

# OPUS2

Scottish Covid-19 Inquiry

Day 53

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Opus 2 - Official Court Reporters

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1 Thursday, 23 May 2024  
 2 (9.50 am)  
 3 THE CHAIR: Good morning, Ms Bahrami.  
 4 MS BHRAMI: Good morning, my Lord. Our first witness this  
 5 morning is Mrs Emma McConnachie. She's a podiatrist in  
 6 private practice and also a media and communications  
 7 officer for the Royal College of Podiatry and Mrs  
 8 McConnachie's statement reference number for the record  
 9 is SCI-WT0669-000001.  
 10 THE CHAIR: Thank you. Good morning Mrs McConnachie.  
 11 A. Good morning, my Lord.  
 12 THE CHAIR: Very good. We'll just start by asking some  
 13 questions by Ms Bahrami. When you're ready, Ms Bahrami.  
 14 MS BHRAMI: Thank you, my Lord.  
 15 EVIDENCE OF EMMA McCONNACHIE  
 16 Examination-in-chief by MS BHRAMI  
 17 MS BHRAMI: Please could you start by telling us a bit  
 18 about your background?  
 19 A. I've been a podiatrist since 2004. I set up my own  
 20 business in January of 2005 and have run that now for 19  
 21 and a half years. In January 2021, I joined the Royal  
 22 College of Podiatry or the College of Podiatry, as it  
 23 was then, as media and communications officer and for  
 24 four and a half years prior to that, I was a  
 25 nonexecutive director with the organisation, known as a

1

1 council member, but I have been involved with the  
 2 organisation since graduation as a volunteer as well.  
 3 Q. Thank you. Now, your business is as a self-employed  
 4 sole trader?  
 5 A. Yes.  
 6 Q. What was your podiatry practice like in terms of  
 7 structure and the cases that you treated prior to the  
 8 pandemic restrictions being put in place?  
 9 A. So despite being sole trader, I do have multiple  
 10 podiatrists that work in my practice as well as an admin  
 11 team. So prior to the pandemic, this would have been I  
 12 think four or five staff that we had podiatrists. We  
 13 provided a wide range of different foot care services.  
 14 It tended to be people who had difficulty accessing  
 15 their own feet and needed assistance with different  
 16 things, those who failed to meet NHS criteria or chose  
 17 to go a private route for speed, convenience, anything  
 18 else. So we would deal with people who just needed  
 19 simple foot care needs, such as difficulty managing  
 20 their own health, right the way through to more complex  
 21 issues where somebody maybe had lost the feeling in  
 22 their feet or the circulation in their feet. We would  
 23 perform minor surgery, issue antibiotics. A bit like  
 24 being a dentist, but just to say for the feet. We  
 25 tended not to see anybody that needed very complex wound

2

1 care or anybody who maybe was exceptionally high risk,  
 2 because they would have usually been seen by the NHS  
 3 podiatry provision.  
 4 Q. Thank you. And as the — once the pandemic restrictions  
 5 were put in place, I understand you had problems  
 6 accessing medical supplies?  
 7 A. Yes.  
 8 Q. Could you tell us about that?  
 9 A. Of course. We had difficulty accessing several types of  
 10 supplies. The most prominent one was personal  
 11 protective equipment or PPE. We had restrictions placed  
 12 on us quite early on. I would say approximately a week  
 13 before lockdown came in some suppliers chose to stop  
 14 supplying to the private sector in order to honour their  
 15 NHS contracts.  
 16 Now, as we use the same PPE as the NHS, this did  
 17 make supply a little bit trickier. Throughout the  
 18 pandemic, sort of the heightened period, this continued  
 19 and then slowly things would ease off. At first it was  
 20 just PPE, then it spread to dressings and general  
 21 medical supplies that we would have used in our everyday  
 22 treatments. So we had to get quite creative sometimes.  
 23 Amazon became one of my most reliable suppliers, sadly  
 24 so ...  
 25 Q. Did you ever have patients who needed dressings or other

3

1 medical supplies that you just simply didn't have?  
 2 A. Yes, there was times where we didn't have the right  
 3 wound care products that we would like, because we  
 4 simply couldn't get the supplies. We would then have to  
 5 think up alternative items that we could use. We had to  
 6 plan quite far ahead as well for things. I mean, for  
 7 example, nail surgeries, typically, we would have maybe  
 8 seen one a week or one every two weeks. At one point,  
 9 we treated ten nail surgeries in one week, which was a  
 10 very stark increase. So I had to plan ahead, get  
 11 supplies. One of my orders didn't actually come in, so  
 12 I had to go to my colleagues in other practices to sort  
 13 of beg and borrow, could we get ones, because orders  
 14 were just failing to appear. The timeline that you  
 15 would be given would not always be accurate so you had  
 16 to plan quite far ahead and often order the same thing  
 17 from maybe three different places to try and make sure  
 18 it would be in in time.  
 19 Q. What were the delivery times scales or was it that  
 20 things still had to be produced then shipped or was it  
 21 just down to the delivery chain essentially?  
 22 A. It would vary greatly. Sometimes it was the supply  
 23 actually coming into your supplier. You would be  
 24 sometimes checking back twice a day to see if something  
 25 had changed. I remember on one occasion an email went

4



1 out from a supplier saying that a certain type of  
 2 disinfectant wipe had come into stock and within about  
 3 half an hour it was sold out, because everybody had just  
 4 clicked that and gone through and that was with it being  
 5 limited to, for example, four per customer.  
 6 Other times it would be a delivery was expected, it  
 7 hadn't arrived, so your order would be put on hold or it  
 8 would just simply be cancelled and refunded. Other  
 9 times it was you were given an expectation and you just  
 10 got no communication as to when it was going to show up.  
 11 It wasn't unusual to see an item might be a four month  
 12 wait.  
 13 Q. As long as four months?  
 14 A. Yes. It was very, very variable, but that was really  
 15 our suppliers also didn't have the information and it  
 16 was kind of changing all the time. I think that was  
 17 probably felt across many sectors, but, yeah, we just  
 18 had to do the best we could with the estimates we were  
 19 being given.  
 20 Q. Yes, thank you. Once the pandemic restrictions were put  
 21 in place in the initial stage, how did your practice  
 22 change?  
 23 A. It pretty much changed quite dramatically the Saturday  
 24 before lockdown came. We read the Corona Virus Act  
 25 2020. We saw that allied health professionals that were

