OPUS 2

Scottish Covid-19 Inquiry

Day 53

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(9.50 am)

THE CHAIR: Good morning, Ms Bahrami.

MS BAHRAMI: Good morning, my Lord. Our first witness this morning is Mrs Emma McConnachie. She's a podiatrist in private practice and also a media and communications officer for the Royal College of Podiatry and Mrs McConnachie's statement reference number for the record is SCI-WT0669-000001.

THE CHAIR: Thank you. Good morning Mrs McConnachie.

A. Good morning, my Lord.

THE CHAIR: Very good. We'll just start by asking some questions by Ms Bahrami. When you're ready, Ms Bahrami.

MS BAHRAMI: Thank you, my Lord.

EVIDENCE OF EMMA McCONNACHIE

Examination-in-chief by MS BAHRAMI

MS BAHRAMI: Please could you start by telling us a bit about your background?

A. I've been a podiatrist since 2004. I set up my own business in January of 2005 and have run that now for 19 and a half years. In January 2021, I joined the Royal College of Podiatry or the College of Podiatry, as it was then, as media and communications officer and for four and a half years prior to that, I was a nonexecutive director with the organisation, known as a

council member, but I have been involved with the organisation since graduation as a volunteer as well.

Q. Thank you. Now, your business is as a self-employed sole trader?

A. Yes.

Q. What was your podiatry practice like in terms of structure and the cases that you treated prior to the pandemic restrictions being put in place?

A. So despite being sole trader, I do have multiple podiatrists that work in my practice as well as an admin team. So prior to the pandemic, this would have been I think four or five staff that we had podiatrists. We provided a wide range of different foot care services. It tended to be people who had difficulty accessing their own feet and needed assistance with different things, those who failed to meet NHS criteria or chose to go a private route for speed, convenience, anything else. So we would deal with people who just needed simple foot care needs, such as difficulty managing their own health, right the way through to more complex issues where somebody maybe had lost the feeling in their feet or the circulation in their feet. We would perform minor surgery, issue antibiotics. A bit like being a dentist, but just to say for the feet. We tended not to see anybody that needed very complex wound

care or anybody who maybe was exceptionally high risk, because they would have usually been seen by the NHS podiatry provision.

Q. Thank you. And as the -- once the pandemic restrictions were put in place, I understand you had problems accessing medical supplies?

A. Yes.

Q. Could you tell us about that?

A. Of course. We had difficulty accessing several types of supplies. The most prominent one was personal protective equipment or PPE. We had restrictions placed on us quite early on. I would say approximately a week before lockdown came in some suppliers chose to stop supplying to the private sector in order to honour their NHS contracts.

Now, as we use the same PPE as the NHS, this did make supply a little bit trickier. Throughout the pandemic, sort of the heightened period, this continued and then slowly things would ease off. At first it was just PPE, then it spread to dressings and general medical supplies that we would have used in our everyday treatments. So we had to get quite creative sometimes. Amazon became one of my most reliable suppliers, sadly so ...

Q. Did you ever have patients who needed dressings or other

medical supplies that you just simply didn't have?

A. Yes, there was times where we didn't have the right wound care products that we would like, because we simply couldn't get the supplies. We would then have to think up alternative items that we could use. We had to plan quite far ahead as well for things. I mean, for example, nail surgeries, typically, we would have maybe seen one a week or one every two weeks. At one point, we treated ten nail surgeries in one week, which was a very stark increase. So I had to plan ahead, get supplies. One of my orders didn't actually come in, so I had to go to my colleagues in other practices to sort of beg and borrow, could we get ones, because orders were just failing to appear. The timeline that you would be given would not always be accurate so you had to plan quite far ahead and often order the same thing from maybe three different places to try and make sure it would be in in time.

Q. What were the delivery times scales or was it that things still had to be produced then shipped or was it just down to the delivery chain essentially?

A. It would vary greatly. Sometimes it was the supply actually coming into your supplier. You would be sometimes checking back twice a day to see if something had changed. I remember on one occasion an email went

out from a supplier saying that a certain type of disinfectant wipe had come into stock and within about half an hour it was sold out, because everybody had just clicked that and gone through and that was with it being limited to, for example, four per customer.

Other times it would be a delivery was expected, it hadn't arrived, so your order would be put on hold or it would just simply be cancelled and refunded. Other times it was you were given an expectation and you just got no communication as to when it was going to show up. It wasn't unusual to see an item might be a four month wait.

Q. As long as four months?

A. Yes. It was very, very variable, but that was really our suppliers also didn't have the information and it was kind of changing all the time. I think that was probably felt across many sectors, but, yeah, we just had to do the best we could with the estimates we were being given.

Q. Yes, thank you. Once the pandemic restrictions were put in place in the initial stage, how did your practice change?

A. It pretty much changed quite dramatically the Saturday before lockdown came. We read the Corona Virus Act 2020. We saw that allied health professionals that were

HCP registered could be called, drafted, conscripted into the NHS, at which point we realised there's very big changes coming quite soon. We cancelled all nonessential appointments at that stage. We took the decision -- it was a collaborative decision led by me. We cancelled all of our nonessential patients. We brought forward anybody who we felt would be at risk if they weren't treated in the next few weeks, at risk of skin breakdown, ulceration or infection and we offered them appointments on a sooner basis in anticipation of lockdown.

I sent my nonessential staff home on the Monday. They were told not to come in and then 8.00 pm on the Monday night we got word that lockdown was coming. So after that we couldn't treat anybody that was general care, it became urgent or critical care only. That would be if somebody had an open or active wound or it was life threatening. Now, within private podiatry that meant pretty much nobody. So for about six weeks we treated nobody and it took a little while until we could start slowly increasing those number of people that we were able to treat, but it was a very sudden change for our business and our practice structure.

Q. Yes, thank you. In paragraph 30 you mentioned you could foresee what was coming because you had worked in

private healthcare during swine flu?

A. Yes.

Q. Did that experience prepare you somewhat for this pandemic and to go to the -- to take the step of reading the Corona Virus Act?

A. Well, when I worked during swine flu, we didn't have restrictions placed on us, but from my colleagues in the NHS they spoke of preparedness within the NHS organisation, there had been talk of them being ready for mass vaccination, you know our PPE classification changed, so it was now swine flu approved, so that gave you a bit of an insight into what was happening. I mean infection control understanding as well came in. This was a Corona virus. It was expected to be transmitted by contact. Therefore, that meant we knew there would be restrictions coming on how we acted as healthcare professionals.

So that teamed with what was happening in other countries around the world being reported in the media and the implementation of the Corona Virus Act, we kind of put two and two together and came up with five and took the necessary steps that we felt necessary to keep our staff and our patients safe.

Q. Thank you. And you've mentioned that you had to cancel the routine work to prioritise more vulnerable patients.

How did the patients whose appointments you cancelled react to that? Were they content and understanding?

A. Some. Some were verbally abusive. They didn't understand. Some didn't believe that this disease was a threat and didn't understand why this would impact on their needs. As time went on, things became a little bit trickier when people were being cancelled that they still didn't believe that their personal needs didn't meet the criteria and everybody's pain is their own and that was the worst pain they were feeling, which I completely understand, but in the later picture we just simply couldn't treat them. But, yes, I was subjected to a reasonable amount of verbal abuse by patients and some of those patients are no longer patients because of the way they acted towards myself or my staff at that time so.

Q. Did you tell them?

A. Yes, they were warned about behaviour and then if that continued, they were struck from our books, but I say probably about 75% of our patients understood at first. As time went on, things did get a little bit more frustrated for them, because they couldn't understand why they weren't allowed to still be seen so.

Q. Thank you. And in paragraph 33 you state that you offered general advice over the phone and by email?

A. Yes.
Q. Is that something you also did prior to the pandemic?
A. Not in the same way, no. Prior to that would have been maybe a little bit of general advice of a, oh, well, this is something that a podiatrist could treat, come on in and we'll have a look at it, you know, can give you some advice. Prior to the pandemic, I wouldn't have ever been prepared to give advice really from a photograph. We had to completely change our thought processes on what is termed remote consultations where you would use video or photographs.

We had to change how we triaged as well, because it simply became it wasn't possible to see the person so we had professional guidance that came out on this and it was really an emerging area, because it wasn't something people were really familiar with. Training your patients how to take a picture with a camera phone, for example, can be quite difficult. I got a lot of unfocused pictures of carpets and rugs and not feet, but those who weren't familiar with technology -- it's very difficult to get an accurate description from, for example, an 86-year-old person who's living alone of what they feel their condition it. You have to learn different language and terminologies to get a patient to accurately explain it to you, so it was a bit of a

learning curve for that one.
Q. And you mentioned that you subsequently moved to start using video calling. Were your older patients able to use that technology or did they need help at home with that?
A. Not just the older patients, some of the younger patients as well. I think there is a general assumption that because of age you will be technological savvy and that wasn't always the case. So we would offer a video call but it wasn't the only option that we would give. Those who were comfortable with it they could have it. We would normally need photographs submitted as well, because -- I don't know if you have ever tried to get your foot on a video camera on a laptop, it's not the easiest thing, so we would have had pictures and we would have sent out a questionnaire or gone through questions with them as well and the video call would be more to have a general discussion about the findings. If not, we would do a telephone call conference.
Q. And with the video calls, if someone was able to get their foot within the image, within the shot, how did that compare to in-person consultations? You were saying the best case when the foot was fully in focus and clear. Were you -- did you feel as confident giving a diagnosis as you would have in person?

A. No, it was making the best of the circumstances available, but there's an awful lot of extra information that you would take in from somebody when they come to your clinic. When you see them in person, you would be able to see how they're dressed, what their footwear is. For example, you might notice that somebody's buttons are buttoned up slightly the wrong way. There's maybe some dried food on their top. Those could be signs somebody's cognitive impairment has been altered, that their vision is altered. We would be noticing the way they walk into our clinic. You know subtle little things you would notice about somebody that might help inform the larger healthcare view. It is what we call more holistic practice. We're looking at the whole person. So a lot of those things were lost.

You would also lose the rest of the body when you're seeing it as well. So although I might be looking at an issue on your big toe, I'm also looking at your leg, your other foot, so many different parts. Often I'll also be looking at your hands, because there are certain conditions that can come up in both. So this whole body picture was lost, but, as I say, we would always let the patient know that this was based on the information available. So we had to sort of put that disclaimer in place as well.

Q. Yes, thank you. You state in paragraph 36 that in time when you had full day appointments an appointment would be 30 minutes, then someone would have to spend 30 minutes decontaminating everything, so for every hour of work done you could only charge for half the time. Did that at any point cause difficulties when it came to paying staff salaries?
A. Yes, so our podiatrists within my practice are all self-employed contractors. We took a collective decision when we started seeing patients again that we would only put our prices up very slightly. We put them up by three pounds. Some practices I know have had to put them up by £20 to purely cover the costs. Pre-pandemic we were basically every 30 minutes we would be seeing a patient, so we would be back-to-back appointments.

Then this became we had to have this gap. You had to air out the room. You had to decontaminate absolutely everything instead of the usual surfaces that would be decontaminated and that included our reception, our front door handle. Our reception team weren't able to return for the first 15 weeks. I had to furlough them so therefore we didn't have any manned reception area. We had to keep the door locked for security. There was also additional issues of you were then in a

lone working situation, which you wouldn't have been in before so we had to consider the security of that as well.

But it did have a significant financial impact. It was something that we collectively felt we didn't want to charge more for at that time, because we also understood that many people had been furloughed or had lost their jobs and they didn't have the same income as before, so as a business we absorbed as much of the cost as we possibly could for as long as we could.

Q. Thank you. And in paragraph 37 you say that by May 2020 you could do urgent work as well as critical work and you had to deal with a backlog of patients, but you were far from working at full capacity. Is the reason you weren't working at full capacity that the backlog was small at that point or is it just because of the time spent cleaning?

A. So we had a bit of a backlog because of the time spent cleaning as well, but in the first four weeks of lockdown we cancelled 500 patients, so that was quite a significant amount to cancel. Prior to that, we would have three treatment rooms in operation. That wasn't possible under the new restrictions. We would often only have one or maximum two staff of the day and we had to stagger when the patients were arriving as well. In

fact, it was actually four years ago today, the 23 May, that we were able to start seeing urgent patients again and that was then we had to start triaging the calls that would come through. Prior to that, we had taken the 500—odd patients we had cancelled and all the treating podiatrists had medically triaged them, because a patient's perceived level of urgency is not always the same time as the medical level.

So we contacted all of our patients that we had classified as high risk of breakdown to offer them appointments first and we worked our way through first of all based on medical need and then based on date order, because, logically, the person who has to wait the longest would be at the highest risk of a medical complication and we also urged our patients, if they hadn't heard from us yet and they were in pain or had an issue, to please contact us to allow us to triage them sooner.

Q. And the patients who didn't fall within the urgent or critical care category were they also trying to make appointments with you at that point?

A. Yes. As I say, everybody's pain is their own and, therefore, you know, by comparison to other people sometimes you have to make those very hard decisions. We did have patients not understand why their need

wasn't the same need as somebody else's. We had some patients lied about their needs to obtain an appointment, because they figured, well, once you have seen me and I'm here, you'll just do my treatment. So they were generally quite disappointed when we would refuse that, because they didn't meet the criteria and we would have been at risk. At that point, it was breaking the law, so we would have been at risk ourselves if somebody had reported us for treating something that didn't fall within the criteria. So, yes, we had some creative things that would be told by patients to try and get in and get an appointment.

Q. When that happened, where they lied about the condition and you had to refuse treatment, would they still pay for the time?

A. We chose not to charge them in that instance. I will clarify, at that point I wasn't actually able to treat patients, I was still shielding, but this is from my colleagues that were working for me at this time, but luckily it didn't happen too often. I do know anecdotally from colleagues in the profession some had it a little bit more than others, but, again, everybody could see different amounts of people and at different times as well, so we would have patients trying to register new with us from other practices as well,

because their practitioners weren't able to practise during that time.

Q. And do you think that the categories, the urgent and critical care, were appropriate in the circumstances or do you have a view that all podiatry treatments should —— you know preventative treatments even should have continued throughout?

A. Personally, I feel it was the right thing at the time. It very much gave leeway to professional judgment and I think that was one of the important things. It wasn't a very rigid set of rules; for example, you know, you must have this disease and this disease in order to qualify. There was clear triaging. Advice was provided by the professional body to podiatrists, which did have —— we had a judgment tree, like a decision—making tree, but it also relied on professional competency and judgment. If you felt that you could justify why that patient had to have treatment and it was important, you could, but you had to justify every treatment; why did they meet this criteria to come in?

So as I say, that really came down to your medical knowledge, your history taking and your professional judgment as to who would meet those categories to see. But I feel at the time it was the appropriate thing to do with the level of risk that was perceived, you know,

by healthcare professionals and the medical experts at that time.

Q. Thank you. Once the restrictions eased and services resumed as normal, had the lack of private and NHS preventative care led to more severe issues requiring more significant essential treatment?

A. Yes, we started to notice a big difference with what was coming in now. This could be something which might sound trivial to someone, for example, that they haven't had their toenails cut, the lower end of what we do as a podiatrist. I have, for example, one patient when they reappeared there were significant changes in their feet. A fungal infection had developed. It had got quite quickly in their toenails. They have now been left with completely altered toenail structure and that has led to ulcerative breakdown underneath their toenails as well. That's an elderly person who lives alone. That has complete changed their risk category now. It's something, I say, that couldn't be foreseen at the time, but that had come up.

We also had other people who were leaving it far longer than they ever would have, so things like ulcers under toenails were common, other wounds that would have developed or just even basic foot care issues that had gone too far because they hadn't been able to have the

intervention they might normally have had. It was a wide and varied presentation that came.

Q. Would ulcers under the toenails affect mobility?

A. Yes, it could be quite painful and people would come in thinking they had, for example, an ingrown toenail and instead we found wounds actually underneath the nail bed instead. But we also had a lot of more complex things that were coming in, not that these weren't things we were able to cope with. Our training is the same as the NHS, our professional scope is the same, but people who were experiencing backlogs from the NHS care and they were now having to seek out private care and this was something that financially they hadn't been used to as well.

They had been in a privileged position where the NHS had been able to provide their healthcare free of charge and all of a sudden they're faced with having to pay for that service and that came as quite a shock to some people as to how much private healthcare actually costs as well.

Q. And that was due to the increased demand on the NHS from these worsened cases?

A. My NHS colleagues were often redeployed to become district nursing services and not provide the same level of -- the same type of care, the same provision of care,

as pre-2020 offered, so there was some significant changes. Some also ended up going on to become vaccinators as well, so that redeployment completely changed what was available within the NHS service provision.

Q. Thank you. And did the lack of preventative care cause health conditions which affected life expectancy or gave rise to the need for palliative care?

A. Within my own profession, I would say not that I noted. I can tell you though that our patients coming in some of them had not sought medical help for certain conditions. Therefore, certain life-altering and life-changing conditions had gone longer before treatment or diagnosis so that in turn had a knock-on effect.

We would see people who just didn't want to bother the doctors or the perception they couldn't get a medical appointment, so they just didn't try and that I say sadly in some situations did have a knock-on effect. So it wouldn't be unusual for some of your patients that they hadn't seen anybody in healthcare for up to 18 months by the end. They were just so scared. Even the panic attacks that we had from patients, we were the first people they had seen and they would have panic attacks in our clinic because this was the first time

they had been out.

Q. Fear of Contracting COVID or fear of seeing people?

A. Fear of people, fear of people, fear of being out in the world again, fear of contracting COVID. We would get a lot of questioning about our infection control procedures, what would we be doing for that. We did try to prepare our patients as best we could through detailing what we would be wearing, pictures of us, videos, even our patients that have learning needs and additional needs, we had to take that into consideration. We put in extra things in place for people with dementia, because if you have dementia seeing somebody in a mask and a visor is a very scary thing. So we had pictures of ourselves up smiling saying -- for example, I had to have a sign up, me smiling without my mask on saying "Hi. I'm Emma. I'm your podiatrist. I'm treating your feet" and we would have that sitting beside us so that could be there and they would have a positive visual cue, because they had no body language to pick up on at all, which could make them more agitated and would have a negative impact on their treatment.

Q. Yes, thank you. And in respect of conditions such as diabetes, did the lack of preventative care lead to situations where amputations became necessary?

A. Within my own practice we didn't have too many that we were having to refer on, because critical wound care was still happening and the lines for wound care within NHS podiatry were still open, but we did have some more patients who were perhaps struggling with their own personal control of certain conditions. And again, this can make things a little bit trickier when they're not as comfortable engaging with their healthcare professionals or feel that they're not as important as other things that are going on in the world.

Within the wider population, I don't believe there's any published statistics that have been made available to me at this time that I could comment on, but some of these things, you know, it's complications that might not just be COVID. It might be other complications that arose during that time.

Q. So you had a situation where some people had very trivial issues and were greatly exaggerating them to be seen ahead of others that had a greater need and then you had people who had significant issues who had picked up the message that they should just not bother anyone and stay at home?

A. Yes. We had some patients as well who weren't willing to travel to us for appointments. They would have an appointment and they just simply didn't come, because

of, for example, the announcements around travelling. They didn't particularly understand it was okay to travel for medical appointments, that even if you were shielded, you were still allowed to come out for medical appointments. So we would reinforce this in our reminders and we implemented email reminders as well which clearly detailed this. We did have some patients were stopped by the police as to why they were travelling and this helped reinforce that they were crossing county lines to attend a medical appointment, but, yes, a little bit of just not quite understanding that medical appointments were safe to travel to and these sometimes sadly were left out of the communications from the government around healthcare appointments. It just didn't get mentioned sometimes so it created a little confusion.

