring them onboard.

4 Q. And at that time you will have lost a number of  
 5 volunteers for the reasons you described; people who  
 6 said, "No, I don't want to be coming in to do it any  
 7 longer". Overall, have the new additions filled the  
 8 gaps?

9 A. I think overall, yes. We've done well, I think, over  
 10 the last year or two to be able to bring new people  
 11 through. All of our branches are operating training  
 12 programmes now and we've got the additional capacity of  
 13 the training school that I've mentioned, so we are now  
 14 able to bring new volunteers through into the service.  
 15 But it remains a priority for us to extend our  
 16 recruitment and our promotion and to make our  
 17 volunteering as accessible as possible to as many groups  
 18 across Scotland as possible.

19 Q. I asked about the number of volunteers that you have and  
 20 you said the number was around 1,000.

21 A. Hmm—hmm.

22 Q. Has that altered significantly over recent years?

23 A. It's remained relatively stable in Scotland. I would  
 24 say that there is probably a trend slightly downwards in  
 25 terms of the number of volunteers that we have at branch

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1 level. It is a challenge to be able to attract and  
 2 support volunteers into the listening service. It's  
 3 a demanding role, it would require quite a big  
 4 commitment from people and they're giving their time  
 5 freely for no reward themselves.

6 So it is a — we have a lot of interest in the role  
 7 itself, we have a lot of applications, we put people  
 8 through training, but we also have a lot of people  
 9 pulling out at that stage and not committing to the role  
 10 itself, partly because of the demands that it has.

11 Q. And so people will start the training and then say, "No,  
 12 this isn't for me"?

13 A. Yeah.

14 Q. Okay. You then move on to talk about specific —  
 15 another specific what I've referred to as "project",  
 16 which is the prisoner listening service, at 38. Again,  
 17 without going through this in particular, can you tell  
 18 us how that works or how that worked?

19 A. So the prison listener scheme is a scheme operating in  
 20 Scotland in partnership with the Scottish  
 21 Prison Service. It's a peer support scheme, so we train  
 22 people in prison as listeners, they make up part of our  
 23 volunteer cohort in Scotland and they provide  
 24 face-to-face emotional support to other people in  
 25 prison. They're supported by a dedicated branch so each

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1 prison scheme will have a branch that's attached to them  
 2 and a team of volunteers that provides that training and  
 3 support to listeners within the prison community.  
 4 Q. And how was that impacted by COVID?  
 5 A. So the prison Listener scheme stopped immediately as the  
 6 lockdown restrictions were brought in. Prison movement  
 7 was no longer possible, face-to-face contact was no  
 8 longer possible, so that had to stop.  
 9 There are two other channels that are provided for  
 10 for people in prison. The helpline which — the 116 123  
 11 number, which you mentioned, remained available to  
 12 prisoners and Scottish Prison Service provided mobile  
 13 phones for —  
 14 Q. And we heard quite a lot about the provision of mobile  
 15 phones, both from SPS and also from the Prison Officers'  
 16 Association, so we know about those going in. I take it  
 17 116 123 was a number that was pre-programmed into the  
 18 phone and that prisoners could freely call?  
 19 A. So prisoners could freely call. I can't say it was  
 20 pre-programmed, but the number was heavily promoted  
 21 across the Prison Service so — and it was free for  
 22 prisoners to use.  
 23 Q. We heard that the — right, that's fine.  
 24 A. I'd just add that the third channel is the letter  
 25 service, so prisoners could also use our letter service

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1 to provide emotional support through written word.  
 2 Q. Right. At paragraph 43 you talk about a particular  
 3 relationship with Network Rail. Tell me about that.  
 4 A. So that's a UK partnership between Samaritans and  
 5 Network Rail. It's funded through Network Rail and it  
 6 provides rail staff and contractors with training and  
 7 support to be able to recognise and respond to people in  
 8 distress both within railway stations and in or near  
 9 railway lines. It also provides what we call  
 10 "postvention support", so anyone who has witnessed  
 11 a suicide attempt or a death by suicide, we provide  
 12 support directly to them to help them with the distress  
 13 that they may feel as a result.  
 14 Q. And do Network Rail fund that?  
 15 A. Network Rail fund that and in Scotland we work closely  
 16 with both Network Rail, ScotRail and British Transport  
 17 Police to support that service.  
 18 Q. And, again, was that impacted by COVID?  
 19 A. We were able to continue that service throughout COVID,  
 20 partly because of the key worker status of our  
 21 volunteers. The rail services were running as well, so  
 22 we were able to continue to do that work. We did use  
 23 online more. In terms of the training it was safer and  
 24 easier to do so, so we brought in that online technology  
 25 to support the work.