5

1 HCP registered could be called, drafted, conscripted  
 2 into the NHS, at which point we realised there's very  
 3 big changes coming quite soon. We cancelled all  
 4 nonessential appointments at that stage. We took the  
 5 decision — it was a collaborative decision led by me.  
 6 We cancelled all of our nonessential patients. We  
 7 brought forward anybody who we felt would be at risk if  
 8 they weren't treated in the next few weeks, at risk of  
 9 skin breakdown, ulceration or infection and we offered  
 10 them appointments on a sooner basis in anticipation of  
 11 lockdown.  
 12 I sent my nonessential staff home on the Monday.  
 13 They were told not to come in and then 8.00 pm on the  
 14 Monday night we got word that lockdown was coming. So  
 15 after that we couldn't treat anybody that was general  
 16 care, it became urgent or critical care only. That  
 17 would be if somebody had an open or active wound or it  
 18 was life threatening. Now, within private podiatry that  
 19 meant pretty much nobody. So for about six weeks we  
 20 treated nobody and it took a little while until we could  
 21 start slowly increasing those number of people that we  
 22 were able to treat, but it was a very sudden change for  
 23 our business and our practice structure.  
 24 Q. Yes, thank you. In paragraph 30 you mentioned you could  
 25 foresee what was coming because you had worked in

6

1 private healthcare during swine flu?  
 2 A. Yes.  
 3 Q. Did that experience prepare you somewhat for this  
 4 pandemic and to go to the — to take the step of reading  
 5 the Corona Virus Act?  
 6 A. Well, when I worked during swine flu, we didn't have  
 7 restrictions placed on us, but from my colleagues in the  
 8 NHS they spoke of preparedness within the NHS  
 9 organisation, there had been talk of them being ready  
 10 for mass vaccination, you know our PPE classification  
 11 changed, so it was now swine flu approved, so that gave  
 12 you a bit of an insight into what was happening. I mean  
 13 infection control understanding as well came in. This  
 14 was a Corona virus. It was expected to be transmitted  
 15 by contact. Therefore, that meant we knew there would  
 16 be restrictions coming on how we acted as healthcare  
 17 professionals.  
 18 So that teamed with what was happening in other  
 19 countries around the world being reported in the media  
 20 and the implementation of the Corona Virus Act, we kind  
 21 of put two and two together and came up with five and  
 22 took the necessary steps that we felt necessary to keep  
 23 our staff and our patients safe.  
 24 Q. Thank you. And you've mentioned that you had to cancel  
 25 the routine work to prioritise more vulnerable patients.

7

1 How did the patients whose appointments you cancelled  
 2 react to that? Were they content and understanding?  
 3 A. Some. Some were verbally abusive. They didn't  
 4 understand. Some didn't believe that this disease was a  
 5 threat and didn't understand why this would impact on  
 6 their needs. As time went on, things became a little  
 7 bit trickier when people were being cancelled that they  
 8 still didn't believe that their personal needs didn't  
 9 meet the criteria and everybody's pain is their own and  
 10 that was the worst pain they were feeling, which I  
 11 completely understand, but in the later picture we just  
 12 simply couldn't treat them. But, yes, I was subjected  
 13 to a reasonable amount of verbal abuse by patients and  
 14 some of those patients are no longer patients because of  
 15 the way they acted towards myself or my staff at that  
 16 time so.  
 17 Q. Did you tell them?  
 18 A. Yes, they were warned about behaviour and then if that  
 19 continued, they were struck from our books, but I say  
 20 probably about 75% of our patients understood at first.  
 21 As time went on, things did get a little bit more  
 22 frustrated for them, because they couldn't understand  
 23 why they weren't allowed to still be seen so.  
 24 Q. Thank you. And in paragraph 33 you state that you  
 25 offered general advice over the phone and by email?

8

1 A. Yes.  
 2 Q. Is that something you also did prior to the pandemic?  
 3 A. Not in the same way, no. Prior to that would have been  
 4 maybe a little bit of general advice of a, oh, well,  
 5 this is something that a podiatrist could treat, come on  
 6 in and we'll have a look at it, you know, can give you  
 7 some advice. Prior to the pandemic, I wouldn't have  
 8 ever been prepared to give advice really from a  
 9 photograph. We had to completely change our thought  
 10 processes on what is termed remote consultations where  
 11 you would use video or photographs.  
 12 We had to change how we triaged as well, because it  
 13 simply became it wasn't possible to see the person so we  
 14 had professional guidance that came out on this and it  
 15 was really an emerging area, because it wasn't something  
 16 people were really familiar with. Training your  
 17 patients how to take a picture with a camera phone, for  
 18 example, can be quite difficult. I got a lot of  
 19 unfocused pictures of carpets and rugs and not feet, but  
 20 those who weren't familiar with technology — it's very  
 21 difficult to get an accurate description from, for  
 22 example, an 86-year-old person who's living alone of  
 23 what they feel their condition is. You have to learn  
 24 different language and terminologies to get a patient to  
 25 accurately explain it to you, so it was a bit of a

9

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

10

1 A. No, it was making the best of the circumstances  
 2 available, but there's an awful lot of extra information  
 3 that you would take in from somebody when they come to  
 4 your clinic. When you see them in person, you would be  
 5 able to see how they're dressed, what their footwear is.  
 6 For example, you might notice that somebody's buttons  
 7 are buttoned up slightly the wrong way. There's maybe  
 8 some dried food on their top. Those could be signs  
 9 somebody's cognitive impairment has been altered, that  
 10 their vision is altered. We would be noticing the way  
 11 they walk into our clinic. You know subtle little  
 12 things you would notice about somebody that might help  
 13 inform the larger healthcare view. It is what we call  
 14 more holistic practice. We're looking at the whole  
 15 person. So a lot of those things were lost.  
 16 You would also lose the rest of the body when you're  
 17 seeing it as well. So although I might be looking at an  
 18 issue on your big toe, I'm also looking at your leg,  
 19 your other foot, so many different parts. Often I'll  
 20 also be looking at your hands, because there are certain  
 21 conditions that can come up in both. So this whole body  
 22 picture was lost, but, as I say, we would always let the  
 23 patient know that this was based on the information  
 24 available. So we had to sort of put that disclaimer in  
 25 place as well.

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1 Q. Yes, thank you. You state in paragraph 36 that in time  
 2 when you had full day appointments an appointment would  
 3 be 30 minutes, then someone would have to spend  
 4 30 minutes decontaminating everything, so for every hour  
 5 of work done you could only charge for half the time.  
 6 Did that at any point cause difficulties when it came to  
 7 paying staff salaries?  
 8 A. Yes, so our podiatrists within my practice are all  
 9 self-employed contractors. We took a collective  
 10 decision when we started seeing patients again that we  
 11 would only put our prices up very slightly. We put them  
 12 up by three pounds. Some practices I know have had to  
 13 put them up by £20 to purely cover the costs.  
 14 Pre-pandemic we were basically every 30 minutes we would  
 15 be seeing a patient, so we would be back-to-back  
 16 appointments.  
 17 Then this became we had to have this gap. You had  
 18 to air out the room. You had to decontaminate  
 19 absolutely everything instead of the usual surfaces that  
 20 would be decontaminated and that included our reception,  
 21 our front door handle. Our reception team weren't able  
 22 to return for the first 15 weeks. I had to furlough  
 23 them so therefore we didn't have any manned reception  
 24 area. We had to keep the door locked for security.  
 25 There was also additional issues of you were then in a