Q. Are you aware of private podiatrists making home visits during that time?

A. Yes, so domiciliary or home visits were still permitted during certain circumstances, wound care in particular, but there was -- had to be a very set, you know, restriction in place, the -- what's call called the donning and doffing of your PPE, where you put it on, some would have to do it on doorsteps and boots of cars. You know, there was a very set procedure that you would

have to follow.

Podiatry isn't something you can do a doorstep drop-off. You know, it is not like you could leave the prescription on the doorstep. You physically have to touch the person and treat the person and that would mean entering somebody's premises. We don't do domiciliaries within in my own practice, but I say I have many colleagues who were doing this. Some of them though did not feel comfortable doing it. It's a big ask. You know you're asking somebody in healthcare to put themselves into somebody else's home during a pandemic. Some just didn't feel comfortable doing it. So the onus, certainly for private practitioners, was it's only within your own comfort level what services you choose to offer. Those within the NHS they were still working throughout and their protocols would be changed by their employer.

Q. Yes, thank you. And you've mentioned there being more serious conditions. Was there a rise in the need for emergency care and did that impact the private podiatry sector too or just the NHS?

A. Yes. We did see quite a rise in things that were a bit more urgent, generally because people had left. They had ignored it and ignored it and then couldn't ignore it anymore. So things like we did have an increase in

the amount of minor surgery we were carrying, specifically for ingrown toenails, because people had tried to fix it themselves, or they had just left something and then by the time they presented, there was no other option but to do surgery, because it had just gone too far or, again, they had ignored an issue that maybe should have been seen a little bit sooner, ordinarily they would have, and it had broken down to the point were you are going, okay, this is now wound care, this isn't our general care, you now need active wound care and that can take a few weeks to heel.

So something that could have been one treatment to fix it then becomes six treatments, so that then adds to your knock-on effect for your backlog as well, because you're having to find more appointment spaces for this person. So lots of little things that could all add up into one bigger thing.

Q. Thank you. Was your role at the college affected during the pandemic?

A. So during the early stages of the pandemic I was a nonexecutive director at the college and this meant that I was on the sort of strategic direction. This changed quite significantly for me so I was then involved weekly in what we termed the COBRA meetings, where all of the management teem would come together to discuss the

changes that would come in. There was quite a lot emails flying backwards and forwards as well, lots of extra meetings being sorted, which I was dealing with on top of running my own business from home, because I had all my clinic phone lines diverted to my mobile. So on top of the seven day a week working for my clinic, trying to deal with all my staff, I also had -- being asked for my professional opinion, being asked for my opinion as a business owner and the college was very keen to speak to people in all different sectors within their network to try and make sure that their member's needs were being appropriately dealt with.

I was also very active on professional forums, so I would often have people see me, rightly or wrongly, as "the college" and reach out to me looking for help. So I would have roughly about hundred private contacts a week from people desperately hoping that I had some kind of insight, information. I remember at one point somebody actually asked me what the Chancellor thought on something, which was Mr Sunak at the time. I did find it amusing they though I had a personal phone line to Mr Sunak, but they actually expected that level of information. So there was an awful lot of work to reassure and to communicate, because we had 10,000 very scared people, people who thought their livelihoods were

going to be lost, people who didn't know if they could go to work next week or what would be happening and anytime there was a government announcement I would get this flood of people asking me, looking for insight or a tidbit of information on what was going to happen.

Q. If you had uncertainty about what certain guidance meant, was there someone that you were able to contact within the body that issued the guidance?

A. So within the Royal College of Podiatry we have what is called a professional support team and those are people who help issue our clinical standards and professional standards that we work by so they were worked off their feet; no pun intended. They were working exceptionally hard to try and make sure that the guidance was as clear as possible.

A typical timeline for them would be that new government guidance would be released at say 12 o'clock. They would be working until maybe 8 or 10 o'clock at night to make sure this was clarified, that everything was understood, it would run past several people in the organisation and it would perhaps be on the website by between 8 and 10 pm at night to make sure our members had access to this as soon as possible. And it's one thing I am personally very proud of the staff that were working at that time for the dedication that they put in

and, as a director of the organisation, it made me so proud to see the work they put in, all the overtime and the dedication to try and make sure that our members could do this, that they could help as many people as possible in as timely a manner, because it was a lot of extra work for them to do that and outside their normal hours as well.

Q. Thank you. Could you tell us a little bit about the financial impacts of the pandemic on the private podiatry sector?

A. So it was quite significant. We have -- private podiatrists are set up in many different ways. They could be sole traders, like myself. They could be set up as limited companies, partnerships. This is where the furloughing system became slightly tricky. So if you were set up as a limited company, you would generally be an employee yourself, you would be a director, and you would have to make the decision of did you continue on or did you accept furlough. If you accepted furlough, you would not be able to contact any patients. It was the very basic administrative duties for your business you could run, which did not include speaking to patients. So you had to decide between putting yourself on furlough to receive an income to support your family and your livelihood or providing

patient care at significant financial detriment to yourself.

Within my own scenario, I was a sole trader. I also owned a limited company at the time which operated in tandem, but I was eligible for a self-employment payment, which was 80 per cent of my earnings over a three-year period and that was the three tax years. During that time, I had actually been pregnant and on maternity benefit, which was the equivalent of statutory maternity pay, so that brought down the level I was able to get. So like many other self-employed people across the country you were given 80 per cent of your average earnings for that three-year period. I was still able to work during that time, which was a -- or for part of it when I wasn't shielding, which allowed me to supplement that income, but for those podiatrists who were having to make the decision in a limited company basis that was a very difficult decision for them.

It wouldn't be unusual that you would pay yourself minimum wage and then see what earnings you could pay yourself as dividends at a later period based on the performance of your business. So if your official salary was minimum wage, you got 80 per cent of that and that had a significant financial and well-being impact on many private podiatrists who had chosen to set up

their businesses in that way, but we didn't get much in the way of financial support. Many businesses didn't. We received one £10,000 grant as a rates registered business, which was taxable, so that was £8,000 and that was the extent of the financial support that we got as a business. So despite rising costs, we had to figure out how to cover all of those.

Q. Thank you. Could you tell us about the childcare issues that were particular to podiatrists in private practice?

A. So when the key worker and front-line healthcare workers provision came out, "key workers" were classified into three sections 1, 2 and 3, 1 being the most important. NHS podiatrists were classified as key level worker 1, because they were NHS employees. The private sector was classified as key worker level 2, so in certain scenarios this meant that we couldn't access childcare provision. If a childcare facility only has 50 spaces and has 200 applicants, it's right that they triage. They have to give priority to key worker level 1, but it did mean that some of my staff in particular, my colleagues, did not get access to childcare. That then impacted on their ability to provide care to others and their ability to earn a living as well, because you cannot take your children to work in podiatry. It is completely inappropriate in that situation. If you're

working admin from home, you can figure out ways around it, but you simply could not take your children into a clinical setting, pop some PPE on them and tell them to sit in a corner and watch a film. That couldn't happen.

Q. Your view is that that distinction between NHS podiatry and private podiatry was justified?

A. I understand why it was taken, the perception that we were not doing the same critical level of work as our NHS colleagues, but we had been asked to stay open. We had been asked specifically to support the NHS by providing access to our services and that had an impact.

My own situation, both my husband and I are healthcare workers. We both work in the private sector. Neither of us qualified in the first instance. Then they had spaces opened up. You know, schools had to look at, oh, if you've two people that do it, what could this do? Where grandparents or family members might have previously been able to provide support, they weren't allowed to so you're asking your family to break the law to look after your children so that you could go and help other people. And these are just the wee things that, you know, would have an impact, but I appreciate it was an emerging situation and it's different looking at it in hindsight than it was at the time as well so.

Q. Thank you. In paragraph 70 you state that you have rheumatoid arthritis, the treatment for which leaves your immune system vulnerable and, accordingly, you shielded from April to July 2020.

A. Yes.

Q. Did you decide to shield or were you placed on the shielding list?

A. I had to decide to shield myself. I didn't receive a shielding instruction in the first few waves. As a healthcare professional, I am aware of what my medication at the time did to me. I was on a medication which severely suppressed my immune system. The communication that was coming out from the government on shielding was if you have one of these conditions, you shield and you wait for your letter. If you do not receive that letter, get in touch with your GP. I didn't receive that letter, so I had to get in touch with my GP, at which point I was reviewed and placed on the shielding list, but, yes, I knew from what was being said that I was very highly susceptible to catching COVID and therefore shielded myself from the public.

Q. How straightforward was it contacting your GP and being placed on the list? Was your GP quite accepting of that?

A. Yes, they were quite accepting. I highlighted that I

felt I should have been receiving a shielding letter and hadn't. I received a callback and I was asked some questions as to why I felt I should be shielded. They agreed and they put it through. I think it was called a Schedule 7 where the GP can choose to place you on the list. It transpired that the advice for original -- the first few passes of shielding was that if you had rheumatoid arthritis you must be on two disease modifying antirheumatic drugs, known as DMARDs, and I was on one, which was a bit more unusual. However, if I had been on that same drug from a dermatological view point, I would have been shielded on one.

That advice, again an emerging situation, the advice changed as time went on and I would have received a letter probably a couple of weeks later anyway. My specialist advised me, oh, they did then change that. The professional bodies reviewed it and I would have been called, but, yes, the rheumatology department had a very large number of people to be looking after as well and trying to make sure that everybody was supported.

Q. Thank you. And then in May 2020 you contracted COVID and required hospital treatment?

A. Yes.

Q. Please could you tell us about your experience of accessing medical care and being treated in hospital?

A. So it's actually two years ago today I was taken as a day patient Forth Valley Royal Hospital in Larbert. The previous day I had tested positive for COVID in the evening. I had written notification in advance of this should I ever contract COVID, here was a local phone number to call for triaging. I called that morning.

I think it was the Sunday night I developed COVID and I called them on the Monday morning and within about an hour, I had had a callback to triage my symptoms and I was asked did I have anybody that could actually bring me to hospital safely and I was seen at hospital a few hours later and I was dropped off at a door, escorted by PPE-clad staff into an isolation unit, I was consented for an antiviral treatment by intravenous method, including that it was experimental and there was a chance of death if I took this, and I was then placed on an IV for a few hours to receive anti-viral treatment, not to make me better, but to stop me from getting worse as they were concerned about the impact that me contracting COVID would have.

By this point, I had had five vaccines and it was a month after my fifth vaccine and, yes, it was quite severe the symptoms that I had developed on the first day, hence they chose to give me an IV antiviral instead of oral antivirals.

Q. And while you were in hospital did you find the use of PPE and infection prevention and control measures all to be appropriate? Were you quite happy with those aspects of things?

A. I noted at the time visors I don't think were being used by that point, as in line with the infection control guidance at the time. It was IIR facemasks, single-use aprons and gloves, which was all -- I was in my own room. I didn't see anybody else on the way in. I was met by staff wearing PPE. I had chosen to wear an IIR facemask -- not a IIR facemask, an FFP2 facemask myself. For more personal circumstances, I preferred an FFP2 for the level of infection control and protection that it would offer people. I was also acutely aware I had a highly contagious disease and I was entering a hospital environment, so I had taken my own measures as well, but all infection control guidance that was provided to healthcare at that time was being adhered to when I was in hospital.

Q. Great, thank you. In paragraph 78 you say that you were very impressed with the guidance from the Scottish Government while you were shielding. This isn't a sentiment that we have heard very often. Could you please tell us about your experience of receiving the guidance?

A. Yes. So I received regular letters, texts and updates on this. I work in communications now so I felt that the communications received were quite clear. For example, when the First Minister would be making an announcement that was relating to shielding, I would be sent a text notification to alert me to this to watch the television at that time, which I felt was quite forward thinking. I didn't then get caught unawares on the TV that something had changed.

I felt the guidance that came out in writing was clear and to the point, contained frequently asked questions that I felt explained things clearly. I received a Christmas card from the First Minister at the time, which also contained some shielding advice as well. But I did feel that the guidance coming out answered any questions that I would have and made it quite clear what I should and should not be doing in certain circumstances.

My friends in England who were shielding would often contact me to ask what I had had, because they didn't feel that what they had had was particularly detailed and that's their personal opinions on it and I would share with them photographs of what I had had and they would go "oh, that makes that quite clear". Some of my friends chose to follow the Scottish advice that was

shielding in England as opposed to the English advice, particularly when the stay alert moved, so it moved from stay at home to stay alert and they did not feel personally safe as people in the shielding category with the new guidance, so they chose to follow the slightly more restrictive Scottish guidance because they felt that was more appropriate for their personal comfort level with their risk.

Q. Can you tell us once shielding came to an end how did you find the transition from shielding to being back at work? Were you concerned for your safety?

A. Yes, it was absolutely nerve-wracking and I have worked in healthcare since 1999, but all of a sudden I was being faced with people who didn't know how to wear PPE, I have seen more noses on top of masks that I knew what to do with. Having to constantly ask patients to actually put their PPE on properly. Making sure they actually washed their hands as well when they came in or used alcohol gel. A lot of people felt it didn't apply to them. It was quite nerve-wracking being faced, you know, with this constant stream of people who could, as I believed at that time, potentially kill me, but I was having to go and still treat them.

You are putting yourself at risk every single time you have that patient contact. I had control of my own

PPE, which I felt made a big different for me. We chose to go a mask level above. We were advised a IIR mask would be all that would be required in healthcare We chose to use an FFP2, because we are in a 30—minute appointment in an enclosed room with somebody. Again, that's —— you'll have people maybe would sneeze. They would take off their mask to sneeze and then put their mask back on again.

So even with my FFP2 mask and a full visor, you know, you were making sure the room was being aired out, because there was particles in it and I'm looking at their feet the whole time. I'm not looking at their face. I would sometimes look up and spotted they had taken their mask down and you're having to say to them put it back up.

We also brought in screens as well which we had to make ourselves, which were acetate suspended on a frame, which we would place over the patient chair so that the feet were with us and there was a screen between us and the patient, which provided an extra level of protection, again for when the sneezes and the masks being removed were there. We did of course have some patients who were mask exempt for medical reasons, which was completely understood and respected in our practice, but that gave us an extra level of protection from that.

Yes, my heart was racing the first time I went back in, which when you're wearing a fully face fitted mask was quite a thing. I would regularly be bruised by the end of the day so I would have bruising across my nose. I had to take to wearing a skullcap covering for my hair because my visor was taking chunks of my hair out as well and I had to wear special strapping to keep the mask on to my face. I have a very small face and masks are made for the average 70kg man. They're not made for women of my stature, so trying to find masks that would fit my face was quite difficult so I would have to fold my mask to make it fit my face and I would have to strap it tightly round the back of my head, because if you didn't have a full seal it didn't work.

Q. How long did it take before you were back to your pre—shielding comfort levels around people?

A. I would say probably a few months. Even when I was back in work, of course I had on PPE the whole time. We staggered our lunch breaks. We didn't eat lunch together. If there was ever a time where two staff members were on lunch together, one would be in the staff room, our back door would be open to ensure free flow of air and another person would be sitting in the corridor. We had two metres between us at all times.

Within my own practice, no staff members contracted

COVID for the first two years of the pandemic. Despite being frontline healthcare workers in constant contact with people, we had no staff cases at all and I like to believe that is because of the measures that we were taking and our understanding of infection control. We were cautious outside of the workplace as well, because you had that knowledge if you got COVID, you were out for ten days at least and the impact that had on patients that was ten days you couldn't provide patient care, so we were all exceptionally careful during that time.

Q. Thank you. You state in paragraph 86 that your son's autism diagnosis was delayed because of COVID?

A. Yes.

Q. Could you tell us the impact of that on your son and on your family?

A. So my son turned 3 in February 2020 and started education, nursery, ten days before the pandemic really hit and lockdown was announced. He hadn't been in formal education settings prior to that so this was really, I would have said, the first opportunity that any learning differences and social differences would have been noticed and we lost all nursery after ten days. He had five months where he saw no other children and he was with only myself and my husband.

This changed any level of tolerance that he had already built up, so when it then came time to reenter nursery, which would have been August 2020, he struggled quite significantly with that. The noise of people, he has sensory issues, which again we hadn't noticed prior to that. During that time he was found crying in a cupboard because he was so overwhelmed with the sound and the amount of people. He had lost many social skills during that time, as had many other children as well. He's an only child so he didn't have any other children to play with.

Because of the impact of the process we were all having to stay away from other people, so many children developed issues with interaction. They missed key stages. The developmental markers all changed. Therefore, so many other children were also nervous of other people, were also experiencing things in a different way that it wasn't really picked up on in the same way.

His educational psychologist he was assigned through the school didn't see any issue at the time. It was here are some things we can try. It wasn't until he actually started primary school, he's currently in primary 2, so that would have been 2022 he started primary school, even with an enhanced transition he

really struggled in the first week and we were still not offered a CAMHS referral. We ended up having to go privately to seek him help and he was found to have significant needs. He is autistic. He is most likely ADHD, which is being confirmed at the moment and suspected dyspraxia as well and is in the first percentile for motor function. So whilst he has learned to cover all these things up very well and is a very happy little boy and his school has provided many, many wonderful ways and their support has been amazing, there are many things that could have been picked up earlier, but because so many other children were experiencing a whole new set of issues, you know, there just wasn't the service provision there to help with it.

So at that time I believe we were told it would be a four-year wait for CAMHS for any form of formal diagnosis, which would have had a severe impact on his ability to form social connections and receive an education, hence we chose to go the route that we did for him.

Q. Going back a bit in your statement, in paragraph 60 you state that the Scottish Government made it clear that all healthcare workers should be provided with the vaccine.

A. Yes.

Q. But in practice it didn't work out that way.

A. No.

Q. We've heard from others that they believe -- well, their experience was that the issue came down to the lack of an NHS email address to book a vaccination appointment. Is this an issue that you faced as well or in your experience was it limited to what you say in paragraph 62 that the NHS space delivery team for the vaccine didn't realise what was included in private healthcare?

A. I think from my personal opinion, I think it was a lack of understanding from those who were actually faced with creating a service delivery plan. So the guidance from the Scottish Government, and from all the UK devolved nations and England, did say that it was for all frontline healthcare workers, private, you know, independent, third sectors, charity, as well as the NHS and social care.

In reality, when you were trying to access this, those numbers and those access points were distributed through an NHS intranet. They were distributed to social care providers. It was like gold dust trying to find that phone number. When I did find it and called it, I was told, well, you're not eligible, you're not NHS, go through your department head. I am the department head. Well, go to your occupational health.

You are my occupational health. Now, this had been something I had experienced pre-pandemic even trying to access a flu vaccine. I would have to go to my GP practice to be told you have to go to your occupational health, you are my occupational health, and it would be a standing battle every year for this.

But it became quite apparent during this time my staff, my team, were being actively refused access to a vaccine because we were not NHS, we didn't have an NHS email or an ID. Even when we did eventually get access, we were told to bring our payslips, our NHS payslips or our NHS ID badges. I had to write all of my staff a letter. I had to generate them physical IDs to take. We actually had to hire a company to make IDs for us so that they had photo ID to meet the requirements and it was just an absolute uphill battle to be recognised as frontline healthcare workers, but I do believe that was just a simple lack of understanding that private healthcare isn't doctors and nurses in hospital, that it is podiatrists, it is physiotherapists, it is audiologists, because opticians and dentist, who are often private, are NHS contractors and, therefore, had access to that. So, yes, it was a -- say I think just a general you didn't know what you didn't know and it just hadn't occurred to them. I don't think there was any

maliciousness to it. It just hadn't entered the thought and that did in time get corrected, but, again, that was quite an uphill battle and varied from Health Board to Health Board as each Health Board was responsible for rolling out their own access to it.