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1 Q. The next project, as it were, you refer to as  
 2 "Step by Step". Can you tell us about that one?  
 3 A. So Step by Step is again a postvention programme, so it  
 4 provides support to — in the main educational  
 5 establishments, schools, colleges and universities —  
 6 directly to senior management teams, who may be in  
 7 a position of preparing or thinking about how to respond  
 8 to a potential suicide and supporting them in the event  
 9 that that happens. So we have a specially trained group  
 10 of volunteers across the UK. We have some in Scotland  
 11 as well. Around 70 volunteers make up that group.  
 12 Q. In the UK or Scotland?  
 13 A. In the UK. I think we have around five or six in  
 14 Scotland. We moved that service on to online very  
 15 quickly. So we have a dedicated phone number and email  
 16 address for that service and can respond within hours in  
 17 the event of any incident.  
 18 Q. Is that a proactive service in the sense that do you  
 19 contact an educational establishment if you hear or read  
 20 of a suicide in the venue or do you wait for people to  
 21 come to you?  
 22 A. We wait for people to come to us. So we don't approach  
 23 schools, colleges or universities in that event.  
 24 Primarily we don't want to be opportunistic around the  
 25 service or presumptuous that we're needed. We do

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1 proactive work in what I'd call "preparedness", so we  
 2 help those institutions with critical incident planning,  
 3 and that is where we can be a bit more proactive and get  
 4 in touch and work with those senior management teams.  
 5 But we wait until they get in touch with us.  
 6 Q. And you also talk about Facing the Future.  
 7 A. So Facing the Future is another service delivered  
 8 through specially trained volunteers. It's  
 9 a bereavement support service for those bereaved by  
 10 suicide. It's a peer support service. Prior to the  
 11 pandemic it had been delivered in person, facilitated by  
 12 our listening volunteers, and has since moved to be an  
 13 online support service, and actually it will probably  
 14 remain that way because of the feedback that we've had  
 15 from those that have engaged with the service that it's  
 16 working well.  
 17 Q. You also talk about, at 49, West Highlands and Skye.  
 18 Tell me about that.  
 19 A. So the West Highlands and Skye project came about partly  
 20 as a recognition that, in rural and remote areas such as  
 21 the Highlands, there was a high rate of suicide. It was  
 22 also an area where Samaritans didn't have any branches  
 23 so we didn't have any existing volunteers. So we  
 24 devised a range of interventions, one, to build  
 25 awareness across those communities in those remote and

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1 rural areas around help-seeking and encouraging people  
 2 to reach out to Samaritans if they needed help and to  
 3 make sure that we were building, I suppose, that  
 4 credibility with people living in that area.  
 5 We conducted some research looking at the impact on  
 6 lone and isolated workers, particularly trying to  
 7 understand what protected lone and isolated workers  
 8 working in remote and rural areas and what could we  
 9 learn from that and share with other organisations and  
 10 with Government. We delivered training to workplaces  
 11 and community organisations in helping to build their  
 12 skills and confidence around conversations with people  
 13 who may be struggling or in distress, so helping  
 14 employers understand when somebody might need additional  
 15 support —  
 16 Q. And you, at paragraph 50, identify a number of worker  
 17 groups that you particularly focused on —  
 18 A. Yeah.  
 19 Q. — in that geographic region. Can you tell us about  
 20 that?  
 21 A. Yeah. So we focused on people who were physically  
 22 isolated through the work that they do, so, for example,  
 23 crofting, aquaculture and so on; those that were working  
 24 in more transitory seasonal work, so, for example, in  
 25 hospitality and tourism, where they may feel isolated

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1 within the communities that they live and not have that  
 2 social network to get the support that they need; and  
 3 then looking at the high-risk occupations, so  
 4 particularly blue-light organisations, people working  
 5 within NHS, where there might be professional  
 6 expectations on their role of always being there for  
 7 others that might make it a barrier for them reaching  
 8 out and getting the support that they need. So those  
 9 were broadly the three areas that we looked at.  
 10 Q. And at 52 you talk about your learning and development  
 11 programme. Again, I think that's something that you may  
 12 have referred to previously about training for  
 13 employers. Tell us about that in a bit more detail.  
 14 A. So we delivered around 20 courses and a number of  
 15 webinars over the last year or so, and that's directed  
 16 towards small businesses, employers, different  
 17 workplaces, community organisations that are working to  
 18 support people within the community, and it was about  
 19 building skills and confidence, around recognising  
 20 distress, providing a compassionate listening support  
 21 and being able to signpost and steer people towards  
 22 support if they needed that. The feedback from  
 23 everybody actually on those courses was it was very  
 24 helpful for them in building their capabilities around  
 25 that.