12

1 lone working situation, which you wouldn't have been in  
 2 before so we had to consider the security of that as  
 3 well.  
 4 But it did have a significant financial impact. It  
 5 was something that we collectively felt we didn't want  
 6 to charge more for at that time, because we also  
 7 understood that many people had been furloughed or had  
 8 lost their jobs and they didn't have the same income as  
 9 before, so as a business we absorbed as much of the cost  
 10 as we possibly could for as long as we could.  
 11 Q. Thank you. And in paragraph 37 you say that by May 2020  
 12 you could do urgent work as well as critical work and  
 13 you had to deal with a backlog of patients, but you were  
 14 far from working at full capacity. Is the reason you  
 15 weren't working at full capacity that the backlog was  
 16 small at that point or is it just because of the time  
 17 spent cleaning?  
 18 A. So we had a bit of a backlog because of the time spent  
 19 cleaning as well, but in the first four weeks of  
 20 lockdown we cancelled 500 patients, so that was quite a  
 21 significant amount to cancel. Prior to that, we would  
 22 have three treatment rooms in operation. That wasn't  
 23 possible under the new restrictions. We would often  
 24 only have one or maximum two staff of the day and we had  
 25 to stagger when the patients were arriving as well. In

13

1 fact, it was actually four years ago today, the 23 May,  
 2 that we were able to start seeing urgent patients again  
 3 and that was then we had to start triaging the calls  
 4 that would come through. Prior to that, we had taken  
 5 the 500—odd patients we had cancelled and all the  
 6 treating podiatrists had medically triaged them, because  
 7 a patient's perceived level of urgency is not always the  
 8 same time as the medical level.  
 9 So we contacted all of our patients that we had  
 10 classified as high risk of breakdown to offer them  
 11 appointments first and we worked our way through first  
 12 of all based on medical need and then based on date  
 13 order, because, logically, the person who has to wait  
 14 the longest would be at the highest risk of a medical  
 15 complication and we also urged our patients, if they  
 16 hadn't heard from us yet and they were in pain or had an  
 17 issue, to please contact us to allow us to triage them  
 18 sooner.  
 19 Q. And the patients who didn't fall within the urgent or  
 20 critical care category were they also trying to make  
 21 appointments with you at that point?  
 22 A. Yes. As I say, everybody's pain is their own and,  
 23 therefore, you know, by comparison to other people  
 24 sometimes you have to make those very hard decisions.  
 25 We did have patients not understand why their need

14

1 wasn't the same need as somebody else's. We had some  
 2 patients lied about their needs to obtain an  
 3 appointment, because they figured, well, once you have  
 4 seen me and I'm here, you'll just do my treatment. So  
 5 they were generally quite disappointed when we would  
 6 refuse that, because they didn't meet the criteria and  
 7 we would have been at risk. At that point, it was  
 8 breaking the law, so we would have been at risk  
 9 ourselves if somebody had reported us for treating  
 10 something that didn't fall within the criteria. So,  
 11 yes, we had some creative things that would be told by  
 12 patients to try and get in and get an appointment.  
 13 Q. When that happened, where they lied about the condition  
 14 and you had to refuse treatment, would they still pay  
 15 for the time?  
 16 A. We chose not to charge them in that instance. I will  
 17 clarify, at that point I wasn't actually able to treat  
 18 patients, I was still shielding, but this is from my  
 19 colleagues that were working for me at this time, but  
 20 luckily it didn't happen too often. I do know  
 21 anecdotally from colleagues in the profession some had  
 22 it a little bit more than others, but, again, everybody  
 23 could see different amounts of people and at different  
 24 times as well, so we would have patients trying to  
 25 register new with us from other practices as well,

15

1 because their practitioners weren't able to practise  
 2 during that time.  
 3 Q. And do you think that the categories, the urgent and  
 4 critical care, were appropriate in the circumstances or  
 5 do you have a view that all podiatry treatments  
 6 should — you know preventative treatments even should  
 7 have continued throughout?  
 8 A. Personally, I feel it was the right thing at the time.  
 9 It very much gave leeway to professional judgment and I  
 10 think that was one of the important things. It wasn't a  
 11 very rigid set of rules; for example, you know, you must  
 12 have this disease and this disease in order to qualify.  
 13 There was clear triaging. Advice was provided by the  
 14 professional body to podiatrists, which did have — we  
 15 had a judgment tree, like a decision—making tree, but it  
 16 also relied on professional competency and judgment. If  
 17 you felt that you could justify why that patient had to  
 18 have treatment and it was important, you could, but you  
 19 had to justify every treatment; why did they meet this  
 20 criteria to come in?  
 21 So as I say, that really came down to your medical  
 22 knowledge, your history taking and your professional  
 23 judgment as to who would meet those categories to see.  
 24 But I feel at the time it was the appropriate thing to  
 25 do with the level of risk that was perceived, you know,

16

1 by healthcare professionals and the medical experts at  
 2 that time.  
 3 Q. Thank you. Once the restrictions eased and services  
 4 resumed as normal, had the lack of private and NHS  
 5 preventative care led to more severe issues requiring  
 6 more significant essential treatment?  
 7 A. Yes, we started to notice a big difference with what was  
 8 coming in now. This could be something which might  
 9 sound trivial to someone, for example, that they haven't  
 10 had their toenails cut, the lower end of what we do as a  
 11 podiatrist. I have, for example, one patient when they  
 12 reappeared there were significant changes in their feet.  
 13 A fungal infection had developed. It had got quite  
 14 quickly in their toenails. They have now been left with  
 15 completely altered toenail structure and that has led to  
 16 ulcerative breakdown underneath their toenails as well.  
 17 That's an elderly person who lives alone. That has  
 18 complete changed their risk category now. It's  
 19 something, I say, that couldn't be foreseen at the time,  
 20 but that had come up.  
 21 We also had other people who were leaving it far  
 22 longer than they ever would have, so things like ulcers  
 23 under toenails were common, other wounds that would have  
 24 developed or just even basic foot care issues that had  
 25 gone too far because they hadn't been able to have the

17

1 intervention they might normally have had. It was a  
 2 wide and varied presentation that came.  
 3 Q. Would ulcers under the toenails affect mobility?  
 4 A. Yes, it could be quite painful and people would come in  
 5 thinking they had, for example, an ingrown toenail and  
 6 instead we found wounds actually underneath the nail bed  
 7 instead. But we also had a lot of more complex things  
 8 that were coming in, not that these weren't things we  
 9 were able to cope with. Our training is the same as the  
 10 NHS, our professional scope is the same, but people who  
 11 were experiencing backlogs from the NHS care and they  
 12 were now having to seek out private care and this was  
 13 something that financially they hadn't been used to as  
 14 well.  
 15 They had been in a privileged position where the NHS  
 16 had been able to provide their healthcare free of charge  
 17 and all of a sudden they're faced with having to pay for  
 18 that service and that came as quite a shock to some  
 19 people as to how much private healthcare actually costs  
 20 as well.  
 21 Q. And that was due to the increased demand on the NHS from  
 22 these worsened cases?  
 23 A. My NHS colleagues were often redeployed to become  
 24 district nursing services and not provide the same level  
 25 of — the same type of care, the same provision of care,