Q. And following on from that you also raised concerns about assumptions by government and other agencies that NHS is healthcare and that guidance, other guidance not about the vaccine, was only distributed through the NHS as well, and that created issues for those in private practice?

A. Yes.

Q. Could you tell us more about that and the impact on the private healthcare sector and consequently on patients?

A. So as restrictions would change the guidance would often change for healthcare workers as well, the guidance for healthcare workers was very different to the guidance for the public in some cases. This would be distributed to the NHS and to social care. The only way the private practitioners would be able to access it was if you happened to know it had been released and you would find it on the Scottish Government website or your own government's website or if you had a professional body that was telling you this.

I was very fortunate at the time my professional

body was part of the Scottish Union's network which was getting given these updates, because there was a special COVID committee I believe that was formed. That committee disbanded. I believe in the past year or so it disbanded. Therefore, the updates stopped.

Now, I believe there was an update to NHS protocols for if you have contracted COVID about attending work. We've never been told that, so we're still operating under if you have —— you know if you have been given COVID, if you have COVID, if you test positive, you have to be off for a set number of days. Whenever these public health guidances came out, sometimes I feel that the private sector was forgotten in that communication chain, but we are still frontline healthcare workers. We still have to have workplace protocols and we see this in other sectors as well, in health and safety and things. It will be NHS that is considered the healthcare providers and, again, your social services from in council, your caring support, these are agencies, these are businesses, they have contracts for these things, so there is a line for this to be sent down.

But if you're a self—employed practitioner, if you're running your own business, who do you have to tell you these things? You rely on a source of

information, but if that source of information isn't been given it, it can be very challenging at times to make sure that you're fully compliant when there is this block on you getting things.

Q. Thank you. Now, we have your statement and we'll consider that in full alongside your oral evidence today. Is there anything we haven't covered today that you would like to highlight or mention at this point?

A. I don't think so. I think we've covered sort of all of the bigger challenges around key worker recognition and vaccines and access to PPE and the general information that was coming out, so I don't think I have anything to add at this time. Thank you.

Q. Thank you very much.

THE CHAIR: Thank you very much, Mrs McConnachie. Very good. We'll come back at 11.15 as scheduled. Thank you very much.

(10.49 am)

(A short break)

(11.16 am)

THE CHAIR: Now, good morning, Mr Edwards.

MR EDWARDS: Good morning, my Lord, the evidence of the next witness, my Lord, is subject to a restriction order and so the witness statement and the recording of the evidence are anonymised.

THE CHAIR: Yes.

A. Now the reference for the witness statement is SCIWT0921—000001.

EVIDENCE OF HSCO249

Examination—in—chief by MR EDWARDS

MR EDWARDS: Good morning, witness.

A. Good morning, Mr Edwards.

Q. Yes. Now, you are providing your evidence today, as I say, subject to restriction order and anonymised, but you are agreeable for your witness statement to be published on that basis and for your evidence to be recorded on that basis; yes?

A. Yes.

Q. Yes. Now, in your witness statement, which I hope you have a copy of in front of you, yes, or you can see online, yes?

A. Yes.

Q. Yes. You explain that you're giving your evidence as someone who worked as a carer in a private care home and also as a union representative for the GMB?

A. Yes.

Q. Yes. Now, you explain that you were employed as a care provider during the COVID—19 pandemic. This was your first job in the care sector, but you held that position for over eight years; is that right?

A. Yes, correct.

Q. And most of your evidence today concerns what you want to say about your work in the private sector, a private care home?

A. Yes, correct.

Q. Yes. And the details of this are set out in paragraph 3 of your statement, where you say that at this time, from the beginning of the pandemic and through the pandemic, you worked in a private care home which had about 60 beds and was a nursing home?

A. Yes, correct.

Q. Yes. Now, if we just look at paragraph 3 of your statement again, you say a few words about how the work structure worked in this care home before the pandemic?

A. Yes.

Q. Could you just summarise that for us?

A. So we had 60 beds. It was split into three different units, so you had 30 beds upstairs. You had one unit, which was our younger adults unit and another unit downstairs that was a dementia unit. You would typically have one nurse in the building and you should for upstairs have three or four care assistants, depending on if there was a senior care assistant on duty. Downstairs in the younger adults you should have two people on at all times and in the dementia,

depending on how full the beds are, there would typically be two to three carers on shift.
Q. Yes. Now, you also say in paragraph 5, just to set the trade union context, that you did have a union recognition agreement in place at the home, but no representative; is that right?
A. Yes, that's correct. There was no representative (inaudible).
Q. And I think you volunteered to be the representative; is that right?
A. I did, yes.
Q. Yes. And did you actually become the representative?
A. Not officially, because I wasn't allowed to go on the training.
Q. Yes. And then you do also give -- you indicate that there was some effort by the home to derecognise the union. This would be before the pandemic, would it?
A. Yes, correct.
Q. All right. That sets the scene for the position at the outbreak of the pandemic and you then turn to some of the initial impacts at the outset of the pandemic, so this would be around February/March of 2020 I think, yes?
A. Yes, correct.
Q. Yes. And you first begin by discussing how people began

to see the developments and their initial concerns?
A. Yes.
Q. Can you remember then when you first became aware of the emergence of the pandemic and the -- and fears about it coming to Scotland?
A. So obviously it was round about when it was in different countries, it wasn't in the UK yet, it hadn't started spreading or anything like that, hadn't -- it just wasn't here. So I started to hear about it on the news and then it just became more regular. Every day you were hearing more and more about it and then you would hear about how COVID had started coming into the UK and they're started to be like rumblings at work -- what would happen if the virus did come here? -- and people started to get a little bit scared about like obviously what would happen if it did.
Q. Now, as many witnesses have said in different contexts, there were initially concerns about PPE and the availability of PPE. Now, interesting at the end of paragraph 8 of your statement you explain what the position was for you and your colleagues in the care home before the pandemic in relation to PPE. So what would be the standard sort of uniform in the care home, as far as you can remember?
A. So the standard uniform before the pandemic you would

have a pinafore, you would have PPE for if there was any infection control, like if there was any infection in the home, norovirus or anything, you would have glove and aprons, disposable aprons. And I don't -- not that I'm aware that we had any masks or anything like that. It was just your standard gloves, apron, your bags to put in -- infectious clothes in and disposable waste bags.
Q. Yes. So masks wouldn't be available in the care home?
A. No.
Q. Now, with the outbreak of the pandemic then in March or February/March 2020 here, what approach was taken by the management where you worked to PPE?
A. There wasn't great concerns from management. They didn't really see COVID as a massive thing when it first started and I remember that myself and some staff members were quite nervous that we didn't have any PPE. So I had taken it -- as like the unofficial union rep taken it upon myself to go to management and speak to them about staffs' concerns, just letting them know that I think we need to get some masks in and that staff are like concerned about contracting COVID-19 and it's starting to become a bigger thing now, so it would be good if management could maybe prioritise that and we got told that we were being dramatic and ridiculous at

the time and said that staff don't need it but -- so I had said staff are wanting to wear their own masks and bring their own masks in and they said, well, if they want to be ridiculous and dramatic, we can do that and wear masks if they so please, so, yes.
Q. So I think what you're saying basically to summarise is when you approached them -- when you approached the management there was some scepticism about the need for any further PPE compared to that which already existed?
A. Yes, correct.
Q. Yes. Now, things did begin to change. Can you remember the timeline of when things began to change? Was it during March 2020 or was it over a longer period? Begin to change, I mean the attitude of management to the need for PPE, when did that begin to change?
A. I would say it was roughly before the first lockdown that that's when it started to feel a lot more serious, because obviously more and more cases were arising and it was on the news every day, on the radio every day, so I think that then they started realising, okay, maybe this might become a little bit serious.
Q. Yes. And in paragraph 11 I think you say -- so this would be around about the first lockdown, so sometime in March 2020. In paragraph 11 you say that management had asked internally for PPE?

A. Yes.
Q. But it had not been received yet. When you say "internally" what do you mean by that?
A. So they had asked HR and people that are above them about -- because is a chain of homes so they asked then what they were doing in other homes and asked them what the measures were going to be in our home.
Q. Yes. But you indicate that one concern was how this was going to be paid for?
A. Yes, they did -- management did mention a lot that there wasn't enough funding to get PPE and that they could only really get what they were given and they had to source more funding in order to be able to actually purchase the PPE that we needed.
Q. So what you remember being told then is that the home itself wouldn't be prepared to pay for it, but there would have to be an additional funding source from someone else?
A. Yes, correct.
Q. Now, one way or another the PPE did arrive and this is when masks first appeared on the scene as you remember; is that right?
A. Yes, correct.
Q. And the masks that initially arrived were the blue surgical masks I think you say in paragraph 12.

A. Yes, correct.
Q. Yes. But there were then some issues with access to the surgical masks; is that right?
A. Yes, correct.
Q. And again, I'll ask you to put it in your own words, but just to set the scene, what you're saying in the following paragraphs is that an administrator was put in charge of access to the PPE and this led to some difficulties for access to the PPE by the night staff, because the administrator wouldn't be working during the night?
A. Yes.
Q. So if we could just go over that a little bit. You talk about this in paragraphs 13 and 14 of your statement, but if we could just deal first with this issue about who was in charge of the access to PPE. So how did that work?
A. So the administrator had been told that she was in charge of allocating the PPE to the staff that were on shift. Typically, I worked day shifts so she was in charge of who would get masks and who would get PPE. At first, when we tried to access like any PPE, we were told that we were using too much too quickly so it started to get locked into the cupboard downstairs so you would have to go to the administrator to ask for

more PPE if you needed anymore.
We had single-use masks so obviously staff were going up and asking for different masks during the day because they had to take it off and didn't want to put it back on so they would ask for more and that sometimes was an issue trying to get it because we got told there wasn't enough PPE, there wasn't enough masks, so we had to keep reusing the masks.
And then when it came to night shift, I had a really good rapport with night shift, I used to work night shift, and they were telling me that by the time their shift started there wasn't any PPE available, because the administrator wasn't actually on duty when they were on nights. So they had went home, the cupboard was locked, they didn't have any PPE. So it came to the point where care staff in the home and myself would have to try and hide some PPE so that the night staff were left with some.
Q. So what you're saying was then it was other staff like yourself who were making provision for the night staff, because the administrator hadn't done that themselves?
A. Yes, correct.
Q. Yes. And you're also saying importantly that there were issues about effectiveness of the masks because single-use masks were being -- at this time single-use

masks were being used repeatedly?
A. Yes, correct. There was posters in the home at the time that stated that staff should not chuck out their single-use masks, because there wasn't enough to go around so we need keep our masks on at all times, which obviously concerned staff because they are single-use masks and it's not very hygienic either.
Q. In paragraph 15 you say you raised these issues. Just to be clear, are you raising these issues as a member of staff or as a union representative?
A. I was raising it as a member of staff. People were coming to me nearly every single day with concerns. Because obviously I was going to be the union rep, they felt comfortable enough to come to me, so I kind of felt like I was acting as an unofficial union rep, but my concerns solely were as a member of staff.
Q. Because you weren't recognised by the management as the union rep at this time, were you?
A. Absolutely not, no.
Q. I think you say that this -- these problems continued during the first lockdown or most of the first lockdown, so between March and July 2020?
A. Yes, correct.
Q. But by the second lockdown, so later in the year, by November, the practices and offering, if I can call it

that, of PPE changed.
A. Yes.
Q. Was that because of an availability issue, it became more available, or simply because the management of it changed?
A. I actually think it was because they had started to realise the severity of the situation and refusing to give staff PPE when there is a COVID-19 pandemic going on and it was becoming very serious, I think they would have had bad implications of that, so I think they realised, okay, we need to actually take this seriously now.
Q. And so what in particular -- sorry.
THE CHAIR: Sorry. That's my fault. I apologise.
MR EDWARDS: No, sorry, my Lord.
Just returning to this question of what changed during the second lockdown, so can you maybe summarise what you remember as having changed. So let me interrupt, sorry. There was more access, but what changed in terms of the availability for you and your colleagues?
A. Well, I think the government started actually recognising that care homes were needing PPE, so that was getting mentioned in the news quite a bit. We started actually getting more access to the boxes of

gloves and the masks and everything. They came out of the cupboards and we started to have PPE stations. Really that should have been how it was like from the start, but they started to stocking up the PPE so it was actually more available to staff now.
Q. Thank you. Now, in paragraph 17 of your statement you make the point that at the care home sanitiser became available as a result of donations?
A. Yes.
Q. Yes, so are you saying that during the first lockdown, by which I mean the period March to July 2020, sanitiser wasn't routinely available?
A. It wasn't available, no. There wasn't enough to go round.
Q. And so you remember that there was -- the availability depended on donations?
A. Yes, or staff bring in their own sanitiser and sharing it amongst each other.
Q. And then there were similar issues in relation to the pinafores, weren't there, about dependence on donations?
A. Yes.
Q. So given that pinafores were a routine part of the uniform before the pandemic, how did this problem come about with pinafores?
A. There wasn't enough uniform to go around so we were told

that we needed to obviously take our uniform in to work and it was to be washed at work. We weren't allowed to leave with our uniform on, but not a lot of staff actually had access to a second uniform and we'd obviously raised concerns about that to management. We were kindly donated some pinafores, but there wasn't enough to go around and they were also donated because they weren't fit for purpose for the hospitals, so they were donated to the care home.
So staff would either have to come in with a t-shirt on and wear a t-shirt if they were working downstairs in the dementia unit or they would have to then go and buy their own pinafores so they had more than enough, because uniform wasn't always like washed by the time they came in.
Q. So the uniform, including the pinafore, was left in the care home and would be washed there?
A. Yes.
Q. But it might not be washed and dried by the time somebody came back to work the next day, for example?
A. Yes, correct. Because we obviously we had so much residents' clothes to wash, they sometimes would fall behind and not manage to get to the uniforms.
Q. Yes, thank you. You then turn to the challenges of social distancing in a care home as you remember it. So

as you said at the beginning many -- not all, but many of the residents in the care home you were at were elderly and had dementia?
A. Yes, correct.
Q. Yes. And when the social distancing rules came in to force, there were particular difficulties in managing the residents in this respect, yes?
A. Yes, correct.
Q. Yes. So can you just explain what some of the difficulties were?
A. Well, we were dealing with residents that had dementia so it's not always possible to -- you know, someone walking where they want to go, you don't want to distress them, you don't want to cause them any difficulties. So when management are telling us you have to keep people isolated, they have to be in their rooms or they have to be separated, it's difficult to do, because you didn't want to take away that person's needs or, you know, we were trying to be as person centred as possible so.
You know, these people are humans. We're not about to tell them they can't do. They have a choice. So it was really difficult trying to manage that situation by trying to keep management happy, but also caring for our residents in the way that we should be caring for them.

Q. One of the issues I think you identify is that when the social distancing rules came in, the normal activities of people, you know, being in the living room area of the home, for example, and engaging in activities changed and people had to stay in their own room; is that right?
A. Yes, that's correct.
Q. Um—hum. And then it was up to carers like you to make sure they stayed in their room, yes?
A. Yes, correct.
Q. As best you could, yes. And that means that all activities in the home stopped, by which I mean games and social activities stopped?
A. Yes, they did, yes.
Q. And what about eating? How did communal eating then work in the dining room, for example?
A. So we were told that we had to separate people at the tables if they were to go into the dining area. Management did ask us to try and keep people in their rooms as much as possible to eat their dinner. Obviously staff and I did not agree with that, because that was the only time that the resident had to socialise, especially because some of them did enjoy socialising quiet a lot and it was the only day that they had to speak with someone.

We didn't agree with what management were trying to get us to do so sometimes we just went against management and would take people into the dining area but just make sure that they were socially distanced, because we just felt that socialising was really, really important for their needs.
Q. And dealing with these challenges was taking place at a time when there were staff shortages because people were off sick, for example.
A. Yes, correct.
Q. You also discuss in paragraph 21 various issues around visiting at the home. Of course visiting inside the home would have stopped, but there were issues about some family members being able to come to the windows of the home and others not?
A. Yes.
Q. And so how did that happen? I mean was that just arbitrary or accidental or deliberate?
A. This was something that I was battling with management at the time. I thought that there was a lot of favoritism from management to some of the residents and some of the residents' families, mainly because some family members would maybe put complaints in if they didn't get to come and visit so they would try to keep them happy. So basically the ones that weren't

complaining were the ones that were almost getting punished for not seeing their families, because they weren't raising any issues.
There was no consistency. It caused a lot of friction between staff, management and residents' family members. There was no clear communication on what the policies were or the procedures were for people coming to visit. It was just kind of, you know, made up as they went along. We just got told, yeah, this person is coming to the window today and then if we would ask for another resident's family member to be able to come and visit, it's, oh, no, sorry we can't. It goes against guidelines. So it was really inconsistent.
Q. And at the end of the section, you address the issue of training that there was some basic COVID—19 training offered. Now, what would this training have covered?
A. So it was e—learning, so it was just about infection control, you know, what PPE you should be wearing, the impacts of COVID—19 and the symptoms. It was your very basic e—learning training.
Q. But you had to do this on your own at home?
A. Yes, unpaid.
Q. Now, you then turn to —— well, you continue this issue about e—learning in the next section. We move on to the problems of changing guidance and keeping up with the

changing guidance and you say in paragraph 23 that the e—learning was never updated?
A. Yes.
Q. Over what period do you mean by that? Did you mean throughout the whole pandemic or during the first and second lockdown, what?
A. During the first and second lockdown it was the same training. The e—learning never really changed, so that was pretty much the same throughout, other than the fact that they would maybe add like additional —— like one additional module or something to the exact same training. But we did get like offered courses for training for COVID—19, but it wasn't mandatory, so it was just whether staff wanted to do it or not and I chose to do it because I wanted to know more about it and, you know, really be clued up on it all.
Q. And you say that at some point, I think by implication a little later in the pandemic, a COVID—19 officer was appointed for every shift?
A. Yes.
Q. Could that be anyone? Could that have been you, for example, or was there some process by which someone was appointed?
A. They wouldn't appoint me. I don't know if it was because I was trying to be the union rep, but they

didn't want me looking at the policies and guidance and procedures in my current role but they just appointed anybody randomly on shift, they would just pick a name and say "you're the COVID officer for this day" but a lot of the staff don't know -- didn't know a lot about guidance and policies and nine times out of ten would actually come to me and ask how to update the folder.

Q. And would this officer have done any special training or as I say, what I'm trying to get at, could it have just been anyone from the staff or was it someone who had a special qualification or had done special -- had done some extra training or something?

A. It was just any member of staff, they didn't need any training.

Q. And what was the -- what was the role of this person, what were they in charge of?

A. So we had like a guidance folder that would put the current guidelines and policies and procedures in place, it would be about the COVID symptoms, you know, how to deal with COVID, just anything that was coming out new and they would be in charge of printing them off and putting them in the folder, making sure they're up-to-date and just making that staff are reading up-to-date guidelines and policies about social distancing, family visit members, all this kind of

thing.

Q. You go on to say that you yourself undertake some courses in relation to infection prevention and control, I think?

A. Yes.

Q. And I mean did you do that because you wanted to or you were asked to or ...?

A. I wanted to do that on my own accord just because I wanted to be clued up on everything that was going on and make sure, you know, that I'm keeping my residency and I could share that information with the staff that I was working with.

Q. Now, inevitably as many others have said, when people got COVID they went off sick, inevitably, and this led to staff shortages and so on but you highlight some issues around COVID sick pay.

A. Yes.

Q. Can you say a bit more about that? First of all, what was COVID sick pay and, secondly, what were the problems with it?