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1 Q. Okay. The next part of your report is statistical in  
 2 the sense of — can you tell us, was there an increase  
 3 in suicide rates during the lockdown and pandemic  
 4 period?  
 5 A. We haven't seen an increase in deaths by suicide over  
 6 the — during the pandemic. Broadly speaking, over the  
 7 last ten years, the rates of suicide in Scotland have  
 8 remained around the 800 figure, so we haven't seen  
 9 a significant impact on that.  
 10 Q. So about 800 a year?  
 11 A. Yeah.  
 12 Q. You move on to talk about the organisation's  
 13 relationship with the Scottish Government. Can you tell  
 14 us a bit about that?  
 15 A. So I've mentioned some of the funding that we've  
 16 received from Scottish Government for both the listening  
 17 service, our work in the West Highlands and Skye and, in  
 18 addition to that, we've been key partners in the  
 19 development of the national Suicide Prevention Strategy,  
 20 Creating Hope Together. So we were a member of the  
 21 National Suicide Prevention Leadership Group up until  
 22 last year, when the new strategy was published. We were  
 23 then appointed strategic outcome lead for outcome 1 of  
 24 the strategy, which is focused on ensuring that the  
 25 environment protects against suicide. So that work is

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1 focused on policy development that tackles inequalities  
 2 and risk factors that lead to suicide.  
 3 Q. And within the organisation, who takes the lead on that?  
 4 A. I take the lead on that.  
 5 Q. And do you have others who work with you on it directly;  
 6 yes?  
 7 A. Yes. So I take the lead on that alongside our head of  
 8 policy and policy manager.  
 9 Q. Okay. At 61 you talk about your research and reports  
 10 and you talk about a number of reports that you've  
 11 produced, including a report which you refer to at  
 12 paragraph 62 as the "Social Renewal Advisory Board's  
 13 report". Then you provide us with a useful summary to  
 14 that. I've read the whole report, but this is a good  
 15 summary. Can you tell us — in fact, could you just  
 16 read 63?  
 17 A. Sure. So:  
 18 "[The report showed] that the mental health impact  
 19 of Covid-19 was not being felt equally across the  
 20 population of the UK and will likely exacerbate existing  
 21 socio-economic inequalities. The impact could lead to  
 22 worsening mental health outcomes for at-risk groups  
 23 including those living in the poorest communities and on  
 24 the lowest incomes. Our Covid-19 caller research, which  
 25 was UK-wide and done in 2020, was undertaken in response

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1 to concerns raised among our volunteers that the  
 2 pandemic was causing similar worries among high-risk  
 3 groups. The research showed an increase in calls to our  
 4 helpline from men discussing feelings of fear and  
 5 uncertainty about the future. Job insecurity, fear of  
 6 job loss and redundancy were [also] key concerns. Young  
 7 people experienced a much greater decline in their  
 8 mental health than others. This was primarily a result  
 9 of a loss of coping mechanisms, a lack of peer contact,  
 10 and uncertainty about what the future holds in terms of  
 11 education and employment. Lockdown has exacerbated  
 12 existing mental health conditions; people were worried  
 13 that their conditions would worsen as access to mental  
 14 health services and community support was significantly  
 15 limited. Failing to address the mental health impact of  
 16 Covid-19 could lead to worsening levels of mental health  
 17 and illness among high-risk groups. In effect this  
 18 could limit the ability of some groups to participate in  
 19 the active labour market and hinder Scotland's economic  
 20 recovery. Poor mental health is a significant barrier  
 21 to secure employment and, conversely, insecure  
 22 employment can lead to poor mental health.”  
 23 Q. Thank you very much for that. That will provide us with  
 24 assistance in drawing our own conclusions.  
 25 At 65 we're into a section headed "Lessons Learned"