18

1 as pre-2020 offered, so there was some significant  
 2 changes. Some also ended up going on to become  
 3 vaccinators as well, so that redeployment completely  
 4 changed what was available within the NHS service  
 5 provision.  
 6 Q. Thank you. And did the lack of preventative care cause  
 7 health conditions which affected life expectancy or gave  
 8 rise to the need for palliative care?  
 9 A. Within my own profession, I would say not that I noted.  
 10 I can tell you though that our patients coming in some  
 11 of them had not sought medical help for certain  
 12 conditions. Therefore, certain life-altering and  
 13 life-changing conditions had gone longer before  
 14 treatment or diagnosis so that in turn had a knock-on  
 15 effect.  
 16 We would see people who just didn't want to bother  
 17 the doctors or the perception they couldn't get a  
 18 medical appointment, so they just didn't try and that I  
 19 say sadly in some situations did have a knock-on effect.  
 20 So it wouldn't be unusual for some of your patients that  
 21 they hadn't seen anybody in healthcare for up to  
 22 18 months by the end. They were just so scared. Even  
 23 the panic attacks that we had from patients, we were the  
 24 first people they had seen and they would have panic  
 25 attacks in our clinic because this was the first time

19

1 they had been out.  
 2 Q. Fear of Contracting COVID or fear of seeing people?  
 3 A. Fear of people, fear of people, fear of being out in the  
 4 world again, fear of contracting COVID. We would get a  
 5 lot of questioning about our infection control  
 6 procedures, what would we be doing for that. We did try  
 7 to prepare our patients as best we could through  
 8 detailing what we would be wearing, pictures of us,  
 9 videos, even our patients that have learning needs and  
 10 additional needs, we had to take that into  
 11 consideration. We put in extra things in place for  
 12 people with dementia, because if you have dementia  
 13 seeing somebody in a mask and a visor is a very scary  
 14 thing. So we had pictures of ourselves up smiling  
 15 saying — for example, I had to have a sign up, me  
 16 smiling without my mask on saying "Hi. I'm Emma. I'm  
 17 your podiatrist. I'm treating your feet" and we would  
 18 have that sitting beside us so that could be there and  
 19 they would have a positive visual cue, because they had  
 20 no body language to pick up on at all, which could make  
 21 them more agitated and would have a negative impact on  
 22 their treatment.  
 23 Q. Yes, thank you. And in respect of conditions such as  
 24 diabetes, did the lack of preventative care lead to  
 25 situations where amputations became necessary?

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

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

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

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

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

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

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

22

1 have to follow.

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

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

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

23

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

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

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

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

24

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

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

25

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

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

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

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

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

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

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

27

1 patient care at significant financial detriment to  
 2 yourself.

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

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

28

1 their businesses in that way, but we didn't get much in  
 2 the way of financial support. Many businesses didn't.  
 3 We received one £10,000 grant as a rates registered  
 4 business, which was taxable, so that was £8,000 and that  
 5 was the extent of the financial support that we got as a  
 6 business. So despite rising costs, we had to figure out  
 7 how to cover all of those.  
 8 Q. Thank you. Could you tell us about the childcare issues  
 9 that were particular to podiatrists in private practice?  
 10 A. So when the key worker and front-line healthcare workers  
 11 provision came out, "key workers" were classified into  
 12 three sections 1, 2 and 3, 1 being the most important.  
 13 NHS podiatrists were classified as key level worker 1,  
 14 because they were NHS employees. The private sector was  
 15 classified as key worker level 2, so in certain  
 16 scenarios this meant that we couldn't access childcare  
 17 provision. If a childcare facility only has 50 spaces  
 18 and has 200 applicants, it's right that they triage.  
 19 They have to give priority to key worker level 1, but it  
 20 did mean that some of my staff in particular, my  
 21 colleagues, did not get access to childcare. That then  
 22 impacted on their ability to provide care to others and  
 23 their ability to earn a living as well, because you  
 24 cannot take your children to work in podiatry. It is  
 25 completely inappropriate in that situation. If you're

29

1 working admin from home, you can figure out ways around  
 2 it, but you simply could not take your children into a  
 3 clinical setting, pop some PPE on them and tell them to  
 4 sit in a corner and watch a film. That couldn't happen.  
 5 Q. Your view is that that distinction between NHS podiatry  
 6 and private podiatry was justified?  
 7 A. I understand why it was taken, the perception that we  
 8 were not doing the same critical level of work as our  
 9 NHS colleagues, but we had been asked to stay open. We  
 10 had been asked specifically to support the NHS by  
 11 providing access to our services and that had an impact.  
 12 My own situation, both my husband and I are  
 13 healthcare workers. We both work in the private sector.  
 14 Neither of us qualified in the first instance. Then  
 15 they had spaces opened up. You know, schools had to  
 16 look at, oh, if you've two people that do it, what could  
 17 this do? Where grandparents or family members might  
 18 have previously been able to provide support, they  
 19 weren't allowed to so you're asking your family to break  
 20 the law to look after your children so that you could go  
 21 and help other people. And these are just the wee  
 22 things that, you know, would have an impact, but I  
 23 appreciate it was an emerging situation and it's  
 24 different looking at it in hindsight than it was at the  
 25 time as well so.

30

1 Q. Thank you. In paragraph 70 you state that you have  
 2 rheumatoid arthritis, the treatment for which leaves  
 3 your immune system vulnerable and, accordingly, you  
 4 shielded from April to July 2020.  
 5 A. Yes.  
 6 Q. Did you decide to shield or were you placed on the  
 7 shielding list?  
 8 A. I had to decide to shield myself. I didn't receive a  
 9 shielding instruction in the first few waves. As a  
 10 healthcare professional, I am aware of what my  
 11 medication at the time did to me. I was on a medication  
 12 which severely suppressed my immune system. The  
 13 communication that was coming out from the government on  
 14 shielding was if you have one of these conditions, you  
 15 shield and you wait for your letter. If you do not  
 16 receive that letter, get in touch with your GP.  
 17 I didn't receive that letter, so I had to get in touch  
 18 with my GP, at which point I was reviewed and placed on  
 19 the shielding list, but, yes, I knew from what was being  
 20 said that I was very highly susceptible to catching  
 21 COVID and therefore shielded myself from the public.  
 22 Q. How straightforward was it contacting your GP and being  
 23 placed on the list? Was your GP quite accepting of  
 24 that?  
 25 A. Yes, they were quite accepting. I highlighted that I

31

1 felt I should have been receiving a shielding letter and  
 2 hadn't. I received a callback and I was asked some  
 3 questions as to why I felt I should be shielded. They  
 4 agreed and they put it through. I think it was called a  
 5 Schedule 7 where the GP can choose to place you on the  
 6 list. It transpired that the advice for original — the  
 7 first few passes of shielding was that if you had  
 8 rheumatoid arthritis you must be on two disease  
 9 modifying antirheumatic drugs, known as DMARDs, and I  
 10 was on one, which was a bit more unusual. However, if I  
 11 had been on that same drug from a dermatological view  
 12 point, I would have been shielded on one.  
 13 That advice, again an emerging situation, the advice  
 14 changed as time went on and I would have received a  
 15 letter probably a couple of weeks later anyway. My  
 16 specialist advised me, oh, they did then change that.  
 17 The professional bodies reviewed it and I would have  
 18 been called, but, yes, the rheumatology department had a  
 19 very large number of people to be looking after as well  
 20 and trying to make sure that everybody was supported.  
 21 Q. Thank you. And then in May 2020 you contracted COVID  
 22 and required hospital treatment?  
 23 A. Yes.  
 24 Q. Please could you tell us about your experience of  
 25 accessing medical care and being treated in hospital?