A. So in the beginning you didn't get paid for being off with COVID so it was just your standard statutory sick pay and if -- that was included even if you tested positive, you didn't get paid anything, and it wasn't until the union had come about and said a social care

fund had been actually set up that we were advised that we would get full pay if you tested positive and you could claim it back from the fund -- the employer could claim it back from the fund. But I only found out about that from the union. The employer didn't notify us, didn't tell any staff, so I obviously went around and told all the staff how they were entitled to sick pay if they did test positive and had to stay off.

Q. Yes, so as far as the employer was concerned, it was just statutory sick pay, there was no continuing pay for being off sick with a COVID absence and it depended on public money in the social fund that was set up; is that right?

A. Yes, correct.

Q. Yes. And did that continue throughout the pandemic, did anything change or ...?

A. Obviously the social care fund that had been set up became more well-known but the employer didn't really implement that and inform staff about that, it was actually me that had told staff about that and staff went to the employer to inform them that they were entitled to the sick pay, they had to fight for it, but some staff members did actually manage to get sick pay whilst they were off.

Q. Thank you. You then turn to the issue of testing and if

you tested positive or weren't showing any symptoms and what the expectations were about being at work or absent. So you yourself, you say in paragraph 27 that you tested positive quite early in the pandemic?

A. Yes.

Q. Yes, but you weren't displaying any symptoms, at least not initially?

A. No.

Q. And what did you do then? Did you stay at home, did you shield, did you come to work? What were the expectations of you?

A. So I had emailed my manager saying that I wasn't symptomatic but I had tested positive for COVID. I wasn't entirely sure on the guidance but I didn't think it was advisable for me to be in work so I was notifying that I would probably be off. Then I got an email back saying, "No, if you don't have any symptoms, then you are expected to come in to work". So I took it upon myself to phone Public Health myself and actually ask what the guidance was because I obviously do not want to go into a care home and spread -- I might not have been symptomatic but I could have been a carrier so I wanted to speak to Public Health and they were like, "absolutely under no circumstances should you be going into work" so I had asked them to put that into writing.

They sent me an email across and I had sent that to my manager and I said "I will not be in, public Health have advised I should not be in" and informed her of the guidance and then I just got an email back saying "okay".
Q. But basically you say there was a disconnect between that information from Public Health and what the expectations of the employer were?
A. Yes, because the employer was telling us that if we weren't symptomatic that we were to go in because that was current guidance but that was contrasting with the actual guidance that was available with Public Health.
Q. And to repeat again, this was quite early in the pandemic that you tested positive?
A. Yes.
Q. Or you had these symptoms?
A. Yes.
Q. Now, you then go on to, of course, a high profile issue of care homes taking patients who were discharged by hospitals.
A. Yes.
Q. And you say in paragraph 29 you give your view that you consider that hospitals were prioritised over care homes at this time?
A. Yes.

Q. And you gave your view that for everything it was hospitals first. And then in paragraph 30 you begin explaining what you remember about patients coming into the care home from hospitals. And so what do you want to say about that?
A. So when the patients were coming in from hospitals, they weren't being tested, this wasn't current guidance, so they were brought into the care home, no testing done, and that had a massive impact on staff and residents because when patients were being discharged from the hospital without COVID testing, we didn't know whether they actually were COVID positive or not because nine times out of ten they were coming into the home with a lot of very similar symptoms to COVID-19 which meant obviously that they could be bringing it into the care homes and we didn't actually have any proof or evidence that they were doing so.
Q. So there must have been space in the care home you worked at for that to happen. I mean, the care home there wasn't full then, was it?
A. A few of the in-residents had passed away so there ended up being space.
Q. And did this happen quite quickly, if someone passed away and a space became available then quite quickly afterwards someone --

A. Very quickly.
Q. Very quickly someone was received into the care home?
A. Yes.
Q. Yes. And did this continue throughout the first lockdown or was it more true at the beginning or end?
A. It continued throughout but when it came to testing towards -- I would say, the second lockdown towards the end, that's when they obviously -- they had to start testing people from the hospitals before they were brought in.
Q. And do you remember the incidents of COVID where you worked increasing at this time --
A. Yes.
Q. -- during March/April 2020?
A. Yes, I remember a lot of residents being brought in not very well and then I remember that our death rate just kept going up and up. We would, you know, have residents in the home that would maybe pass away every couple of months but when these patients started coming in from the hospital, they were passing away in droves, it was like every week, one, two, three people a week, if that.
Q. And then in paragraph 32, continuing this theme, I mean you -- again I want you to put it in your own words but summarising, you describe something like a sort of

collapse of regulatory arrangements. I mean, you say that you were entering rooms with positive cases because of lack of staff.
A. Yes.
Q. Yes. And what you mean by that I think is that people were in the rooms, had tested positive, but you were still having to go in there for example, to deliver meals or what?
A. Yes, or even just provide care. You know, you just can't leave them because they were COVID positive but we weren't fully equipped with the PPE to be dealing with people that were COVID positive.
Q. And what you say in paragraph 32 is that some of these people had recently arrived from hospitals.
A. Yes.
Q. Now, you then go on in paragraph 33 to describe the impact on the health and in particular the mental health of staff arising from this pressure.
A. Yes.
Q. And is there anything further you want to specifically say about that subject?
A. Well, the rate of the death of the residents like passing had massive impact on us all because we are meant to support people who are on palliative care and we want to obviously be there at their end of, life we

have looked after these people for years, and during COVID and the lack of staff, we weren't actually able to sit with someone that was on palliative care and because they weren't allowed their family members in, sometimes, you know, our resident might have had to pass away alone and that's not the kind of care that we wanted to provide, we wanted to be there at their end of their life and it was really, really difficult and I know that that had a massive impact on my mental health and I still think about it and get emotional when I talk about it to this day.

Q. And as you said previously, this was combined with problems of family members visiting of course too.

A. Yes, correct.

Q. Your statement then turns to issues around pregnancy at work and the need for or the absence of risk assessments of pregnant workers. And you say that during the end of the first lockdown you yourself became pregnant.

A. Yes.

Q. Yes. And so when you learned you were pregnant, did you ask for any risk assessment in relation to workers who were pregnant?

A. Yes, so when I became aware that I was pregnant, I obviously informed management and asked them if there was any risk assessments available because I didn't know

the risks of COVID-19 in pregnant women and I just kept getting, you know, told that there was no time to do a risk assessment at this current moment of time so I had to kind of keep badgering management and say, "you know, it's kind of really important that I get a risk assessment because I don't know the implications of what could happen I want to make sure that I'm following correct health and safety to make sure that I'm protecting myself and the residents". I had actually asked to be furloughed because I was told that this was happening in hospitals for pregnant women and I got told, "no", there wasn't enough staff.

Q. Yes. You say in paragraph 35 that there was a protocol that a risk assessment should be done. When you refer to a protocol, do you mean a protocol in the home's policies?

A. Yes, so I obviously went straight to the policies folder and highlighted in their contract and their policy on pregnancy that a risk assessment should be done as soon as the employee notifies management. I brought that highlighted paper in and told management at this point, "this is in your own policies and procedures, I would like a risk assessment done" and I think they took it a little bit more seriously because they knew it was their own policy.

Q. Now, we'll turn a little later to what you want to say about your own experience of having a baby during the pandemic but before we do that, if we just stay with your experience as a worker in this care home. You say in paragraph 36 that you were recommended, naturally I think, that lighter duties should be taken on while you were pregnant?

A. Yes.

Q. But this didn't -- this didn't happen, did it?

A. No, it absolutely did not.

Q. And was that partly because of shortage of staff or ...?

A. I think it was the shortage of staff but it was also the lack of care from management. I don't think that they prioritised my needs. I think they had a lot more bigger worries that they didn't really -- they weren't prioritising any risks that I could have had as a pregnant women in their own.

Q. And during your pregnancy, your duties continued to include things like hoist lifting?

A. Yes.

Q. And you weren't limited to staying in the downstairs part of the home, for example?

A. No, so in my risk assessment, it was advised that I should be upstairs because it was lower risk because there was less people with dementia upstairs, it was

more frail and elderly, and there was usually more staff upstairs so that I would have maybe a little bit more support whereas downstairs was just a little bit more risky because it was a dementia ward, things were quite unpredictable, there was a couple of residents in there that did hit out quite a bit at staff so it might have been a bit risky for me to go down there. However, it just kind of what went by what suited management on the day because I did get put between upstairs and downstairs depending on what staff were in.

Q. And in paragraphs 40 to 42 of your statement, specifically in 40 to 42, you do describe some severe impacts on your own mental health from the combination of these experiences. So in the first place -- if I understand correctly; in the first place you're pregnant; in the second place you've got what's going on in the care home, and the third place you've got the pressures of work.

A. Yes.

Q. Yes. So. Do you want to say a little bit more about how you felt, how this was impacting you?

A. So when I was going to work everyday, I was starting to have panic attacks like before I went to work, and then it come to the point where I was actually in work and I would start breaking down and it was to the point where

I couldn't do it anymore, I was coming home, I was crying. I was scared because I thought I was putting my baby at risk and I was also scared because I didn't want to leave the residents I was looking after and I knew that I couldn't afford to be off work because I had a mortgage to pay and I was going to be on maternity leave so it was really a lot of pressure. I was very depressed in thinking about going to work and it's quite hard to say but I just remember like every morning waking up thinking I just wish that I would get hit by a bus so I don't have to go to work. I was so depressed that I just didn't want to go in anymore.

Q. And it didn't get any better later in your pregnancy as you say in paragraph 45 and in fact quite graphically you say that you suffered a panic attack one day I think later in your pregnancy because of —— well, you and I think one other —— you and the nurse were basically alone in charge of 30 residents in the home so, in other words, half the residents of the home?

A. Yes. There was a lot of staff that were phoning in sick and the home weren't bringing in agency, one, because they were getting hired in the hospitals and there weren't enough to go around but, two, they said they couldn't afford to bring agency in the home. So when I went on shift that day, I found out it was me and a

nurse upstairs and I just went into panic attack because I was, I can't do this, not only am I severely pregnant and at risk, we can't provide the care we want to provide people with that much staff, it's just not possible.

Q. And this is quite —— this is later on, isn't it, because you say it was later in your pregnancy, so that's likely to be towards the end of 2020, isn't it?

A. Yes.

Q. And just to be clear about what you said there, was this a problem in finding agency staff or ——

A. There wasn't a problem in actually having —— finding agency staff. It was whether or not the home wanted to pay for it. There was quite a few agencies out there, but the ones that were available were the agencies that were a little bit more costly, because a lot of other care homes were hiring agency staff as well so they were tending to find that the only agency staff that were available were the ones that you had to pay higher rates for.

Q. And then in paragraph 46 you do say that —— well, you raise this issue. You don't quite say you brought a complaint, but you raise these concerns and specifically that experience that you've just described about more or less being, you know, alone with a nurse in charge of

half the residents of the care home and what you suffered.

A. Yes.

Q. You raise that with management and what was the response to that?

A. So I had sent an email to HR. I had actually raised it with management and didn't hear back, so I raised it with HR after that. My email was ignored, but then I got a phonecall asking for clarification and what had happened, how I was getting on and I had been telling them about the shortages of staff. I told them that I had had another panic attack and I had actually walked out the previous week, because I couldn't cope and that I was 36 weeks pregnant and I just couldn't do it and that it was unacceptable and that I just basically told HR that they needed to sort out my annual leave that I had accumulated (inaudible) during my pregnancy or I would be taking them to tribunal because of how they were discriminating against me being pregnant. And I had also raised the concern about not being furloughed as well.

It wasn't long after that phonecall —— I think it maybe would have been like five/ten minutes after that they were like you can finish your shift today, but I obviously said to them I'm not going to do that to the

staff and the residents. I need to make sure that I finish out the week so they have enough cover, but after this week I will go off on maternity.

Q. Now, after you had your baby and you returned to work, in paragraph 47 onwards of your statement you discuss what you feel are the impacts of the pandemic on the working environment that you were in.

A. Yes.

Q. Yes. And that in particular there was a significant staff turnover?

A. Yes.

Q. A lot of people left, in other words.

A. Yes. When I was on maternity leave, I was getting emails from staff, phonecalls from staff asking to help write their resignation letters and I must have one week got like seven messages in one week of people resigning.

Q. Hm—hmm. And after your maternity leave ended, what did you do? Did you return to the care home or did you leave it to ——

A. So I had requested for flexible working, because at the time I was with my then partner, he was working full—time, I couldn't afford the cost of childcare with just his wage alone, so I wanted to go back to work. I had requested flexible working. They were quite difficult about it and, because of everything that I had

experienced before, I started to feel my anxiety flare—up again and I was like it's not even worth it so I decided to resign. I didn't I want to return and then I got asked for a meeting with the new manager, who I had never met before, because a new manager had been hired when I was on maternity and I told her —— she had asked like me to tell her things that had happened before like in the home, how things worked and I just went in and told her everything that had been going on and why I didn't want to return and I just got told, you know, best of luck to you.

Q. Now, eventually you decided to leave and went to work for a public sector care home; is that right?

A. It was —— it's more public and private.

Q. Right.

A. That I work for, yes.

Q. Right. And very briefly, you say in paragraph 55 of your statement that, admittedly after the pandemic, your experience is more positive there?

A. Yes, there was a lot less pressure, because I had to go on a zero—hour contract so I was picking my own shifts around childcare, so it wasn't that I was going in doing 12 hour shifts, four days a week anymore. It was I could do a half shift here, a half shift there, you know, pick up when I could around childcare.

Q. Yes. All right, well, thank you for that.

Earlier I said that we would turn to something else which was your own experience of maternity services during the pandemic when you had your baby. So you say you found out you were pregnant towards the end of the first lockdown. That's in paragraph 56 onwards.

A. Yes.

Q. And you gave birth sort of around early in the third lockdown I think. But you say in paragraph 57 that the maternity experience, in your own words, was absolutely horrendous.

A. Yes.

Q. Yes. So do you want to say a little bit more about that then. So when did your experiences with the maternity services begin? Obviously you became pregnant. You knew you were pregnant in June 2020, but when did you start to have your visits to the maternity service?

A. So there was a bit of a lack of visits with maternity, so that was one thing that I think that was pretty bad and because it was my first pregnancy as well, so I didn't really know what I was doing, didn't feel like I had adequate support, and I was going to scans on my own.

And then the maternity services in terms of what I'm talking about is after I've actually had my child, I did

not get the support that I needed. I was going to be —— I was trying to breastfeed. During the pandemic there wasn't actually any services available on how to breastfeed. You could normally attend classes and that before the pandemic. There was nothing like that. There was no online classes or anything that I could have attended. So I kind of really struggled with breastfeeding after because I had a C—section. So trying to ask for support from maternity services on me breastfeeding was really, really difficult. And the hospitals and the healthcare centres there was a severe lack of it.

So I was really struggling, so I had actually contacted a volunteer service breastfeeding support like cafe in my area and if it wasn't for that service being available, who were actually volunteers, I don't think I would have been able to breastfeed and I ended up breastfeeding for two years, so that service was absolutely amazing, but I feel like that service should have been available from the hospital and from the staff. It just wasn't there. And also I dealt with postpartum anxiety and depression and I didn't get any support with that whatsoever.

Q. But you also describe your —— the period of labour as being very difficult while in the hospital. It was long

and difficult.

A. Yes, so I was in the hospital for ten days. I would probably say it was the worst experience of my life, because we weren't allowed to go outside in those ten days, so no fresh air for ten days was absolutely horrendous. We weren't allowed to leave the rooms. We were stuck inside the room for the first six days whilst I tried to have a natural birth. We weren't allowed to go walking about the hospital or anything like that. We weren't allowed visitors.

If my partner at the time wanted to leave the hospital, he was told he wouldn't be allowed back in, so he couldn't leave to get like any food or anything like that. If we needed new clothes, family had to come to the door, drop off the clothes and then the staff would go downstairs and pick it up and then bring it up to us.

I think it got to the point where like after I had had my little girl after my section one of the porters or the janitors, I can't remember the name of the staff, he had actually came to take me for one of my MRI scans and I remember being so excited because he went the long way around the hospital so I could actually see air and other people. I just felt like I was losing my mind and I think when you were so vulnerable after you have just given birth I really think that had a massive impact on

me.
Q. And you say towards the end of this section that postnatal care was, in your opinion, poor?
A. It was very poor. They didn't -- you could tell the staff was under pressure, you could tell that they were short staffed, you could tell that they were being run into the ground and as a careworker, I get it. I understood how they felt. But as a patient I felt neglected and I felt like my needs or, you know, anything that I needed to ask them wasn't prioritised, they didn't really have a person-centred care. It was just as quick as they could get in and get out.
Q. You don't expressly deal with this in your statement, but what do you want to say about care after you left the hospital, for example, health visiting services, children's visiting services?
A. So that was really difficult. I had barely seen a health visitor. I actually had to contact the health visitor in order to ask when they were going to be coming out to see my little girl, because obviously her development was really important to me. I wasn't getting her weighed. I wasn't getting -- they weren't coming out to tell me anything.
I was a first-time mum so I didn't really have any experience of how it was meant to work before, but

I know from my sister giving birth previously that she had seen a health visitor quite regularly after she gave birth and I had barely seen -- I had maybe seen her once, twice, maybe even three times during my aftercare.
Q. And this would be during the third lockdown in the first part of 2021?
A. Yes, but it also continued -- it was up to me to be able to contact the services, not the other way around.
Q. Well, thank you. You then turn finally to the lessons you would like to be -- you would like to think will be learned from what you've described and I suppose there are two parts to this. There's the lessons to be learned from what you've been saying about your experience as a careworker in a care home and then, secondly, the lessons to be learned from what you've just described about maternity services.
So if you want to deal with the first one first. What would you hope would be the lessons that will be learned?
A. Well, I'm really hoping that when the government are doing the national care service and the registered care work that they're going to hold private care homes accountable. And what I mean by this I think they need to start listening to staff that are on the floor, rather than the people who own these private care

companies. I think it's important for careworkers to be able to share the experiences in order to be able to actually improve policies and procedures in the future.
I think that involvement with trade unions is really, really important in care homes, because no one is holding private care companies accountable at the moment and I think careworkers need a voice and they need someone to hear them, regardless of who the union is, and I think it's important that they have someone to advocate for them, because a lot of staff aren't aware of their rights and if it wasn't for me knowing my rights already, I probably would have been treated a lot worse than I already was. So I think it's really important if we're going to introduce a national care service and fair work scheme that we actually have fair work procedures put in place and the government really, really learn from the mistakes that was made and I also think -- sorry just to add in -- that all of these COVID inquiries and people like me talking it's really good that the public can hear how transparent we are being, because they didn't actually know a lot of what actually went on in the care homes. So it's good to hear from people like me and people who worked in the care homes, because they can see what actually went on.
Q. You do say in paragraph 67 that you think especially in

terms of not following correct procedures, I mean you have referred to protocols and a handbook of procedures and so on, but I mean are you -- is the implication from that what you want to say is that, yes, there were procedures and guidance books and so on, but I think you said once you had to go and look at it yourself and the books there, but there's a difference between the guidance book and the protocols being in place and actually being followed; is that what you're saying?
A. Yes, correct. I mean I was a union rep so I kind of knew what I was doing and talking about, but what about people who don't have a union rep in the care homes? How do they -- how do care home providers be held accountable for following these policies and procedures if there's no one there to help them be accountable.
It's down to the government to make sure that they are following correct procedures and policies and protocols and make sure they are held accountable if they don't.
Q. Hm-hmm. And is there anything specifically you want to say about lessons to be learned from what you experienced in relation to maternity services?
A. I think, you know, a lot of the hospital staff were actually the same. We have the same experiences as well in the care homes, in terms of they're absolutely run

into the ground, so I think we need a lot more mental health support in the hospitals.