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1 and there you have some positive things to say about the  
 2 Scottish Government in terms of their dealings with you.  
 3 Do you want to say a bit more about that?  
 4 A. I think our experience both in terms of working  
 5 collaboratively with the Scottish Government on our  
 6 West Highlands and Skye project has been very  
 7 constructive and positive. We've worked in a way that  
 8 was about trying to understand what could be done  
 9 differently and could be improved and to cascade that  
 10 learning through that project to influence practice in  
 11 the future, and Scottish Government wholeheartedly  
 12 supported and got involved in that area of work.  
 13 I think the other element to highlight would be the way  
 14 in which we've worked with them on influencing the  
 15 strategy for suicide prevention and the role that we now  
 16 play in trying to lead the delivery of certainly part of  
 17 that.  
 18 Q. In terms of lessons learned at paragraph 67, you talk  
 19 about your newly developed email hub. Tell us about  
 20 that.  
 21 A. So I mentioned the email service earlier and indeed  
 22 during the pandemic we saw an increase of that service  
 23 by 23%, I think we had around half a million contacts  
 24 through our email service. Partly as a response to that  
 25 and to ensure that we were responding timely to those

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1 contacts, we created an email hub. So our branches  
 2 contribute to the email service but the email hub is  
 3 a way of being able to recruit volunteers specifically  
 4 to deliver that service alone rather than also  
 5 contributing to the helpline. That was a key focus of  
 6 our West Highlands and Skye project, so recruiting  
 7 people from that region where we couldn't offer an  
 8 opportunity to help us with the helpline but where we  
 9 could provide remote working opportunities to contribute  
 10 to the email hub.  
 11 Q. At paragraph 70 you say:  
 12 "We are only now beginning to get the face-to-face  
 13 part of our service up and running again and had to work  
 14 out how we were going to do that safely."  
 15 Could you tell me a bit about that?  
 16 A. So the face to face in branches is now up and running in  
 17 a lot of branches but we had to make some physical  
 18 adaptations. We took the opportunity during the pause,  
 19 where we brought that to a close, to look at our service  
 20 standards around that, make improvements, particularly  
 21 around safeguarding and protecting our volunteers who  
 22 provide that service. It's an ad hoc service, so people  
 23 don't make an appointment. They can just turn up at the  
 24 door and ask for that support. So that is now up and  
 25 running, but not in every branch.

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1 We also provide face-to-face emotional support in  
 2 community settings. So many of our branches,  
 3 immediately as we were able to do so, would go out into  
 4 public spaces and provide that listening support where  
 5 people are. That's something that we want to see  
 6 increased over the next few years and indeed my team is  
 7 looking at how we can target that in West Highlands and  
 8 Skye particularly, so working alongside community  
 9 organisations that are trusted by local people and  
 10 ensuring that that emotional support is provided in  
 11 a place that they feel safe and trusted.  
 12 Q. Now, you said earlier in your evidence, when you were  
 13 talking about in prisons, that your face-to-face  
 14 engagement had ended at the time of lockdown. Has that  
 15 come back?  
 16 A. We're almost back to where we were pre-pandemic. So  
 17 pre-pandemic we had 19 Listener schemes running in  
 18 Scotland. We now have 17 Listener schemes.  
 19 Q. In prisons?  
 20 A. In prisons.  
 21 Q. And is it the intention that you'll get back to 19?  
 22 A. It's our intention to grow it beyond that. We feel it's  
 23 a really vital service. People in prison are  
 24 a high-risk group in a high-risk setting, so this year  
 25 we'll be looking to do a valuation of the Listener

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1 scheme to better understand its value and impact and  
 2 look at ways in which we can grow that further.  
 3 Q. Okay, thank you very much. I have one final thing to  
 4 say to you in a moment, but those are all the questions  
 5 that I have for you. I hope that I've covered all of  
 6 the ground that you indicated you wanted covered in your  
 7 witness statement. Is there anything else of  
 8 significance that you want to add that I've not asked  
 9 you about?  
 10 A. No, I think we've covered a great deal.  
 11 MR CASKIE: I just wanted to say, to take your organisation  
 12 from two members of staff to ten members of staff in the  
 13 short time you've been there is very impressive.  
 14 A. Thank you.  
 15 THE CHAIR: Yes, thank you, Mr Mathers. And that's all for  
 16 today.  
 17 MR CASKIE: That's all for today, my Lord.  
 18 A. Thank you, my Lord.  
 19 THE CHAIR: Tomorrow morning at 9.45.  
 20 (2.28 pm)  
 21 (The hearing adjourned until Friday, 10 May 2024 at 9.45 am)  
 22  
 23  
 24  
 25

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