32

1 A. So it's actually two years ago today I was taken as a  
 2 day patient Forth Valley Royal Hospital in Larbert. The  
 3 previous day I had tested positive for COVID in the  
 4 evening. I had written notification in advance of this  
 5 should I ever contract COVID, here was a local phone  
 6 number to call for triaging. I called that morning.  
 7 I think it was the Sunday night I developed COVID  
 8 and I called them on the Monday morning and within about  
 9 an hour, I had had a callback to triage my symptoms and  
 10 I was asked did I have anybody that could actually bring  
 11 me to hospital safely and I was seen at hospital a few  
 12 hours later and I was dropped off at a door, escorted by  
 13 PPE-clad staff into an isolation unit, I was consented  
 14 for an antiviral treatment by intravenous method,  
 15 including that it was experimental and there was a  
 16 chance of death if I took this, and I was then placed on  
 17 an IV for a few hours to receive anti-viral treatment,  
 18 not to make me better, but to stop me from getting worse  
 19 as they were concerned about the impact that me  
 20 contracting COVID would have.  
 21 By this point, I had had five vaccines and it was a  
 22 month after my fifth vaccine and, yes, it was quite  
 23 severe the symptoms that I had developed on the first  
 24 day, hence they chose to give me an IV antiviral instead  
 25 of oral antivirals.

33

1 Q. And while you were in hospital did you find the use of  
 2 PPE and infection prevention and control measures all to  
 3 be appropriate? Were you quite happy with those aspects  
 4 of things?  
 5 A. I noted at the time visors I don't think were being used  
 6 by that point, as in line with the infection control  
 7 guidance at the time. It was IIR facemasks, single-use  
 8 aprons and gloves, which was all — I was in my own  
 9 room. I didn't see anybody else on the way in. I was  
 10 met by staff wearing PPE. I had chosen to wear an IIR  
 11 facemask — not a IIR facemask, an FFP2 facemask myself.  
 12 For more personal circumstances, I preferred an FFP2 for  
 13 the level of infection control and protection that it  
 14 would offer people. I was also acutely aware I had a  
 15 highly contagious disease and I was entering a hospital  
 16 environment, so I had taken my own measures as well, but  
 17 all infection control guidance that was provided to  
 18 healthcare at that time was being adhered to when I was  
 19 in hospital.  
 20 Q. Great, thank you. In paragraph 78 you say that you were  
 21 very impressed with the guidance from the  
 22 Scottish Government while you were shielding. This  
 23 isn't a sentiment that we have heard very often. Could  
 24 you please tell us about your experience of receiving  
 25 the guidance?

34

1 A. Yes. So I received regular letters, texts and updates  
 2 on this. I work in communications now so I felt that  
 3 the communications received were quite clear. For  
 4 example, when the First Minister would be making an  
 5 announcement that was relating to shielding, I would be  
 6 sent a text notification to alert me to this to watch  
 7 the television at that time, which I felt was quite  
 8 forward thinking. I didn't then get caught unawares on  
 9 the TV that something had changed.  
 10 I felt the guidance that came out in writing was  
 11 clear and to the point, contained frequently asked  
 12 questions that I felt explained things clearly. I  
 13 received a Christmas card from the First Minister at the  
 14 time, which also contained some shielding advice as  
 15 well. But I did feel that the guidance coming out  
 16 answered any questions that I would have and made it  
 17 quite clear what I should and should not be doing in  
 18 certain circumstances.  
 19 My friends in England who were shielding would often  
 20 contact me to ask what I had had, because they didn't  
 21 feel that what they had had was particularly detailed  
 22 and that's their personal opinions on it and I would  
 23 share with them photographs of what I had had and they  
 24 would go "oh, that makes that quite clear". Some of my  
 25 friends chose to follow the Scottish advice that was

35

1 shielding in England as opposed to the English advice,  
 2 particularly when the stay alert moved, so it moved from  
 3 stay at home to stay alert and they did not feel  
 4 personally safe as people in the shielding category with  
 5 the new guidance, so they chose to follow the slightly  
 6 more restrictive Scottish guidance because they felt  
 7 that was more appropriate for their personal comfort  
 8 level with their risk.  
 9 Q. Can you tell us once shielding came to an end how did  
 10 you find the transition from shielding to being back at  
 11 work? Were you concerned for your safety?  
 12 A. Yes, it was absolutely nerve-wracking and I have worked  
 13 in healthcare since 1999, but all of a sudden I was  
 14 being faced with people who didn't know how to wear PPE,  
 15 I have seen more noses on top of masks that I knew what  
 16 to do with. Having to constantly ask patients to  
 17 actually put their PPE on properly. Making sure they  
 18 actually washed their hands as well when they came in or  
 19 used alcohol gel. A lot of people felt it didn't apply  
 20 to them. It was quite nerve-wracking being faced, you  
 21 know, with this constant stream of people who could, as  
 22 I believed at that time, potentially kill me, but I was  
 23 having to go and still treat them.  
 24 You are putting yourself at risk every single time  
 25 you have that patient contact. I had control of my own

36



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

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

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

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

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

17 A. I would say probably a few months. Even when I was back  
 18 in work, of course I had on PPE the whole time. We  
 19 staggered our lunch breaks. We didn't eat lunch  
 20 together. If there was ever a time where two staff  
 21 members were on lunch together, one would be in the  
 22 staff room, our back door would be open to ensure free  
 23 flow of air and another person would be sitting in the  
 24 corridor. We had two metres between us at all times.  
 25 Within my own practice, no staff members contracted

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

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

14 A. Yes.

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

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

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

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

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

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

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

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

25 A. Yes.

41

1 Q. But in practice it didn't work out that way.  
 2 A. No.  
 3 Q. We've heard from others that they believe — well, their  
 4 experience was that the issue came down to the lack of  
 5 an NHS email address to book a vaccination appointment.  
 6 Is this an issue that you faced as well or in your  
 7 experience was it limited to what you say in paragraph  
 8 62 that the NHS space delivery team for the vaccine  
 9 didn't realise what was included in private healthcare?  
 10 A. I think from my personal opinion, I think it was a lack  
 11 of understanding from those who were actually faced with  
 12 creating a service delivery plan. So the guidance from  
 13 the Scottish Government, and from all the UK devolved  
 14 nations and England, did say that it was for all  
 15 frontline healthcare workers, private, you know,  
 16 independent, third sectors, charity, as well as the NHS  
 17 and social care.