I think there needs to be a lot more training in terms of aftercare when it comes to maternity services. I definitely think there needs to be better training when it comes to breastfeeding and more services provided for mothers who haven't breast-fed before and, yes, I just think that the government need to be looking at how care is provided in a hospital after birth, because it's just so important when someone so vulnerable that they get person-centred care, rather than just treated like a number.

Q. Yes. Well, thank you very much. Is there anything else you would like to say to the Inquiry?

A. I think I have said most of what I wanted to say in my statement and today. I just hope that, you know, that lessons can be learned from this and I do -- I hope that there is positive change when it comes to private care homes, because I feel like we have been forgotten for quite a bit now and it's time that care is prioritised, social care is prioritised as much as the hospitals are.

Q. Well, thank you for your evidence and the effort you have put in both today and to your statement. Once again, thank you.

MR EDWARDS: My Lord, that concludes the evidence of this

witness.

THE CHAIR: Yes, thank you very much indeed and can I just thank the witness very much. Very good. 12.30, I think you're taking the next witness -- 1.30, I think you're taking the next witness, Mr Edwards.

MR EDWARDS: Yes.

THE CHAIR: Thank you.

MR EDWARDS: Thank you.

(12.16 pm)

(Luncheon adjournment)

(1.31 pm)

THE CHAIR: Now, good afternoon, Mr Edwards.

MR EDWARDS: Good afternoon, my Lord. This evidence session is evidence from Mr Neil Craig, who has worked for many years as a porter at the Glasgow Royal Infirmary and he's giving his evidence as a union representative for Unite.

THE CHAIR: Very good. Thank you. And good afternoon, Mr Craig.

THE WITNESS: Good afternoon, my Lord.

THE CHAIR: Yes, Mr Edwards.

EVIDENCE OF NEIL CRAIG

Examination-in-chief by MR EDWARDS

MR EDWARDS: Yes, thank you, my Lord.

Mr Craig, could you give your full name to the

Inquiry?

A. Neil Thomson Craig.

Q. And you have worked as a porter at Glasgow Royal Infirmary for 25 years; is that right?

A. That's right.

Q. That's right. And you're also a union representative for Unite?

A. That's right.

Q. Yes, that's right. Now, do you have a copy of your statement in front of you online? Good.

A. Not yet. It's not on yet.

Q. Is it not. It is now.

A. Thank you.

Q. Good, so you have that in front of you. Have you had an opportunity to read over it?

A. Yes.

Q. Yes, and you are happy for that statement to be published?

A. Yes.

Q. Yes, and for your evidence today to be recorded and published?

A. Yes.

Q. Yes. The reference for Mr Craig's witness statement is SCI-WT0118-000001.

Now, if you could begin, Mr Craig, with just

describing briefly what your duties are or indeed what a porter's duties are in a hospital, as you do in paragraph 3 of your statement?

A. So my main duties is taking patients from department to department for x-rays, theatres, collecting blood samples, collecting waste, delivering prescriptions, basic left and lay between the departments and the hospital.

Q. And those were the duties that a porter would have had before the pandemic?

A. Yes, same duties.

Q. Yes. And more or less continued afterwards?

A. Yes.

Q. Yes, and you worked as a porter at the Glasgow Royal Infirmary throughout the pandemic?

A. Yes.

Q. But you -- and sorry -- when did you become a Unite representative?

A. So I became a Unite representative in the January 2020.

Q. Right, so just before?

A. Just before COVID.

Q. Right, very good. Now your witness statement, as most of them are, are organised around a number of themes and what we are going to do is just look at some of those themes and the first theme is the first learning about

COVID and the sort of first impact of it when began to see what was happening abroad and when it first hit Scotland. And then we'll move on to issues around PPE, which we'll spend some time on.

So I mean can you remember when you first learned of the outbreak of the pandemic?

A. Probably just in the news. In Italy I think was at first . We'd learned about it in the media.

Q. Now ——

A. It was probably February.

Q. Yes, February 2020, but in paragraph 6 of your statement you describe the sort of first response of the hospital that you remember when a COVID—positive patient arrived.

A. So the first patient I remember in the GRI was a patient that had been on holiday and had been transferred to the GRI. So when that first patient came in, they came in off the ambulance. There's everybody round about them had serious PPE masks, like Hazmat suits. No, we couldnae be clear. The only thing we had to do was make sure that the corridors and the lifts that that patient was going to be through to get to the ward was all clear . So we didn't need to go near that patient at all at first .

Q. So there was definitely a sort of response to the unknown, if you like?

A. Yes, it 's like made you feel safe at the time, because of the precautions they were taking.

Q. But things quickly changed you say in paragraph 7?

A. Yes. So in that ward that that patient was he was in a side room, they were in a side room, the door was always closed and then gradually through the week the door was open to his room, the PPE that staff had on going into his room sort of reduced to like a surgical mask and then sometimes none.

Q. Now, that brings us to PPE which you begin discussing at paragraph 8 so at the —— before the pandemic, what sort of PPE would a porter normally have, if any?

A. Before —— usually for a patient had say for an MRSA you wear a mask and gloves and apron just for that patient if they were confirmed, but then for any other patient we wouldnae use any PPE at all.

Q. Yes. And at the beginning of the first lockdown, so March 2020, did that change?

A. So at the beginning it sorta you would wear a mask. PPE it was changing day—to—day at first and then it was changing if you had a patient it was confirmed COVID and it was contact COVID, so basically you didnae really know at first if the patient had COVID, so you didnae wear PPE, only when it was COVID.

Q. You say at paragraph 9 in the initial periods —— after

this first experience when great precautions were taken then it relaxed and now we're moving into the initial period sort of March 2020. You say in paragraph 9 that the default position was that patients were getting treated as if they did not have COVID?

A. Yes, aye, nae symptoms, if you had nae symptoms, you didn't have COVID

Q. Yes, and obviously there was no testing at this time?

A. No, testing, no.

Q. Now, in paragraph 10 you say you remember collecting a patient from a ward to take them to x—ray and you say they were feeling sick and you gave them a sick bowel. Now, did they think they had COVID or what do you remember about that?

A. Well, I don't know if at the time any of the staff thought that patient had COVID, but I had to take that patient fae the ward to x—ray and they didn't have any PPE. I didn't have any PPE, because obviously they were getting treated as somebody who didnae have COVID confirmed, they werenae confirmed it, PPE at the time.

Q. Yes. And what you say in the next paragraph is that you remember this because the hospital opened a COVID ward the next day?

A. So the next day that's when normal —— we had normal wards and then in that day there's been the first

experienced a particular ward getting open for COVID patients, COVID patients only. And that patient was one that I'd pushed the first day was the first patient in that ward, so obviously I was a bit upset about that.

Q. Because you thought you would now ——

A. I thought there was a great risk of me catching COVID because of the contact I had with the person.

Q. Now, you explain that you live with your family, you live with your partner and your daughter, and in paragraph 12 you raise the issue of provision that was made or not made for staff that might not want to go home to their family?

A. Aye, so at that time, at that time I was aware that —— so there was the opportunity for surgeons and nurses they get put up in a hotel. Instead of going home to their families at the time, they could put up at a hotel, but that never extended, my knowledge and as I remember in my experience, it never extended to porters and facility staff , domestics at the time.

Q. If I could just explore that with you for the moment. What you're saying is —— it is one of the themes of your statement that there was an unequal treatment of certain staff compared to others and, at the moment, we're focusing on the beginning of the pandemic for the first lockdown, but what you're saying in paragraph 12 is that

clinical staff were offered the opportunity of not having to go home, but the domestic staff, as you call them, including porters, were not?
A. So I never heard any communication about that offer being made to porters or domestics.
Q. Right. So just to be clear, you're not saying that it was definitely the case that someone was not offered that?
A. No.
Q. But your recollection is they are not?
A. That's the way I remember it. I am no saying definitely, but just I remember it -- well, I don't remember any communication was extended to the porters.
Q. And you don't remember ever being offered that possibility?
A. No.
Q. No. Now, again at this time certainly no PPE was routinely offered to porters?
A. No. So at that time that's when PPE was still what type of patient, all depends, but it was confirmed COVID, contact, but it was still basically we never had at that time that we had to wear PPE with every patient, so it was still unsure.
Q. And what you say in paragraph 13 that it is possible that PPE would have been offered to porters if there was

a confirmed COVID patient?
A. If it was -- the PPE was there to use if it was a COVID patient confirmed, but at that time there's still no testing, so the only way of confirming the patient at that time was probably when we take the patient up to CT scan and that was where most patients were getting confirmed at the time during their CT.
Q. And you wouldn't routinely be told if someone was or was suspected?
A. No. What happened then was we took that patient to CT. The staff -- the nursing staff up in PPE were a bit angry about you turning up with a patient, but the patient didnae have the mask on either and we didnae have a mask, so they were a bit no annoyed about us turning up with a patient without PPE on for them or us.
Q. When you say that after April 2020 porters began to be issued with PPE, are you saying that this was only in relation to when a patient was suspected of having COVID?
A. That's been the start, aye. At that time we were asking could we no just wear PPE wae every patient, because we knew patients were going up there to get confirmed that they had COVID.
Q. But in relation to masks, we'll return to masks in a moment, but in relation to masks at this point masks

were not routinely issued?
A. No, no.
Q. To porters that is?
A. To porters -- no, they could get them. It was all just about confirmation of a COVID patient. If it was confirmed, you definitely got one, and it wasnae, you didnae need one.
Q. Now, in paragraph 14 you discuss the union's response to this and you say you remember one Friday -- do you roughly remember when that would be? Would that in April 2020 as well?
A. That was in April and that would have been sometime in April 2020.
Q. But which time you had been the union rep for three months?
A. Aye, so in that paragraph that's me talking about I went to a meeting, fulfilled their meetings with a manager to tell facility staff the guidance, what PPE were expected to wear. So at that time that's when we were getting told that you wear PPE, masks, gloves, aprons with every patient, but then later on that night it sort of changed. The porter -- some porters went up and they get told they no longer had the need to wear the mask face to mask, because they werenae face-to-face with patients, they were working with patients at arm's

length.
Q. Yes.
A. But that's me talking about then a contact, James and Esther, to see if that's the guidance or to get their guidance and whether that had changed or anything like that, because to my knowledge it hadnae changed Friday from afternoon.
Q. Yes, but it was a meeting at which you were -- it was explained to you how PPE was going to be issued?
A. Yes, I had to support the managers, managers at that meeting. They say like the union rep was there and I was there to support the manager with what they were telling people, you need to wear a glove, mask, apron with every patient now, and then it changed later on that night.
Q. Yes.
Excuse me, my Lord, if I could just take instructions on one small point for a moment.
Yes, my Lord, I just wanted to make clear that Ms O'Connell and Ms O'Hara have already given evidence to the Inquiry, as my Lord might remember.
So what you're saying is those representatives, along with yourself at the hospital, were instrumental in organising this meeting? Is that what you are saying?

A. Yes, James was, yes. James was obviously a full time Esther was a convenor at the time, so they're senior reps to me. That's where I was getting my advice, getting asked to support management, because obviously it settled staff's minds if they have the union rep there to support the manager and they're agreeing with they're getting told.
Q. And so what was the follow—on from this meeting then?
A. So that meeting went well on the Friday. As I say, I just basically just was there to support the management at the time and back up everything they were saying and then the follow—up was the Friday night some porters were getting told they didnae need.

So when I went in to work the next day, the Saturday morning, I couldnae understand why there was a change when I had spent the full day, the Friday, supporting management to tell them we need to wear the masks at all times now, gloves and aprons, and then it was changing.

But then that Saturday I quickly phoned James, contacted James, and James got it all cleared up that the guidance hadnae changed and the porters will definitely still wearing masks. From that day on, we always wore masks with every patient.
Q. What you explain in paragraph 17 is that following the meeting on a Friday a porter had experienced been told

by another member of staff that they didn't have to wear a mask?
A. Aye.
Q. But it continued to be the case that the availability of masks were a bit erratic?
A. At that time it was definitely. That's when there was a wee bit of masks are out of date, boxes of masks might have been out of date and stuff like that. There was all sorts of things. That was when the availability wasnae great.
Q. Now, you also say in paragraph 20 that some of your colleagues were unhappy with these arrangements and refused to do their job?
A. Aye, so whilst they were getting told that there was nae need for them to wear masks then porters were contacting myself or other union reps and our advice was, no, the guidance hasnae changed. You need to wear a mask. Doesnae matter no matter if any nurse or any doctor or anybody was saying that you don't need to, it's not —— that isnae formal. Formally we get told to wear masks and that was it.
Q. Hm—hmm. And insofar as the there was confusion around this, the impact of that on you and your colleagues in the domestic staff, if I can call everyone that?
A. So that for us that impacted, made you feel a bit angry

that you could see that there was a lack of masks here and then we were the ones that's getting asked not that we didnae need. There was a change and we werenae to wear them anymore. We didnae need to wear them, but then obviously we knew that nothing really had changed.
Q. So I think what you're saying is, as you remember it of course, that insofar as there were problems with the supply of PPE and in particular masks there was a prioritisation ——
A. Yes.
Q. —— of the allocation which porters didn't come out of favourably?
A. Yes, we didnae —— a porter's job is you have face—to—face with a patient, but it's not for a massive amount of time.
Q. I think you say that you were —— there was an issue in paragraph 18, just going back a little bit, in paragraph 18 you say that one rationale for porters not needing to wear masks is that they were pushing patients from behind.
A. Yes, at arm's length. That was ——
Q. At arm's length. Sorry.
A. That was like —— that was the scientific evidence that I got told at the time.
Q. When you say you were told it was scientific evidence,

who told you it was scientific evidence or where did that information come from?
A. That came from management team. They said —— and it was —— the guidance did change daily so and it was a fluid thing. It did change daily, so that's what they where saying the guidance has changed fae the day before.
Q. And then you say in paragraph 23 that the issues around PPE added to the general anxiety which staff were suffering?
A. Definitely, definitely, aye.
Q. Now, when in paragraph 24 when you describe as fit—testing for FFP3 masks, so I think what you mean by that is FFP3 masks would be issued and would be tested on people to see if they fit?
A. Actually, you had to get tested to see if they fitted you properly. So around about April some of the porters that were based in the A&E department they got fit—tested for them, but, as I say, they never —— that was for patients that were on ventilators or getting oxygen at the time, but we never came into contact wae they patients because the ICU staff or high dependency staff actually moved their patients themselves. So even though some of the porters were fit—tested for them they never needed to wear them, because that meant —— that

was a good decision. That minimised the people that were actually going near they patients.
Q. Now, when PPE did become more readily available and broadened out to all members of staff, you raise the question in paragraph 25 of training issues, the availability of training to use PPE, remembering that historically porters would only use it rarely, if at all. So when it became widely available and people were expected to use it, obviously there is a danger of people not using it properly so what were the issues around that?
A. So the PPE there's actually a way to —— an order where you put the gloves and the apron on. So before that we were —— we were probably never even aware in a proper way about the PPE goes on. We had earlier patients, MRSA patients, but then there was guidance came out, there was an order you would put all your PPE on. There was an order how length you would keep a mask on. If your mask became damp, you had to change it. If your mask —— if you went into the ward with a clean mask on you had to take that off or if you went with a mask on, you took that off and put a clean one on. If you went into a patient's room, you took the one you owned and put another one on, a different on. So every time you came into another space, another area, you changed your

dirty mask for a clean one and you hand sanitised it as well. So we got trained in the circumstances where you would change your PPE.
Q. Now, you say a little later in paragraph 27 that certainly by the time of the second lockdown full PPE with surgical masks was provided to every porter so by November 2020?
A. Sorry.
Q. By about November 2020?
A. Aye, so the first —— I think first lockdown's finished in August and then time —— even for then August we were always wearing —— even when a lockdown was finished we actually still wore PPE with every patient, gloves, mask, apron and by that time, we knew how often to change it as well.
Q. Yes. But what you say is —— you say that as you feel it the worst period was in between July/August 2020 and November, the end of the first and the beginning of the second lockdown?
A. Aye.
Q. That this was at the worst period. Why do you say that?
A. Because for me that was the worst period, because we had a rise in staff that actually had COVID numbers. There was by this time COVID patients there was a great amount of COVID patients in the hospital, but we had normal

patients. I just say normal. We had normal everyday patients returning back to hospital as well, so the capacity in the hospital was up. And at that time I've got my members that were shielding, they're coming back to work. So the vulnerable staff we had after the first COVID lockdown, they're starting to come back into work so that back there has been prevalence about the hospital with COVID staff and more COVID patients was greater than it was at the start. April, May wasn't as bad as ——
Q. You're right in that the statistics do show that there was a rapid increase in August/September 2020 of people getting COVID and going into hospital. So what you're saying is there was a significant increase in patients coming into hospital with COVID and a significant increase in the number of your colleagues getting COVID?
A. And probably a significant increase of people catching COVID in hospital.
Q. You then turn —— is there anything else on this point that you would like to say about PPE at this moment before we move on? Is there anything else you want to say about PPE?
A. No. By then PPE was fully you understood, when we need to use it and why it was we need to use.
Q. Well, your statement then turns to the impact of the

pandemic on shift patterns, so work shift patterns and we just wind the clock back a little bit to the outbreak and the beginning of the first lockdown. So you begin in paragraph 28 by describing the pre—pandemic situation that certainly in your case you would work about 48 hours per week, albeit some of that was —— ten hours or so of that was overtime. That was the routine position.
A. Aye.
Q. And you say that, interestingly, that as you remember it at first your colleagues as porters were not getting COVID or not catching it.
A. Not at first, because when —— at the start a lot of the porters, because we were essential workers, we were going to work, where lots of people were going to work, obviously you're reading media and it was like a, well done, you're going to work, this is your duty. So a lot of porters were going in and working and the managers didnae know the impact of COVID at first, how the capacity in patients that was going to be. So thought the workload was going to be higher and so we were all there and we could be there as long as we wanted to be really, because people weren't sure if you were going to be needed, but it turns out we werenae really needed.
Q. So people were coming to work, they weren't getting COVID at the beginning and the shift patterns at first

stayed the same, but what you're saying is there was a significant fall in the amount of work porters had to do?
A. Definitely, yes. We didnae have the capacity in the hospital. A lot of patients -- obviously a lot of patients they discharged out of the hospital, either to home or care homes or other places. They didnae do theatres, they didnae do schedule elective surgeries or anything like that, aye so the workload was definitely no as bad.
Q. And that's partly because you explain in paragraph 30 that the medical block was less than half full, but by the medical block you mean where preparing for theatre or --
A. No, the medical block would be like your everyday general medicine patients. So we're used to the wards being full to capacity most days, but then you gone to the wards and they were half empty, half full, whatever way you look at it.
Q. In paragraph 31 you say people were still coming to work but a long period could pass before a porter was asked to do a job?
A. Because of the amount of workload wasnae the same and because we had probably that was the best time we were well staffed in the hospital, because people felt it was

their duty to go into work and work through it and, aye, we had lots of free downtime.
Q. But then from sometime in April 2020 admissions to hospital of COVID patients increased?
A. Aye.
Q. Did that mean the workload increased for porters?
A. So gradually the workload would increase but they would still --
Q. Or return to normal?
A. Aye, it still wouldn't be anywhere near as a normal day, because you've no got elective surgeries on, you've no got clinic appointments, so you've only got people that need to be, seriously need to be in hospital in emergency theatres.
Q. And you go on to say that as more COVID patients were admitted to hospital, the designation of COVID wards changed. There didn't seem to be any, as you put it -- I'm putting words into your mouth. I don't want to do that. But there didn't seem to be anything systemic about the designation of COVID wards?
A. That was definitely -- that was a thing that changed. Maybe it changed through the day. You would get -- so if one patient had COVID in a ward then that ward would now become a COVID contact ward, so you could no longer put patients that didnae have COVID into it and then if

that got confirmed as most patients in that ward was COVID now, then it became a COVID ward. So wards were changing. Sometimes they would change -- you would go in the morning and it wasnae a COVID ward, but by the afternoon it was now a COVID ward because somebody tested positive.
Q. And what were some of the communication issues around that?
A. So that was -- that wasnae communicated to the porters, domestics or anything like that. You wouldnae know you were going into a COVID ward at first, because you didnae get told.
Q. Until you went in?
A. Until you went in, aye.
Q. Now, of course we all know that many people died in hospital as well at this time and one of the responsibilities of porters is to move deceased patients?
A. Yes.
Q. Which is the next subject that you turn to in your statement. Now, again, before the pandemic what would be the protocol or the procedure in relation to moving deceased patients?
A. So a deceased patient we would take to the mortuary department. If they were in ICU, they would be in a

body bag, but if they were not an ICU patient, they would be wrapped up in a sheet, in sheets, and we would take them to the mortuary.
Q. And how long would a deceased person normally stay in the mortuary?
A. So --
Q. Or was there a general rule?
A. In my opinion probably maybe one to two days. It all depends how full the mortuary was at the time probably.
Q. Now, at the outbreak of the pandemic or a few weeks into the first lockdown, the practice changed in relation to deceased patients, didn't it?
A. Yes. So as we had gone a few weeks into the pandemic then deceased patients were all going in in a body bag, so they would all go into a body bag and then if you go further on in the pandemic, it would be double bagged, a COVID patient would be double bagged.
Q. When you say "further on" what do you mean by that?
A. So probably -- maybe a month later into it.
Q. So may or something like that?
A. May/June 2020 you would be double bagged by then, but a patient -- all patients would be double bagged.
Q. Right. So even if it wasn't established that someone had --
A. No, even if it wasn't established.