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

42

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

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

43

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

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

12 A. Yes.

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

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

25 I was very fortunate at the time my professional

44

1 body was part of the Scottish Union's network which was  
 2 getting given these updates, because there was a special  
 3 COVID committee I believe that was formed. That  
 4 committee disbanded. I believe in the past year or so  
 5 it disbanded. Therefore, the updates stopped.  
 6 Now, I believe there was an update to NHS protocols  
 7 for if you have contracted COVID about attending work.  
 8 We've never been told that, so we're still operating  
 9 under if you have — you know if you have been given  
 10 COVID, if you have COVID, if you test positive, you have  
 11 to be off for a set number of days. Whenever these  
 12 public health guidances came out, sometimes I feel that  
 13 the private sector was forgotten in that communication  
 14 chain, but we are still frontline healthcare workers.  
 15 We still have to have workplace protocols and we see  
 16 this in other sectors as well, in health and safety and  
 17 things. It will be NHS that is considered the  
 18 healthcare providers and, again, your social services  
 19 from in council, your caring support, these are  
 20 agencies, these are businesses, they have contracts for  
 21 these things, so there is a line for this to be sent  
 22 down.  
 23 But if you're a self-employed practitioner, if  
 24 you're running your own business, who do you have to  
 25 tell you these things? You rely on a source of

45

1 information, but if that source of information isn't  
 2 been given it, it can be very challenging at times to  
 3 make sure that you're fully compliant when there is this  
 4 block on you getting things.  
 5 Q. Thank you. Now, we have your statement and we'll  
 6 consider that in full alongside your oral evidence  
 7 today. Is there anything we haven't covered today that  
 8 you would like to highlight or mention at this point?  
 9 A. I don't think so. I think we've covered sort of all of  
 10 the bigger challenges around key worker recognition and  
 11 vaccines and access to PPE and the general information  
 12 that was coming out, so I don't think I have anything to  
 13 add at this time. Thank you.  
 14 Q. Thank you very much.  
 15 THE CHAIR: Thank you very much, Mrs McConnachie. Very  
 16 good. We'll come back at 11.15 as scheduled. Thank you  
 17 very much.  
 18 (10.49 am)  
 19 (A short break)  
 20 (11.16 am)  
 21 THE CHAIR: Now, good morning, Mr Edwards.  
 22 MR EDWARDS: Good morning, my Lord, the evidence of the next  
 23 witness, my Lord, is subject to a restriction order and  
 24 so the witness statement and the recording of the  
 25 evidence are anonymised.

46

1 THE CHAIR: Yes.  
 2 A. Now the reference for the witness statement is  
 3 SCIWT0921-000001.  
 4 EVIDENCE OF HSCO249  
 5 Examination—in-chief by MR EDWARDS  
 6 MR EDWARDS: Good morning, witness.  
 7 A. Good morning, Mr Edwards.  
 8 Q. Yes. Now, you are providing your evidence today, as I  
 9 say, subject to restriction order and anonymised, but  
 10 you are agreeable for your witness statement to be  
 11 published on that basis and for your evidence to be  
 12 recorded on that basis; yes?  
 13 A. Yes.  
 14 Q. Yes. Now, in your witness statement, which I hope you  
 15 have a copy of in front of you, yes, or you can see  
 16 online, yes?  
 17 A. Yes.  
 18 Q. Yes. You explain that you're giving your evidence as  
 19 someone who worked as a carer in a private care home and  
 20 also as a union representative for the GMB?  
 21 A. Yes.  
 22 Q. Yes. Now, you explain that you were employed as a care  
 23 provider during the COVID-19 pandemic. This was your  
 24 first job in the care sector, but you held that position  
 25 for over eight years; is that right?

47

1 A. Yes, correct.  
 2 Q. And most of your evidence today concerns what you want  
 3 to say about your work in the private sector, a private  
 4 care home?  
 5 A. Yes, correct.  
 6 Q. Yes. And the details of this are set out in paragraph 3  
 7 of your statement, where you say that at this time, from  
 8 the beginning of the pandemic and through the pandemic,  
 9 you worked in a private care home which had about 60  
 10 beds and was a nursing home?  
 11 A. Yes, correct.  
 12 Q. Yes. Now, if we just look at paragraph 3 of your  
 13 statement again, you say a few words about how the work  
 14 structure worked in this care home before the pandemic?  
 15 A. Yes.  
 16 Q. Could you just summarise that for us?  
 17 A. So we had 60 beds. It was split into three different  
 18 units, so you had 30 beds upstairs. You had one unit,  
 19 which was our younger adults unit and another unit  
 20 downstairs that was a dementia unit. You would  
 21 typically have one nurse in the building and you should  
 22 for upstairs have three or four care assistants,  
 23 depending on if there was a senior care assistant on  
 24 duty. Downstairs in the younger adults you should have  
 25 two people on at all times and in the dementia,

48

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

49

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

50

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

51

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

52

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

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

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

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

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

57

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

58

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

59

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

60

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

61

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

62

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

63

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

64

1 didn't want me looking at the policies and guidance and  
 2 procedures in my current role but they just appointed  
 3 anybody randomly on shift, they would just pick a name  
 4 and say "you're the COVID officer for this day" but a  
 5 lot of the staff don't know -- didn't know a lot about  
 6 guidance and policies and nine times out of ten would  
 7 actually come to me and ask how to update the folder.  
 8 Q. And would this officer have done any special training or  
 9 as I say, what I'm trying to get at, could it have just  
 10 been anyone from the staff or was it someone who had a  
 11 special qualification or had done special -- had done  
 12 some extra training or something?  
 13 A. It was just any member of staff, they didn't need any  
 14 training.  
 15 Q. And what was the -- what was the role of this person,  
 16 what were they in charge of?  
 17 A. So we had like a guidance folder that would put the  
 18 current guidelines and policies and procedures in place,  
 19 it would be about the COVID symptoms, you know, how to  
 20 deal with COVID, just anything that was coming out new  
 21 and they would be in charge of printing them off and  
 22 putting them in the folder, making sure they're  
 23 up-to-date and just making that staff are reading  
 24 up-to-date guidelines and policies about social  
 25 distancing, family visit members, all this kind of