Q. Right. So the practice then was to put all patients into a bag and then shortly after to double bag patients?
A. Aye.
Q. Deceased persons. Yes. But that didn't continue consistently either, did it?
A. No, that did not, because there was a time where patients were coming —— they were just in the one bag, they werenae double bagged and we'd take them down to the mortuary. We would be asked to take them down to the mortuary, but the mortuary attendant was asking us to like can you make sure they're double bagged, because funeral directors —— the guidance was still —— the guidance by now was to double bagged and the funeral directors wouldnae take the patient from the mortuary unless they were double bagged, so that meant the mortuary attendant —— she was double bagging them and she was putting them in the bag herself so —— which is quite a hard task to do.
Q. Yes. So at some point the practice or the recommendation to double bag a deceased person wasn't being followed?
A. Wasnae.
Q. And the porters were taking that person to the mortuary and it was up to the mortuary attendant to do that?

A. Yes.
Q. And part of the reason for that was because funeral directors were refusing to take people who weren't double bagged?
A. So the funeral directors —— the guidance did say double bagged, but the funeral directors they stuck to that guidance. They wouldnae take the patients out of the mortuary, unless it was double bagged.
Q. How did this work in terms of space in the mortuary? Was there a sort of back up or ——
A. So in the mortuary —— I am only speaking to the mortuary attendant and she would tell me this. The mortuary would be full and she would need to contact —— she would need to contact the funeral directors and you need to get this patient out of there, out of the mortuary into your funeral parlor or wherever it is you need to take them. And then because of the double bagging so didnae want to have a delay she would double bag them probably not to cause that delay. That's the reason why she would do that and that's the reason why she asked us not to leave the ward with a patient unless it was double bagged so ——
Q. I mean as a porter you will be familiar, I would have thought, with how this resolved. I mean when did this problem resolve?

A. That didnae actually happen for long. That was —— that only went for a week and probably the fact that mortuary —— funeral directors wouldnae take the patient and we then porters wouldnae leave the ward without the patient double bagged probably helped, but then, aye, so that was —— that was only for a week.
Q. That was only for a short period?
A. A short period of time.
Q. Right. You then turn to the exposure for porters to COVID and what you said earlier was in the first lockdown there didn't seem to be a significant incidence of COVID amongst porters where you were working?
A. Aye, because then again we didnae have —— we didnae have the latter flow test or anything like that. We didnae —— people —— you could have COVID and be asymptomatic, so there was nae porters at the time turning up to work with symptoms with COVID up until probably, as I say there, the end of July, August.
Q. Sorry. Go on. I was just going to turn to paragraph 41, but I think you were going to anyway.
A. Aye, so my first recollection of a porter turning up to work with COVID was in August 2020 and this porter was actually an agency staff, so he didnae work for one department, he worked between two departments. So he worked —— he worked with the casualty porters and he

worked with we call them the poolroom porters so a lot of the staff were in contact with that porter at the time.
Q. Now, by this time that we weren't in lockdown between August and October 2020, and what you're saying is that the incidents of COVID amongst porters increased at this time?
A. Definitely.
Q. And the union's advice, you say in paragraph 42, was that porters who tested positive or had symptoms of COVID shouldn't have any contact with patients. That was the union's advice.
A. Aye, that was —— that was not just union advice. That was probably the guidance —— that was the guidance of porters about their work. Porters shouldnae be at their work if they had COVID at that time.
Q. Right. But as you remember it, that was not the management's position?
A. No, at that time that porter has been to their work, then normal guidance for every other —— all the other departments were if there was a member of staff, a contact how has is COVID, then everybody who had been in contact with that porter or member of staff was meant to be off-site.
Q. Yes.

A. Occupational health advice was to leave work, go home, occupational health will contact you, go through their checklist and see if you're all right to go back to work.
Q. And is that what happened?
A. With the porters? No, we got asked to stay there and occupational health would contact us that day. So my advice at that time and we were asked to still push patients until occupational health confirmed that you could go home or stay. My advice that day was and obviously speaking —— phoning James for James' advice on it.
Q. That's James O'Connell?
A. Aye. We will no be pushing any patients until occupational health confirmed that we were safely —— we were to be still at work.
Q. Yes. And in paragraph 45 you maintain that generally, so not always, but generally, porters were never sent home if they had been in contact with an infected colleague, whereas other departments were getting sent home?
A. Aye. So in that incidence there, we had two porters that were sent home that day, two porters. Probably 15/20 that came in contact with that porter had COVID confirmed.

Q. And you say the decisions —— just to be clear, the period we're talking about now is when there was an increase incidents of COVID so this is the second half of 2020?
A. Yes.
Q. You say in paragraph 46 that the practice of not sending staff off—site was one —— well, was one that led to an increased exposure to COVID?
A. Definitely, definitely. Because we were come in contact with porters or domestics staff that had confirmed COVID and we were nae getting so —— basically there was a checklist that would ask you if you had been two metres away, had your mask on, but then it's your manager asking these questions, so there was an element —— for me an element of staff maybe no telling the truth when it came to, because they thought there might be consequences.

But that's when definitely the rise in porters catching COVID, that's when it came, but then we were coming face—to—face with not just COVID, porters, staff members, patients with COVID as well.
Q. Now, by this time of course there was more guidance on shielding and risk assessments and so what you say in paragraph 47 where you turn to this is that in October —— in and after October 2020 there was a rise in

shielding porters?
A. Aye, returned —— rise in shielding porters back at their work.
Q. There was a rise in shielding porters returning to work. Why was that?
A. Because —— well, after the first lockdown it was like the government guidance was like lockdown is over, people that were shielding can return and go back into —— go back to your work. So the staff members that were shielding, they were —— it was —— guidance was that they could return to work now. So they were back at their work between probably October, November, I think.
Q. And there were COVID risk assessments in place by this time?
A. So they would get risk assessed and they were meant to come back at the end of lockdown and that was just a phonecall off a manager. They say like —— ask a few questions. They say are you okay? You come back. You're all right to come back to work.
Q. What you're saying is the risk assessment was done by a manager?
A. Yes.
Q. And not by an occupational health qualified person?
A. No, not at that —— no. That was in end August and between August, start August and the end August, these

shielders were getting the phonecalls like "right you've had the risk assessment. You can come back to work." Remember the prevalent —— there was nae lockdown then so COVID was maybe —— was going down.
Q. Yes. So again we're talking about this period when the incidents of COVID increased amongst porters?
A. Aye.
Q. So it's after the first lockdown before the second lockdown. People who had been shielding during the first lockdown were returning to work more significantly, and any risk assessment that was done was done between them and a manager.
A. Yes.
Q. Yes, and not by an occupational health person?
A. No, no, no.
Q. No. I mean and you say in paragraph 50 and 51 that you consider that to be a fault of the arrangements?
A. In my opinion, yes, and then —— in that —— about that period that's when I know there's staff with underlying health issues that were shielding and now they are not shielding and the prevalence is starting to rise again August/September and then I was actually concerned that they werenae getting risk assessment whilst the risk assessment has started back again to send them back off, but then they werenae getting done properly because they

werenae getting done by somebody with medical knowledge.
Q. With the qualifications to do it?
A. Aye.
Q. Yes. And in fact you do discuss one practical example of this, don't you, in paragraph 49 where someone with a COVID age of 99 was determined that he could still work?
A. Aye. I witnessed his —— I witnessed —— he took me in. He asked me to come with him to do his risk assessment. I witnessed a manager doing the risk assessment. It came back as age 99 and you could have a —— there was guidance of if you're 99, basically you shouldn't have left your house, never mind be at your work and then the porter was told that, again, because he was pushing patients from the back behind the patient and it was arm's length then he would be okay to go back to work, but that's when —— for me that's the most concerning in my experience.
Q. And while this was going on, in the next section of your statement you do mention that you and your colleagues experienced a colleague porter dying?
A. Yes, aye.
Q. This would be in November 2020?
A. Aye. So that was all within the same week or two—week period. So a porter passed away, the risk assessments were getting —— again, the prevalence again is high up

in the society, the porter passed away, risk assessments are not getting done in my opinion the right ——
Q. By the right people?
A. Be the right people and then there's another porter same week ends up in ICU as well.
Q. And, in fact, there were two incidents quite close together, within a month of each other, of a porter dying; is that right?
A. One porter passing away and another porter in ICU.
Q. Yes. Now, at this time you also say there was in the —— well, this would now be the start of the second lockdown, there was a significant increase in the number of agency staff doing domestic jobs in hospitals?
A. Aye. So there was agency staff. There was a four nations agreement where they made getting hands cleaning in the hospital, so obviously employed the agency staff to do it. We didnae have full—time substantive posts for that and there was a great rise in the amount of agency staff doing domestic work, because it was fully funded on this four nation's agreement.
Q. But there were problems with agency staff because they weren't familiar with the hospital; is that right?
A. Aye. So it was great that you had these agency staff, but the supervision of them wasnae great, because, obviously, there's just too many for the amount of

supervisors that were there in the first place.
Q. Now, when do you say things began to settle down, began to return to some sort of normality?
A. So ——
Q. From the point of view of a porter?
A. Aye. For normality I think by the end of —— after Christmas that year, after Christmas that year was probably when everything started to settle down.
Q. When you say that year, do you mean 2020 or 2021 during the third lockdown?
A. Aye. I think by then, when you get into the third lockdown, quite clearly got PPE sorted, when you were wear it, who you wear it with. The tasks that we were doing was also back to normal. Again, I don't know if there was some elective surgery going on then, so it felt more normal and we were doing whatever we were meant to be doing.
Q. You do then turn to the post—pandemic or the post—lockdown impact on the health of your colleagues and you say in paragraphs 66 and 67 that there has been a significant increase in health terminations of employment?
A. Aye. So in my role as a union rep I need to represent people in some of these attendance management things. When I was representing members in attendance management

meetings, it was like how can we help you? People were off sick because they were waiting on appointments that they couldnae get at clinics. They were waiting in maybe some surgery things that they couldnae get in clinics. So the reason they were off work longer was down to because of the NHS's —— the backlog in obviously getting seen, getting treated. So there was a couple that got terminated, ill—health terminations, because of that so they couldnae confirm a date when they would be back at because they didnae date when they were treated.
Q. Has that had impact on staff levels amongst porters?
A. Well, probably aye. Long—term sick in they days was a lot higher, higher percentage maybe. You could probably look back on some reports and long—term sickness levels is probably 10, 15 per cent at the time, the staff off work.
Q. And the current levels of staff amongst porters, has that returned to normal to pre—pandemic levels?
A. Similar, similar.
Q. Similar.
A. Probable not as —— I'm a union rep so I always want more staff.
Q. Now, as many witnesses to the Inquiry have said, there have been significant mental health impacts ——

A. Aye.
Q. —— on people who worked in many roles in hospitals and care homes during the pandemic and you also identify that. Is there anything particular you want to say about mental ill health impacts, either in your own case or others that you know or represent?
A. Aye. So, aye, for mental health—wise there was people that were on shielding for a long time and then they came back to their work and when they came back to their work, obviously, they've got their fears and anxieties. they were shielding for a reason. They have been shielding because it's no been safe to go out in society for their benefit, but then all of a sudden it's all right to mingle —— back mingling with everyday society, work. So these people were definitely still anxious. Even though it was deemed safe to go back in to society, they still had their anxieties about it.
Q. Now, you have been giving your evidence today to the Inquiry as a union representative, but you also in paragraph 70 and 71 describe a personal experience that your family had and this would be with a healthcare issue with healthcare during the pandemic and specifically cancer care of your father, I think.
A. Aye. So my dad got diagnosed with cancer in the December 2019 so he had his couple of first episodes of

chemotherapy and he didnae get his last two, his last two appointments because obviously lockdown came in so he had to ——
Q. That would be the first lockdown?
A. First lockdown, March.
Q. So the last two appointments ——
A. So he didn't get his last two sessions of chemo.
Q. Why was that? They were cancelled?
A. They were cancelled because, obviously, lockdown came in and, obviously, he's going through chemotherapy at the time so his immune system has been compromised so he was not allowed to go out because of lockdown. So that was —— the lockdown was a benefit to my dad because that probably kept him alive, reduced the risks to him, but it wasnae great that you couldnae see your family. Your dad had (inaudible).
Q. Yes and he —— as a result of not being able to get the last two sessions of chemotherapy?
A. I don't know. I couldnae tell you the impact of that really.
Q. Was he living on his own?
A. No, he lived with my mum, so we couldnae see my mum and dad. I would take him to every appointment so no longer could really see him, because until lockdown finishes and I think it's June or July, I think. I can't

remember.
So even though I could —— I was a key worker, I could go out to push other patients about the hospital or anything like that, I couldnae actually see my dad and he was a patient.
Q. Yes. Well, finally, Mr Craig, you turn to lessons to be learned, and you make a number of points. Of course you have already made a number of points about the importance in your view what you say about risk assessments being done by occupational therapists, but is there anything else —— or occupational health qualified persons. Is there anything else you would like to say about lessons you would hope to be learned from the pandemic?
A. Aye. So I think —— I believe they probably would learn this lesson anyway about all the PPE that was needed and when we needed it and who —— what type of patient needed it. If there is a pandemic in hospital again, I would expect everybody that would automatically wear, masks, gloves aprons with a patient. Don't even take the risk whether it's a COVID patient or not a COVID patient.
I think the thing about the increase in domestics, I think we learnt that a hospital wasnae as clean as we needed. We had to get enhanced cleaning and I think why have we reduced that?

Q. Reduced it after the end of the lockdown?
A. Why have we reduced that after the end of lockdown? Are we no better keeping that hospital clean enough for during a pandemic? Shouldn't it always be like that. And obviously, just the occupational health like risk assessments getting done off —— getting done of management who didnae know —— have got any medical background and they have got a —— they have got a position —— they have got a —— it's —— what's the word I'm looking for? They have got an interest in keeping porters there.
Q. Yes, of course.
A. They have got an interest in keeping staff there. It's gonnae impact —— they know the impact to it so it would be better than maybe somebody who is independent or an occupational health person.
Q. Yes, you have made that point forcefully throughout your —— in a number of places in your statement and certainly again in paragraph 75.
Now, Mr Craig, your witness statement as a whole, along with your evidence today, will stand together as your evidence to the Inquiry. Is there anything else you would like to say or add before we close?
A. No, no. I'm just —— I'm just grateful we got a chance to give my experience and as a union rep and a porter,

so that's it.
Q. We are very grateful for the evidence you have given and for the effort you have put in to the preparation of your statement and I thank you for that.
MR EDWARDS: My Lord, that completes Mr Craig's evidence.
THE CHAIR: Very good, thank you very much, Mr Craig.
Right. Well, we finished a little early, Mr Edwards. I think —— I'm not sure if the next witness is available yet, but if the next witness is available, the last witness, we could start that witness at shall we say quarter to —— I know Mr Gale is going to lead that witness. We could start is at quarter to three if that's possible.
MR EDWARDS: I can ask, my Lord.
THE CHAIR: Very good.
MR EDWARDS: If it's possible, my Lord, we'll inform you, yes.
THE CHAIR: That's kind, super. Thank you very much indeed.
(2.27 pm)
(A short break)
(2.59 pm)
THE CHAIR: Now, good afternoon, Mr Gale.
MR GALE: Good afternoon, my Lord. The last witness today, and indeed the last witness in this section of the hearings is Ms Helen Goss. She is ——

THE CHAIR: Good afternoon, Ms Goss.
MR GALE: She is connecting with us remotely from her home.
EVIDENCE OF HELEN GOSS
Examination—in—chief by MR GALE
Q. Ms Goss, you have given evidence to the Inquiry before. I think that was on 2 November last year when you gave evidence about the work of the organisation of which you are a leader, Long Covid Kids?
A. Yes.
Q. So we have all that evidence. Your details are obviously known to the Inquiry and you provided the Inquiry for the purposes of today with a lengthy and detailed statement. The reference to that is SCIWT112—000001.
As I understand it, Ms Goss, as with the situation on the last occasion you gave evidence, you are content that that statement, together with the evidence that you will give today in amplification of that statement, will be recorded and published and indeed as today's hearing broadcast and that that will constitute your evidence to the Inquiry.
A. Yes, that's right.
Q. Thank you. Now, you are obviously now somewhat familiar with the process of giving evidence, but I wonder if I can just remind you of one or two things before we

start. You are here today principally to talk about the impact that Long COVID has had on your daughter and, just to give some context, your daughter first contracted COVID in the first wave in 2020 when she was seven; is that right?
A. That's correct, yes.
Q. She's now 11?
A. Yes.
Q. And can I remind you, Ms Goss, not to refer to her by name?
A. I'll try my hardest.
Q. Well, if we can be careful. And simply to refer to her as your daughter. I know that may seem a little artificial, but please try to do that. Also, can I remind you not to name any other of your family members.
And finally, you have in your statement referred to a number of medical professionals who have been involved in the treatment of your daughter at various levels and, again, can I ask you not to name them as we're going through your evidence.
Now, as you explained the last time you were here, you yourself suffer from Long COVID?
A. Yes.
Q. And I think from my own knowledge of following the production of your statement, that this statement has

been quite an effort or involved quite an effort on your part to produce it, both I think physically and emotionally; is that right?
A. Yes. I have found it incredibly difficult to write this statement, not only because of the difficulty that we've had over the last four years, but also because we were reinfected with SARS—Cov—2 in early December last year and my cognitive processing has been really bad so I was finding it very difficult to actually compose sentences, but we got there in the end.
Q. Well, you did and we are very grateful to you for doing that.
Now, in your statement, it is divided up into various sections which provide a narrative of you describing your daughter's condition by reference to certain time periods. You're aware of that obviously. And you've largely confined your narrative to the period to the end of 2022?
A. Yes.
Q. Now you've done that so as to comply with the timeframe that's contained within the Inquiry's terms of reference which takes us to the end of that year. There are certain references within your statement to your daughter's condition after the end of 2022, but —— and we note those, but we are grateful for the way in which

you've confined your statement. But all that said, the Inquiry is very mindful of the fact that your daughter's condition and indeed your own is an ongoing one, so we are very mindful of that.