65

1 thing.  
 2 Q. You go on to say that you yourself undertake some  
 3 courses in relation to infection prevention and control,  
 4 I think?  
 5 A. Yes.  
 6 Q. And I mean did you do that because you wanted to or you  
 7 were asked to or ...?  
 8 A. I wanted to do that on my own accord just because I  
 9 wanted to be clued up on everything that was going on  
 10 and make sure, you know, that I'm keeping my residency  
 11 and I could share that information with the staff that I  
 12 was working with.  
 13 Q. Now, inevitably as many others have said, when people  
 14 got COVID they went off sick, inevitably, and this led  
 15 to staff shortages and so on but you highlight some  
 16 issues around COVID sick pay.  
 17 A. Yes.  
 18 Q. Can you say a bit more about that? First of all, what  
 19 was COVID sick pay and, secondly, what were the problems  
 20 with it?  
 21 A. So in the beginning you didn't get paid for being off  
 22 with COVID so it was just your standard statutory sick  
 23 pay and if -- that was included even if you tested  
 24 positive, you didn't get paid anything, and it wasn't  
 25 until the union had come about and said a social care

66

1 fund had been actually set up that we were advised that  
 2 we would get full pay if you tested positive and you  
 3 could claim it back from the fund -- the employer could  
 4 claim it back from the fund. But I only found out about  
 5 that from the union. The employer didn't notify us,  
 6 didn't tell any staff, so I obviously went around and  
 7 told all the staff how they were entitled to sick pay if  
 8 they did test positive and had to stay off.  
 9 Q. Yes, so as far as the employer was concerned, it was  
 10 just statutory sick pay, there was no continuing pay for  
 11 being off sick with a COVID absence and it depended on  
 12 public money in the social fund that was set up; is that  
 13 right?  
 14 A. Yes, correct.  
 15 Q. Yes. And did that continue throughout the pandemic, did  
 16 anything change or ...?  
 17 A. Obviously the social care fund that had been set up  
 18 became more well-known but the employer didn't really  
 19 implement that and inform staff about that, it was  
 20 actually me that had told staff about that and staff  
 21 went to the employer to inform them that they were  
 22 entitled to the sick pay, they had to fight for it, but  
 23 some staff members did actually manage to get sick pay  
 24 whilst they were off.  
 25 Q. Thank you. You then turn to the issue of testing and if

67

1 you tested positive or weren't showing any symptoms and  
 2 what the expectations were about being at work or  
 3 absent. So you yourself, you say in paragraph 27 that  
 4 you tested positive quite early in the pandemic?  
 5 A. Yes.  
 6 Q. Yes, but you weren't displaying any symptoms, at least  
 7 not initially?  
 8 A. No.  
 9 Q. And what did you do then? Did you stay at home, did you  
 10 shield, did you come to work? What were the  
 11 expectations of you?  
 12 A. So I had emailed my manager saying that I wasn't  
 13 symptomatic but I had tested positive for COVID.  
 14 I wasn't entirely sure on the guidance but I didn't  
 15 think it was advisable for me to be in work so I was  
 16 notifying that I would probably be off. Then I got an  
 17 email back saying, "No, if you don't have any symptoms,  
 18 then you are expected to come in to work". So I took it  
 19 upon myself to phone Public Health myself and actually  
 20 ask what the guidance was because I obviously do not  
 21 want to go into a care home and spread -- I might not  
 22 have been symptomatic but I could have been a carrier so  
 23 I wanted to speak to Public Health and they were like,  
 24 "absolutely under no circumstances should you be going  
 25 into work" so I had asked them to put that into writing.

68



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

69

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

70

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

71

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

72

1 have looked after these people for years, and during  
 2 COVID and the lack of staff, we weren't actually able to  
 3 sit with someone that was on palliative care and because  
 4 they weren't allowed their family members in, sometimes,  
 5 you know, our resident might have had to pass away alone  
 6 and that's not the kind of care that we wanted to  
 7 provide, we wanted to be there at their end of their  
 8 life and it was really, really difficult and I know that  
 9 that had a massive impact on my mental health and I  
 10 still think about it and get emotional when I talk about  
 11 it to this day.  
 12 Q. And as you said previously, this was combined with  
 13 problems of family members visiting of course too.  
 14 A. Yes, correct.  
 15 Q. Your statement then turns to issues around pregnancy at  
 16 work and the need for or the absence of risk assessments  
 17 of pregnant workers. And you say that during the end of  
 18 the first lockdown you yourself became pregnant.  
 19 A. Yes.  
 20 Q. Yes. And so when you learned you were pregnant, did you  
 21 ask for any risk assessment in relation to workers who  
 22 were pregnant?  
 23 A. Yes, so when I became aware that I was pregnant, I  
 24 obviously informed management and asked them if there  
 25 was any risk assessments available because I didn't know

73

1 the risks of COVID-19 in pregnant women and I just kept  
 2 getting, you know, told that there was no time to do a  
 3 risk assessment at this current moment of time so I had  
 4 to kind of keep badgering management and say, "you know,  
 5 it's kind of really important that I get a risk  
 6 assessment because I don't know the implications of what  
 7 could happen I want to make sure that I'm following  
 8 correct health and safety to make sure that I'm  
 9 protecting myself and the residents". I had actually  
 10 asked to be furloughed because I was told that this was  
 11 happening in hospitals for pregnant women and I got  
 12 told, "no", there wasn't enough staff.  
 13 Q. Yes. You say in paragraph 35 that there was a protocol  
 14 that a risk assessment should be done. When you refer  
 15 to a protocol, do you mean a protocol in the home's  
 16 policies?  
 17 A. Yes, so I obviously went straight to the policies folder  
 18 and highlighted in their contract and their policy on  
 19 pregnancy that a risk assessment should be done as soon  
 20 as the employee notifies management. I brought that  
 21 highlighted paper in and told management at this point,  
 22 "this is in your own policies and procedures, I would  
 23 like a risk assessment done" and I think they took it a  
 24 little bit more seriously because they knew it was their  
 25 own policy.

74

1 Q. Now, we'll turn a little later to what you want to say  
 2 about your own experience of having a baby during the  
 3 pandemic but before we do that, if we just stay with  
 4 your experience as a worker in this care home. You say  
 5 in paragraph 36 that you were recommended, naturally  
 6 I think, that lighter duties should be taken on while  
 7 you were pregnant?  
 8 A. Yes.  
 9 Q. But this didn't --- this didn't happen, did it?  
 10 A. No, it absolutely did not.  
 11 Q. And was that partly because of shortage of staff or ...?  
 12 A. I think it was the shortage of staff but it was also the  
 13 lack of care from management. I don't think that they  
 14 prioritised my needs. I think they had a lot more  
 15 bigger worries that they didn't really --- they weren't  
 16 prioritising any risks that I could have had as a  
 17 pregnant women in their own.  
 18 Q. And during your pregnancy, your duties continued to  
 19 include things like hoist lifting?  
 20 A. Yes.  
 21 Q. And you weren't limited to staying in the downstairs  
 22 part of the home, for example?  
 23 A. No, so in my risk assessment, it was advised that I  
 24 should be upstairs because it was lower risk because  
 25 there was less people with dementia upstairs, it was