Can I also indicate that in your statement you've included a section headed "Educational Impacts" and I think we find that —— it's not necessary to show it at this stage —— but we can find that at paragraphs 134 to 155. It's quite a lengthy passage in your statement. Now, we've obviously read what you've said in that section, Ms Goss, but as you know my colleagues in the Inquiry, working in what we call P4, are involved in considering the impacts on children and young people and their education and they have been in touch with you and it's my understanding that they have taken or are taking a statement from you to inform their investigations. Is that the position that you understand?

A. Yes, it is, yes.

Q. Yes. So today it's not my intention with a couple of exceptions to look at that section of your statement, but the one area that I will ask you a little about is the extent to which absence from school has been an isolating factor for your daughter and we'll come to that in due course.

Now, as I have said, you provided a detailed

progression of your daughter's condition up to the end of 2022 and this began with you, your then partner and your daughter contracting COVID just prior to the first lockdown in 2020. And you tell us about that in your statement beginning at paragraph 8 and following and as I understand it, you kept —— with the knowledge of that infection, you kept your daughter off school at that time; is that right?

A. Yes, we didn't know exactly what it was, but I had a suspicion that it could have been COVID—19.

Q. Right. And do you remember for how long you kept your daughter off school?

A. It was only a week because then we went into lockdown.

Q. Yes.

A. So ——

Q. That took over?

A. Sorry.

Q. I'm sorry. I'm saying that lockdown then took over.

A. Yes, yes, that's right.

Q. Yes. As you say at paragraph 14 of your statement, your daughter's symptoms were initially mild, because I think both you and your then partner contracted COVID at the same time?

A. He had it first, and then my daughter started to feel a bit unwell and it wasn't until a few days after that

that I started to feel unwell. So it was like a succession of getting knocked down.

Q. Dominoes. Yes. Okay. But if one was looking at it in a comparative way, her initial symptoms were milder than yours, as I understand it?

A. Much so. Oh goodness, yes. If it had been in isolation, we would have barely thought she was unwell at all. She just felt a bit under the weather. She was still able to do some school work and play a bit. It was very mild for her.

Q. And in order to get a little context, and you do refer to certain of this information in paragraph 23 and 24, prior to this, can I put it bluntly, was your daughter a sickly child?

A. No, not particularly. She had had childhood illnesses in the past, but she had always recovered just fine, so I wouldn't have called her a sickly child, no.

Q. Was she active?

A. Oh very, yes, very active. She would —— she loved swimming, she had swimming lessons all the time, we went swimming a lot. We played tennis occasionally. She loved that, but her main hobby, the thing that she misses the most, is that she has been horse riding since she was about, gosh, four or five years old, so she can't do that anymore.

Q. Right. And could you also tell us about her school attendance, was that relatively normal prior to this ——

A. It wasn't —— yes, prior to the pandemic, yes, it was relatively normal. We did have a small bit of difficulty in her primary 2. It turned out that she had a condition called PANDAS which we didn't know at the time, which actually interestingly got triggered again by COVID. But you know she had a lovely friend group. She really liked the school. She was always quite happy there. Yes, there were no concerns.

Q. Okay. Now, what you do tell us in paragraph 14 is that your daughter three to four weeks post infection took a very sudden turn for the worse. Can you just describe what that turn was?

A. Oh, my goodness. This —— that was honestly the scariest time of my entire life and that is not even an exaggeration. I remember we were just in the sitting room watching TV and all of a sudden she just gets up and says "I'm not feeling well" and then took herself upstairs to bed. That was really weird for her. Anyway, and it happened really quickly. Within a few hours, she had a wild temperature and she was feeling feverish, hot and cold. She was feeling really, really unwell and it came so out of the blue, I had no idea what on earth was going on.

Anyway so, you know, she stayed in bed and because she was so ill I just stayed up all night next to her and she was shivering and sweating and it was really scary, really scary, and it just carried on the whole next day, and then she wasn't wanting to eat, she wouldn't drink, a rash developed on her upper arms and later on other parts of her body. My immediate thought was, oh, my God, is this meningitis or something, but I did the glass test and all that and you know it was fading and I thought okay well —— but her temperature wouldn't come down.

I was giving her Calpol regularly, you know, according to the instructions of course, but it wouldn't budge, it just would not come down and I remember at the time there had been some rumblings in the news that you shouldn't have ibuprofen if you even suspect it might be COVID—19 related and I was desperately trying to figure out, you know, what on earth could this be? You know, we had COVID. We had it like a month ago, three or four weeks ago. Can you get it again so quickly? What on earth is this? So because I didn't know what it was and because the news was telling us don't use ibuprofen, I didn't give her any. I was too scared it would make it any worse. It turned out later on that actually ibuprofen was the only thing that would bring her

temperature down.

Q. Sorry. Can I just interrupt there. You did seek advice from NHS 24 I think?

A. Yes, I did. I didn't delay that. I did seek advice from them. They didn't seem too concerned and I was trying to emphasise how severe this was, whatever this was and you have to remember as well back in that sort of era, I suppose, right at the beginning of the pandemic, it was very much an environment of fear. We were told, you know, don't go to your GP surgery. Don't go to the hospital. Save the NHS. You know, all of these buzz words and slogans. So I was frightened to take her anywhere so, yes, I called 911 and I described all of her symptoms and everything and they said, oh, can we see if she can go to the bathroom. I was I really don't think she can, but they were insistent she had to go to the bathroom and my daughter was —— she was almost delirious at that point. She was —— there were some times when I couldn't even rouse her from her sleep. It was so frightening.

Anyway, I tried to encourage her to get up, said it's really important that we try, that we try to go to the bathroom. She was you know complaining and saying "I don't need to go to the bathroom, I don't feel well. Let me sleep." Anyway, she did ——

Q. Can we just ——

A. She got up with some help.

Q. Can I just interrupt. Can we just get this in a little context. This came on three or four weeks after the initial contracting of COVID that you've told us about. In the period between contracting COVID and this onset had your daughter recovered or apparently recovered from COVID?

A. Yes, yes, when we had COVID it was really mild for her.

Q. Hm—hmm.

A. She was —— she was fine.

Q. Yes.

A. We thought we had got off lightly, you know. I was almost glad that we had had it. I was, oh, well, maybe that's it over and done with and we all came through the other side, thank goodness.

Q. I don't mean this as a criticism or an insult, was there any chance in your mind that your daughter was conning you about her condition? You're laughing. I think I can take it your answer ——

A. It's such a ridiculous thing to say. No, of course she wasn't. She was incredibly sick when she had, you know, four weeks after and we had COVID, the acute infection. The reason we knew it was COVID was because of me, my symptoms were really awful. I had a horrible cough,

I couldn't breathe, my oxygen stats were down at 91, 92 sometimes even 90. I mean there was no mistaking that it was COVID at all. We didn't need a test to tell us that even though there was no testing.

Q. You do tell us at paragraph 18 of your statement that that you came across some information about a condition named Paediatric Inflammatory Multisystem Syndrome. It was temporarily linked to SARS—Cov—2. It's called PIMSTS. This from what you say was information which was reflected in the condition that your daughter was suffering; is that correct?

A. Yes.

Q. You did eventually obtain a diagnosis of this. You refer to this in paragraph 19, and this was a diagnosis provided I think by Royal Aberdeen Children's Hospital, but it was qualified with the word "suspected"?

A. Yes.

Q. Did you gain, albeit two years later, some satisfaction of obtaining that diagnosis?

A. I wouldn't say satisfaction because of what they have put us through the last four years. I mean I knew that's what she suffered from and because they were hesitant to admit her and so she wasn't assessed, you know, they said, well, we can't backdate her diagnosis, because she wasn't assessed, and I said, well, that's

absolutely reasonable, but the reason she wasn't assessed is because, you know, we were told not to come in at one point. I think that will forever be burned into my memory: under no circumstances should you turn up at the hospital with your daughter. That's insane.

If she was so ill like that right now, I would call an ambulance. That's how sick she was. So I wouldn't say it was satisfying. It was frustrating. It was infuriating. I'm glad it's on her record now, but I get no satisfaction out of that, because she was so ill. I honestly thought I might lose her.

Q. You do tell us at paragraph 21 that she had —— if your daughter had become horrifyingly unwell now, you wouldn't hesitate but to take her to hospital; is that correct?

A. Yes.

Q. Now, I would like to ask you a little of what you say in paragraph 20. This may be of some significance for the Inquiry. You refer to an FOI request submitted by a member of the public and also evidence gathered by the UK Covid Inquiry, revealing that organisations including the NHS and the government, by which I assume that is a reference to the UK Government, were very well aware of this condition, this is the condition PIMS—Ts, but had chosen not to inform the public so as not to panic

parents. Now, can you just expand on that a little, please?

A. They in their ivory towers decided that they weren't going to tell the public that this condition even existed, which I think is just stupid, because if I had known, if I had known what she was suffering from, I would have taken her straight there. I wouldn't have hesitated. You know, the context of fear around that time, don't go near the hospital, don't —— save the NHS, I would have just completely ignored all of that and taken my kid to get medical treatment. I'm just so —— sorry —— it's really traumatic remembering it.

Q. No, no, take your time. Do you feel able to go on?

A. I just think if they had informed parents then I would have taken her in and it's very possible that she with treatment early maybe she wouldn't be so sick now.

Q. Right. You do say in paragraph 20 that the institutions, including the government, had chosen not to inform the public so as not to panic parents. Is that something that you have seen in writing or is that a supposition that you have made?

A. Yes. I'm pretty sure it's in the emails between people like Dr —— oh, I can't say their names, can I?

Q. No, if you don't mind.

A. I'm pretty sure it's in writing in emails between

high—level decision—makers in healthcare and policy and all of those areas.

Q. Right, okay. Can we move on, please, to —— are you all right? Can we move on to the period that you describe in paragraphs 22 and following of your daughter's symptoms during the summer of 2020.

Again, we can read what you say. Can we just again go back to —— well, perhaps go to two expressions that you use, one in paragraph 23 and the other in paragraph 24. The expression in paragraph 23 is in the last sentence and you say that your daughter had "no fuel in the tank", and then in paragraph 24, you say that "there was no spark in her."

Again, can you just give us an indication, given her condition and the symptoms that she was displaying during this period, what you mean by those two expressions?

A. She was just really, really lethargic. She was exhausted all the time. She didn't want to do anything. I mean, you know, we're lucky enough to have a back garden, she didn't want to come out in the back garden to do anything, even anything really simple. I did manage to get her out a couple of times, but she would just sit in the shade with her coat on and it was warm, it was summer, and she just looked like such a sad and

exhausted figure. There was nothing to her.

When I say "there was no spark in her", she was just, you know, she was quiet, she was withdrawn, she was —— she wasn't herself.

Q. Yes. And you give an indication in paragraph 24 of a number of sensory difficulties that she was experiencing, including that she couldn't have a bath because the water hurt her and also that she was sensitive to sunlight.

A. Yes.

Q. These were conditions that were impeding her obvious enjoyment of life?

A. Yes, that's right and it's difficult to as a —— I don't want to say as a healthy person, but as somebody who doesn't experience these symptoms, it's really hard to understand how light and noise can actually be painful, physically painful, and I have experienced it myself with my Long COVID. Luckily, I don't get it very often, but she gets it still everyday and it is very, very common in Long COVID and also PANS which she was later diagnosed with. So quite often —— you know quite often she has to stay in a dark quiet room, very little sensory input. You know, it's no life for a kid. It's very difficult to deal with.

Q. Now, and paragraph 26, and I don't think it's necessary

to look at the circumstances that gave rise to you asking for advice from a GP, but you tell us that the GP attributed her behaviour to the fact that she had not been at school and she was suffering from an accumulation of isolation and anxiety and you go on to say that the GP was very dismissive of her symptoms.

Now, before we go on, the —— one of the points I think you want to make through your evidence is the extent to which your daughter's condition was readily attributed to the effects of isolation and anxiety and that any other cause of your daughter's symptoms were dismissed by certainly some health professionals. Is that what you want to convey to the Inquiry?

A. Most professionals. In fact, pretty much all of them, except one. It was a ridiculous time. Right from the beginning I think people thought we were imagining it, making it up, that perhaps it was the effect of isolation and anxiety. None of us felt isolated or anxious at that time. It was a ridiculous conclusion to come to quite honestly and I didn't believe that was the case when the GP was suggesting that this is what the problem was, but I didn't argue with it. I know better now, but at the time I thought, well, maybe they're right. Maybe they're right.

Q. Presumably these interactions with the GP were through

you and remotely; would that be right?

A. On the phone.

Q. Yes.

A. On the phone.

Q. There was not a physical examination of your daughter?

A. No, no not at that time. There was later on when she had much more severe symptoms.

Q. Okay. Now, the next period that you talk about in your statement is at paragraphs 28 and following and this is the period between August 2020 and the end of the year 2020, and you tell us that your daughter became very ill again in August 2020 and you tell us the symptoms of that. And you then took her to the GP, your GP, and subsequent to that her condition worsened and the GP sent her directly to hospital, the Royal Aberdeen Children's Hospital; is that right?

A. Yes, that's right.

Q. And one of the issues that you were confronted with then was that there had not been a diagnosis or a positive test of COVID at the outset of the pandemic in March 2020 and, therefore, the —— those who were interacting with your daughter indicated that you and they could not be sure that it was COVID in the absence of a test. How did you feel about that?

A. Oh, it was so infuriating and, you know, this attitude

lasted for years. Oh, you didn't have a test so you can't know it was COVID, you know, basically completely undermining our entire experience. You know we had —— I had been very sick with the acute infection and then my daughter had been unbelievably sick with PIMS and not treated and then we go to seek help when she's really quite unwell again and they're saying, no, we don't believe —— we don't believe what you're saying essentially. It's infuriating.

THE CHAIR: Can I ask you a question, please? Sorry to interrupt and I'm not seeking to be confrontational, but I want to be very clear. The language that you've just used and you use in the final sentence of paragraph 28 and you say:

"The hospital did not believe that we had COVID—19 in March."

Now, I fully understand if that's the case your irritation, anger, frustration in relation to the attitude, but I think you accept that it's a fact that there was no test, because there wasn't one, in March 2020.

Now, from a clinician's point of view, do you accept that in the absence of a test, a positive test for COVID, the clinician would be —— I'm not suggesting this is what happened, but I just want to be clear about

that —— there would be nothing wrong with a clinician saying, well, you report that you or your daughter had COVID in March, but in the absence of a positive test, we cannot be definitively sure and we have to in considering her condition at the moment proceed on the basis that there is an undiagnosed report or an unconfirmed, I beg your pardon, report of COVID some months ago.

Now, can I be clear, that wasn't the approach they took; is that your evidence?

A. Yes, that's not the approach they took. They were completely resistant.

THE CHAIR: They were completely resistant.

A. And I mean ——

THE CHAIR: Do you accept that I am right that there would be nothing wrong with them saying we can't be absolutely sure that she had or we can't proceed on the basis that she definitely had COVID without a positive test. You're saying that they didn't believe you, which is obviously a different thing. That's your position, is it?

A. Yes, they didn't believe.

THE CHAIR: That's fine.

MS BAHRAMI: I was clinically diagnosed albeit over the phone based on my symptoms ——

THE CHAIR: Symptoms.
A. —— that I was presenting with that were quite terrifying quite honestly. When you feel like you can't breathe, it's not very pleasant and my cough was really quite violent. It lasted for so long.
Anyway, they were completely dismissive of it. Obviously, I understand as a medical professional you have to exclude everything. You can't just assume that it, you know, comes from one thing, you have to rule out hundreds of things, but they just simply wouldn't believe that we had had it.
THE CHAIR: I apologise for pressing you on this, but you'll appreciate that I have to consider at the end of the day whether there's any criticism to be made of medical professionals, but I have your position, and you've explained it clearly and I'm grateful for that.
MR GALE: Just on that point, Ms Goss, as I understood it from your earlier evidence, the situation was that it was your ex—partner who first displayed symptoms, shall I put it that way, of which you know or now —— possibly even at the time and now certainly with hindsight know to be those of COVID. You then acquired COVID, so you believe. So that there was, as it were, a history of the three members within your family group of having COVID at or around that time.

A. Mm—hm.
Q. Is that correct?
A. Yes.
Q. And the clinicians that you spoke to at the hospital, were they made aware of that?
A. I said that, yes.
Q. Yes, okay. Now, can I take you on, please, to paragraph 35 of your statement. You mention there that your daughter's teacher raised certain concerns with you about what's described as "uncharacteristic behaviour".
Now, just to understand the situation, when this occurred, do I take it that your daughter was back at school?
A. Yes, so after that illness in the August I pushed her regrettably to go back into school, and she was trying her best and it was really difficult. Everyday was very difficult trying to get her into school. She wasn't feeling well. She didn't want to go, but I was pushing her for the sake of attendance, which is —— I wouldn't do that now, but at the time it felt very important to get her back to school after lockdown and be with her friends and —— but then, yes, I by chance met her past teacher in the community here and she said "I'm really —— it's such a shame, it's such a shame to see her, she's so different, she's just not able to engage

with her work, she's so exhausted, she just —— it's not her."
Q. Right. Now, that prompted you to call the GP again and, again, there was an insistence that your daughter had anxiety and, as you put it in paragraph 35, "She just needed to stay in school and would get over it."
A. Yes.
Q. Yes. And again you say the GP was very dismissive and unwilling to consider that COVID—19 was a contributing factor and she made you feel as if you were an overanxious parent.
Now, is there any possibility that you were overreacting to your daughter's condition or that you were being an overanxious parent?
A. I really don't think so, and given the fact that four years on she's much worse, I think that if anything I underreacted.
Q. Yes. I think you indicate, if I can go to paragraph 37, that up to this point your daughter had only been seen by GPs, who, as you say, had all minimised her symptoms and only briefly by hospital doctors, but as I understand it you are critical, as you go on in paragraph 37, that the GP continued to refuse to refer your daughter onwards to pediatrics for further investigation, insisting that she was suffering from

anxiety and nothing more.
A. Mm—hm.
Q. Now, at that time were you arguing for a contrary view.
A. Arguing for what, sorry?
Q. Were you arguing for a contrary view to the fact that what was being said to you was that your daughter was suffering from anxiety and possibly isolation?
A. Yes. Well, I —— I won't say I argued with the GP, but what I then did do is talk to the school about it, and I said, look, "I'm not getting anywhere, they just insist that she's anxious" and I guess I went to them for some advice and guidance and it was the school who then referred her onwards to pediatrics, community pediatrics.
Q. Yes. You tell us at the bottom of paragraph 37 the school stepped in and referred your daughter to the community pediatrics and also to the Child and Mental Health Service, CAMHS, and that was in November 2020. How did you feel about that? Did you feel that that was a positive step forward?
A. Yes, absolutely. I was relieved that we were finally accessing a service and it was definitely a positive, a positive move.
Q. I think you tell us that the pediatrician who saw your daughter was, you put it, baffled by the numerous and

wide-ranging symptoms that fluctuated wildly on a daily basis. That was the reaction of the pediatrician.
A. Mm-hm.
Q. Yes?
A. Quite reasonably I think. I believe my daughter was one of the first, if not the first, to present with Long COVID.
Q. Yes. You then tell us that at Christmas 2020, this is paragraph 40, that your daughter's condition worsened and it was round about this time that you came across -- I think you say "stumbled across" -- a small Facebook group called Long Covid Kids and I think you have told us about that in your earlier evidence, but I think, just taking that briefly, that for you was, as you put it, I think a eureka moment, a eureka moment, discovering this group. Why was it such a significant moment for you?
A. It had been at that point about nine months and we didn't know what was wrong with her. We had no idea and it was very confusing. Something clearly wasn't right and we -- but we didn't know what to do and what it was.
I was sure, I was absolutely convinced that COVID had started this, because she was fine prior to infection and then she got the infection and then it all fell apart after that so I knew -- I was absolutely

adamant that it had to have been COVID that triggered this, but I couldn't figure out what this was. So when I found this group of other families whose kids were experiencing such similar symptoms and difficulties getting into school again and -- it was just a revelation. I thought, oh, my gosh, you know, I'm not making this up myself, this is actually happening and it's happening to other people too. It was kind of a relief to realise that actually my instincts were correct.
Q. Now, the section of your statement beginning at paragraph 43 which deals with the NHS medical intervention between January 2021 and June 2021, you tell us at paragraph 47 that after involvement of the pediatrician, who was not convinced that your daughter had Long COVID but she remained openminded -- but remained openminded to that possibility, you go on to say that in this appointment your daughter was diagnosed with Pediatric Acute-Onset Neuropsychiatric Syndrome PANS. Tell us just a little bit about that, please?
A. PANS, oh my goodness, wow, it is unbelievable this condition. One minute you could have a quiet child just doing something benign like drawing and the next minute they are tearing the house down screaming trying to attack you. It's Jekyll and Hyde.

It's impossible to describe PANS. It's wild, wild. Sometimes with no apparent trigger it was just all of a sudden a switch and it was scary. You know, there were times when I thought she had actually broken my bones, everything in a house was a weapon to use, she was spitting everywhere, stuttering her words. It's horrifying to see, it really is, and it's all caused by inflammation in the brain. It's a treatable condition.
Q. Yes. Now, you tell us that at paragraph 52. You say:
"This is a treatable condition with early diagnosis and treatment providing better outcomes."
And you feel that if your daughter had been treated earlier, through the NHS, she would not have suffered for so long and may not be suffering to the extent she is today?
A. Yes.
Q. That remains your view?
A. Yes, I absolutely agree with that.
Q. Yes. There was another diagnosis made I think at or around the same time by the pediatrician, which was a diagnosis of ME or Chronic Fatigue Syndrome and, again, do you have a comment on that?
A. I'm not sure what you're asking.
Q. I'm just --
A. Can I comment on it?

Q. Well, can you comment on -- clearly you know what ME, Chronic Fatigue Syndrome is and what are its manifestations?
A. Yes.
Q. Do you feel that that was an appropriate diagnosis in relation to your daughter?
A. It was definitely a step in the right direction. You know, we do know now that around 50 per cent of people with Long COVID reached the criteria for an ME diagnosis and my daughter is one of those. So I was -- I was -- I was, you know, content with that, but I still was determined to get the validation that COVID-19 was the root cause of this and I really -- I wanted a Long COVID diagnosis which they wouldn't give her.
Q. Right. Could we move on to the section of your statement relating to private medical intervention in -- and you put this as a timeframe of June 2021 to August 2021. It's paragraph 58 and following of your statement.
Now, I know that in other parts of your statement you talk about the need that you've had to engage with the private sector in medical treatment for your daughter and if we could just use this point as a focus for that evidence. That I think, as you've indicated throughout your statement, has been a very considerable

financial burden and pressure on you.
A. Yes.
Q. And I think you've indicated that what you have had to spend has gone into the —— certainly into the thousands of pounds?
A. Tens of thousands of pounds.
Q. And what effect has that had on you? I'm talking about you yourself.
A. I'm skint. That's what effect it has on me. My savings are gone. I've got nothing to fall back on now. You know, if the boiler broke in the house, well, I really hope it doesn't, because I can't replace it. I have spent every single penny that I have had trying to find treatment to ease her symptoms, to help her, to give her a better quality of life and I did find those treatments, but I had to pay for them, when I believe, and I believe this to be true, the NHS could and should have provided these.
Q. Hm—hmm. I think you indicate in paragraph 58 and, again, can I ask you not to name the individual concerned, but you contacted a consultant of pediatric immunology and you had a remote consultation with him and a treatment plan was put in place in relation to your daughter by him?
A. Yes.

Q. Now, how did you feel about that? This was I think in June 2021.
A. It was amazing. It was absolutely unbelievable. This clinician came highly recommended. He was extremely expensive but, God, worth every penny. He knew exactly what she was experiencing, exactly what she was suffering. He had seen it before. He had treated it before. It wasn't particularly difficult case for him I believe. Speculation, sorry.
And he —— yes —— he took her an extremely thorough history. It was, wow, nothing we had ever experienced before and he started a treatment plan for her and eventually when she had been on this treatment for not even that long, a few months, oh my goodness, it gave me my daughter back. It was incredible. She was going from this so unwell and having these insane meltdowns, I mean terrifying, psychotic, you can't —— I can't describe it. I mean I literally have to lock myself in the bathroom so she wouldn't hurt me. It was terrifying. You know, there were times when I wasn't sure who I should call, but I think I should call somebody, the police or ambulance, I don't know. Anyway, so he treated her.
Q. I mean I don't want to go into questions about your private life, Ms Goss, but I think by this time you and

your partner had separated; is that right?
A. No, not by this time.
Q. Subsequently you did I think?
A. Yes, and it was largely to do with this situation.
Q. Okay. But I think coincidental with the treatment that you had been talking about, your daughter contracted the Delta variant of COVID?
A. Yes.
Q. What effect did that have on her?
A. It made her worse, so by the sort of June 2021, although her PANS symptoms were very severe, she was starting to improve in other symptoms, so she was slightly less fatigued, we were able to do a little bit more, she looked like maybe she was even potentially starting to recover somehow —— somewhat, and then we got the Delta variant and it just slammed her right back down again.
It's so upsetting because when you start to see that light at the end of tunnel and then it just get taken away so quickly like that, it's really hard to deal with and it ended up making her even worse than she was before. So her cognitive processing just plummeted. You know, she had actually been able to do some online education up until that point and she just wasn't able to do it anymore. She just couldn't focus, couldn't concentrate, couldn't understand what she was seeing on

the screen, couldn't follow classes, the noise and the brightness of the screen and the online class were really overwhelming her and upsetting her and causing pain.
It really just put us right back to square one and even beyond that. It was worse.
Q. There is one perhaps interesting part in the second part of paragraph 59 that you quote a number of things that your daughter would say to you, which tend to suggest that she had an awareness of the problem that she was suffering from and probably the problem that it was causing for you?
A. Yes, it was very distressing for her. She couldn't control it when it was happening, the meltdowns, the violence, the physical attacks, verbal attacks. She couldn't control any of this and quite often actually mid meltdown she would start crying and ask me to help her, and I didn't know how. All we did was just —— I just held her. I just held her. And just tried rub her back and tell her she was going to be okay. Don't make me start crying again.
It was really, really hard. Yes, she was aware that it was ——
Q. Let's possibly endanger you in crying again, because can we go on to the baby tigers?

A. Oh, God, the baby tigers.
Q. You mention in paragraph 63 and following that you and you are daughter had been interested in news reports about a pregnant tiger in a wildlife park in —— I think it was in Aviemore and you arranged that you and your daughter would go to see the tiger cubs when they were born and I think you did that and you tell us about the arrangements that you had to make for that.
Was that successful so far as your daughter was concerned, going to Aviemore and to seeing these tiger cubs?
A. I think we have to define successful before I answer that. I mean we did it and I guess it was successful in the way that we actually managed to get there. We actually managed to go see the tiger cubs, but she —— the trip did have a hardcore effect on her. She just was constantly having headaches and stomachaches and she was so tired. Honestly, there were so many times where we nearly just turned right back and went home and thought we just can't do it, but we carried on and she really wanted to see the babies so we kept on going, but, yeah, when we got to see them she just collapsed and there were so many people there, you know, who wanted to also see the baby tiger and, yes, she just collapsed. And it wasn't until some —— a stranger said

why don't you get her a wheelchair? And I was like, oh my God, never even thought about that so we did.
We got her one of the park chairs and we managed to stay there for another few hours and saw some other things because she was able —— we could wheel her around and that was —— so it was successful in that sense, in that we discovered that actually a mobility aid was going to be —— was something that we could use to help her.
Q. And I think thereafter you did in fact buy a wheelchair for her. You tell us about that in paragraph 67. You tell us about the cost of that. Although it wasn't, as it were, a wheelchair fitted for her it was just a wheelchair that was available and you bought it essentially.
A. Yes, that's right. We rented one initially because we really hoped it would just be temporary, but after six months we thought, do you know what, we're just going to buy a really comfortable one for her, but, you know, it is important that you get measured for a wheelchair, but the pediatrics are a very funny about mobility aids. It's not just us that have had problems with this.
They say that it's going to make the child lazy or increase any deconditioning and, yes, well, that might be true, but, you know, it's the difference between her

sitting at home inside or sitting in a chair outside and getting some fresh air and sunshine and the difference of opinion between the pediatrics and occupational therapy and physical therapy, who were both very supportive of the use of such wheelchair. It was just such contradicting advice and there still is, but we use it regardless although she's too sick to use it now. It is actually the cats are using it as a bed.
Q. Paragraph 70 onwards you describe a period of observation of your daughter in Aberdeen Royal Infirmary and it's quite a lengthy account and, without suggesting any disrespect to you and given the time, I think we can take what is in there as read.
There's just one or two things I would like to pick up from that. One of the points you make on a number of occasions in this section is that you were terrified that they —— by that I assume the medical staff of the hospital —— would accuse you either of Munchausen's or what is termed Fabricated or Induced Illness, FII, at any given point. And I think you go on to talk about this more fully in paragraph 92 and following that you felt that the consensus was based around your daughter having anxiety, but there were other contra—indicators and the focus appeared to be on the anxiety and education.

Now, what was your reaction to these suggestions or your view that these were being suggested of you that you were engaging in Munchausen's or this Fabricated Induced Illness?
A. They never came out and said it, but they were flinging around terms such as "perplexing presentation", and "medically unexplained symptoms", which I found quite ridiculous. Just because they didn't understand it doesn't mean it wasn't happening. It wasn't unexplained. It was triggered by COVID—19. Just because they can't understand the mechanisms yet doesn't mean it's not real.
And I think now that, you know, the more research that comes out and supports everything that we've been through over the past four years, I'm not concerned about us being accused of that now, but back at that time there wasn't as much research. We frequently were not being believed about that her symptoms weren't that bad and they were that bad. And, yes, it was very scary, because, you know, you feel like you're on a knife edge at all times, and, you know, is there a possibility that they're going to try and take your child away, because I know it's happened to other families whose kids have been —— had Long COVID, severely, and they have been accused of making their

children ill themselves?
Q. Can I put this to you ——
A. It's wild.
Q. Did you feel that you were under suspicion?
A. I felt like I was under suspicion, yes.
Q. Okay. And was that —— how you felt, was that a suspicion that either you were exaggerating your daughter's condition or that you were causative of your daughter's condition?
A. Both. I was actually told by another clinician, a CAMHS clinician, who had never met me, never met my daughter, had only scanned the case notes, and told me on an online meeting that she believed my —— my anxieties are making her sick. It's ludicrous. I'm doing everything I can to try and make her better. Recovery is the only goal. We still hope for recovery and I have read every single research paper that is out there.
Q. Yes.
A. I am trying to so hard to make her better and then they're accusing me of making her worse. Blows my mind. I mean I just —— I couldn't handle it actually. I burst into tears again, and I just had to leave the meeting when they said that.
Q. Ms Goss, we can read the section which begins at

paragraph 70 and goes on to I think paragraph 95, beyond that, yes, 95, about the period during which your daughter was an inpatient at the hospital and it was quite clearly, and I don't want to go through it with you, because as I say we can read it, and I don't want to upset you, but it was clearly a distressing experience for you?
A. For me, but it was more distressing for my daughter.
Q. Now, I'm conscious of the time. You have made a complaint to NHS Grampian and, again, we can read what you say about that. It begins at paragraph 99 and carries on to paragraph 115.
There are just two points I want to take and they're really factual matters from you. Paragraph 103, that after certain communications your daughter was finally diagnosed with Long COVID in March 2022?
A. Yes, that took a lot of work on my part, because they were very resistant and so I turned it around back on them and I said, "Okay. Well, you tell me why you can't diagnose her with Long COVID? Here's the WHO's definition. Here's all of the —— she ticks every single box. So you tell me what are the other conditions that you have not excluded yet that means that you cannot diagnose her?" and they didn't have an answer so they gave her the diagnosis.

Q. You feel that was done reluctantly?
A. Oh, gosh, yes, very reluctantly and we're not the only ones. There are so many kids out there who quite clearly have Long COVID and are not been diagnosed with it, despite all conditions being excluded. There's a big reluctance to diagnose Long COVID in children.
Q. So only other point I want to take from you in relation to that section of your statement is that you have an ongoing legal action against NHS Grampian which began earlier this year. We don't need to go into any more detail than that, but just as a matter of fact you have begun a legal action in relation to the conduct of NHS Grampian.
A. Yes.
Q. You've given us the section on the impact on your daughter and indeed on yourself. Now, this is paragraph 123 and following. You mention in paragraph 124 something that I have already asked you about, that your savings are gone and, as you put it, you're skint?
A. Yes.
Q. And you live paycheck to paycheck.
A. Yes.
Q. This has been while we're talking about obviously principally the impact on your daughter, this had had a very significant impact on you?

A. Yes, it has.
Q. Yes.
A. This is the bit where I'm not going to cry again.
Q. Try not to.
A. It has —— yes, it has had an incredible impact on me. We've lost so much. We've lost our health, we've lost friends. You know, you kind of think that people might rally round when you're dealing with a very difficult situation, but it turns out, they don't so, yes, it's very isolating, it's very boring.
Q. Now, you say at paragraph 129 of your statement that you have involuntarily shielded throughout the pandemic and are still involuntarily shielding, mostly because your daughter is unable to leave the house.
A. Yes.
Q. Is that —— I appreciate that's taking us up to the current time. Is that an ongoing situation, that you are effectively shielding?
A. Involuntarily, yes. I mean we have had four COVID infections now and every single one has made us sicker, so, you know, we can —— it's never a linear trajectory, you know, it's —— you get the infection, you get really sick and then you start to maybe feeling bit better, then you get reinfected, you go back again but maybe worse than before, then you start to maybe get a bit

better, get infected again, the cycle continues and each time you get infected, your baseline gets lowered, which is why I think I had such a horrible time trying to write this statement is because after a fourth infection my brain is shot, just I can't process things anymore, I feel really dumb all the time, and, you know, we don't want to get reinfected a fifth time so we do all we can to avoid it. We still wear masks. Well, she can't leave the house but when I need to go out, maybe go to the shop, I'll wear a mask to try and lower my risk. But, you know, she can't leave the house anyway so we don't really see very many people. We have to rely on people coming to us but turns out people don't do that.

Q. We're coming to the end of the period of time we have for your evidence, Ms Goss. There are just a few points I would like to just ask you about further. Paragraph 131 of your statement, you talk about a disconnect between what the Scottish Government is saying and what is happening on the ground and you say that the government is adamant that children are being seen and treated and you say they are not. They're also saying that they provided adequate funding to Long COVID services and you have said that the funding has been tokenistic and not guaranteed long-term so recruitment has been extremely challenging. There are currently no

functioning Long COVID services for children and young people in Scotland. Has that always been the case?

A. Yes. They talk a good game but actions speak louder than words and, you know, where are these services that we were promised in 2021? Don't have them.

Q. The other point I would like to ask you about is vaccinations which you refer to in paragraph 132 and 133. Your daughter hasn't been vaccinated; is that right?

A. She hasn't.

Q. No, and I think you took that decision having taken the view of the immunologist that you have been -- who has been treating your daughter who didn't necessarily --

A. Yes, I asked for his opinion.

Q. He didn't necessarily say that it shouldn't happen but cautioned against it, I think is possibly the way to describe it.

A. Well, yes but it was a discussion, weighing up the risks and the benefits. He suggested that perhaps it might be a bit taxing on her immune system at that given time so maybe just wait a bit until she's feeling a wee bit better, but vaccination eligibility for her age group was very short-lived so even if I wanted to get her a vaccination now, I don't think I could.

Q. Right. You have provided us at the end of your

statement, and I've passed over the section on educational impacts for the reasons I gave earlier. You have given at the end of your statement a section on the lessons to be learned and hopes for the inquiry. We can obviously read all of those. One of the lessons to be learned that you do highlight is at 165 of your statement and this is in relation to infection control and prevention of transmission and you say that "we know SARS-Cov-2 is an airborne virus and this has not been communicated to the public, the public are unaware of how to protect themself."

Now, we have heard in the inquiry some evidence of differing views on the means of transmission but there seems to be now an accepted -- an acceptance amongst the experts that SARS-Cov-2 is transmitted by aerosol, not by droplet, so that is I think the point you want to particularly get across, that we should be more aware of that.

A. They knew that in March 2020.

Q. Yes.

A. This isn't new.

Q. Yes.

A. It just wasn't communicated.

Q. Yes. Yes. And again so for the "Hopes for The Inquiry", I think combined with what you have said

earlier when you gave evidence and what you have said today, I think we can take what you have said there as read. You have also told us about documentation that you can make available through your solicitor. I think what I can indicate is that the Inquiry will be in touch with your solicitor to ask for certain or perhaps all of these documents so that we can see them and they can be utilised in our work in the Inquiry. So from me, Ms Goss, I'm sure you'll be pleased to know, that is the end of what I have to ask you. Very briefly, is there anything that you feel that we haven't touched on that you would like to emphasise before we finish?

A. Do you know, I had written something that I thought I might read out but honestly I'm so tired, I'm exhausted, and this was really emotional, I just don't think I have got it in me so I'm just going to bow out graciously hopefully and hope that I haven't embarrassed myself quite too much.

Q. I'm sure you don't need to feel that, Ms Goss, and I think we're very grateful to you for the evidence that you've given, the time that you have taken to provide this and we do appreciate that it's not been easy for you so from the Inquiry team, thank you very much indeed.

MR GALE: Thank you, my Lord.

THE CHAIR: Indeed, Ms Goss, there is absolutely no need for you to feel embarrassed, thank you very much indeed and that's all of your evidence.

That brings us to the end of the evidential hearings in relation to the Health and Social Care Impact Section, portfolio 3 in this Inquiry. Mr Gale, I would like to thank you for leading your team throughout this long period of evidence which has spanned I think about seven or eight months now, I'm very grateful for all your efforts, but I'm also very grateful to your team, both counsel and solicitors for all their efforts in this time and also to the paralegals and witness takers and all the other backroom staff who assisted you in putting together which has been an exceptionally complicated and lengthy piece of evidence, which I'm very happy to say, so far as I'm concerned, has proceeded essentially without a blemish, my thanks to all of you.

MR GALE: Thank you very much, my Lord, and we are similarly very grateful to your Lordship for his guidance and his attention that he has paid throughout the evidence that we have led.

THE CHAIR: Thank you all. That's this part of the evidence hearings finished. The next hearing will be the hearing on Mr Gale's submission in relation to this evidence

which is set for, I think is it the 27 June, Mr Gale?

MR GALE: 27, my Lord, yes.

THE CHAIR: So until 27 June that's adjourned.

MR GALE: Thank you, my Lord.

(4.25 pm)

(The hearing was adjourned to 27 June 2024)

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