75

1 more frail and elderly, and there was usually more staff  
 2 upstairs so that I would have maybe a little bit more  
 3 support whereas downstairs was just a little bit more  
 4 risky because it was a dementia ward, things were quite  
 5 unpredictable, there was a couple of residents in there  
 6 that did hit out quite a bit at staff so it might have  
 7 been a bit risky for me to go down there. However, it  
 8 just kind of what went by what suited management on the  
 9 day because I did get put between upstairs and  
 10 downstairs depending on what staff were in.  
 11 Q. And in paragraphs 40 to 42 of your statement,  
 12 specifically in 40 to 42, you do describe some severe  
 13 impacts on your own mental health from the combination  
 14 of these experiences. So in the first place --- if I  
 15 understand correctly; in the first place you're  
 16 pregnant; in the second place you've got what's going on  
 17 in the care home, and the third place you've got the  
 18 pressures of work.  
 19 A. Yes.  
 20 Q. Yes. So. Do you want to say a little bit more about  
 21 how you felt, how this was impacting you?  
 22 A. So when I was going to work everyday, I was starting to  
 23 have panic attacks like before I went to work, and then  
 24 it come to the point where I was actually in work and I  
 25 would start breaking down and it was to the point where

76

1 I couldn't do it anymore, I was coming home, I was  
 2 crying. I was scared because I thought I was putting my  
 3 baby at risk and I was also scared because I didn't want  
 4 to leave the residents I was looking after and I knew  
 5 that I couldn't afford to be off work because I had a  
 6 mortgage to pay and I was going to be on maternity leave  
 7 so it was really a lot of pressure. I was very  
 8 depressed in thinking about going to work and it's quite  
 9 hard to say but I just remember like every morning  
 10 waking up thinking I just wish that I would get hit by a  
 11 bus so I don't have to go to work. I was so depressed  
 12 that I just didn't want to go in anymore.  
 13 Q. And it didn't get any better later in your pregnancy as  
 14 you say in paragraph 45 and in fact quite graphically  
 15 you say that you suffered a panic attack one day I think  
 16 later in your pregnancy because of -- well, you and I  
 17 think one other -- you and the nurse were basically  
 18 alone in charge of 30 residents in the home so, in other  
 19 words, half the residents of the home?  
 20 A. Yes. There was a lot of staff that were phoning in sick  
 21 and the home weren't bringing in agency, one, because  
 22 they were getting hired in the hospitals and there  
 23 weren't enough to go around but, two, they said they  
 24 couldn't afford to bring agency in the home. So when I  
 25 went on shift that day, I found out it was me and a

77

1 nurse upstairs and I just went into panic attack because  
 2 I was, I can't do this, not only am I severely pregnant  
 3 and at risk, we can't provide the care we want to  
 4 provide people with that much staff, it's just not  
 5 possible.  
 6 Q. And this is quite -- this is later on, isn't it, because  
 7 you say it was later in your pregnancy, so that's likely  
 8 to be towards the end of 2020, isn't it?  
 9 A. Yes.  
 10 Q. And just to be clear about what you said there, was this  
 11 a problem in finding agency staff or --  
 12 A. There wasn't a problem in actually having -- finding  
 13 agency staff. It was whether or not the home wanted to  
 14 pay for it. There was quite a few agencies out there,  
 15 but the ones that were available were the agencies that  
 16 were a little bit more costly, because a lot of other  
 17 care homes were hiring agency staff as well so they were  
 18 tending to find that the only agency staff that were  
 19 available were the ones that you had to pay higher rates  
 20 for.  
 21 Q. And then in paragraph 46 you do say that -- well, you  
 22 raise this issue. You don't quite say you brought a  
 23 complaint, but you raise these concerns and specifically  
 24 that experience that you've just described about more or  
 25 less being, you know, alone with a nurse in charge of

78

1 half the residents of the care home and what you  
 2 suffered.  
 3 A. Yes.  
 4 Q. You raise that with management and what was the response  
 5 to that?  
 6 A. So I had sent an email to HR. I had actually raised it  
 7 with management and didn't hear back, so I raised it  
 8 with HR after that. My email was ignored, but then I  
 9 got a phonecall asking for clarification and what had  
 10 happened, how I was getting on and I had been telling  
 11 them about the shortages of staff. I told them that I  
 12 had had another panic attack and I had actually walked  
 13 out the previous week, because I couldn't cope and that  
 14 I was 36 weeks pregnant and I just couldn't do it and  
 15 that it was unacceptable and that I just basically told  
 16 HR that they needed to sort out my annual leave that I  
 17 had accumulated (inaudible) during my pregnancy or I  
 18 would be taking them to tribunal because of how they  
 19 were discriminating against me being pregnant. And I  
 20 had also raised the concern about not being furloughed  
 21 as well.  
 22 It wasn't long after that phonecall -- I think it  
 23 maybe would have been like five/ten minutes after that  
 24 they were like you can finish your shift today, but I  
 25 obviously said to them I'm not going to do that to the

79

1 staff and the residents. I need to make sure that I  
 2 finish out the week so they have enough cover, but after  
 3 this week I will go off on maternity.  
 4 Q. Now, after you had your baby and you returned to work,  
 5 in paragraph 47 onwards of your statement you discuss  
 6 what you feel are the impacts of the pandemic on the  
 7 working environment that you were in.  
 8 A. Yes.  
 9 Q. Yes. And that in particular there was a significant  
 10 staff turnover?  
 11 A. Yes.  
 12 Q. A lot of people left, in other words.  
 13 A. Yes. When I was on maternity leave, I was getting  
 14 emails from staff, phonecalls from staff asking to help  
 15 write their resignation letters and I must have one week  
 16 got like seven messages in one week of people resigning.  
 17 Q. Hm--hmm. And after your maternity leave ended, what did  
 18 you do? Did you return to the care home or did you  
 19 leave it to --  
 20 A. So I had requested for flexible working, because at the  
 21 time I was with my then partner, he was working  
 22 full-time, I couldn't afford the cost of childcare with  
 23 just his wage alone, so I wanted to go back to work.  
 24 I had requested flexible working. They were quite  
 25 difficult about it and, because of everything that I had

80

1 experienced before, I started to feel my anxiety  
 2 flare —up again and I was like it's not even worth it so  
 3 I decided to resign. I didn't I want to return and then  
 4 I got asked for a meeting with the new manager, who I  
 5 had never met before, because a new manager had been  
 6 hired when I was on maternity and I told her — she had  
 7 asked like me to tell her things that had happened  
 8 before like in the home, how things worked and I just  
 9 went in and told her everything that had been going on  
 10 and why I didn't want to return and I just got told, you  
 11 know, best of luck to you.  
 12 Q. Now, eventually you decided to leave and went to work  
 13 for a public sector care home; is that right?  
 14 A. It was — it's more public and private.  
 15 Q. Right.  
 16 A. That I work for, yes.  
 17 Q. Right. And very briefly, you say in paragraph 55 of  
 18 your statement that, admittedly after the pandemic, your  
 19 experience is more positive there?  
 20 A. Yes, there was a lot less pressure, because I had to go  
 21 on a zero—hour contract so I was picking my own shifts  
 22 around childcare, so it wasn't that I was going in doing  
 23 12 hour shifts, four days a week anymore. It was  
 24 I could do a half shift here, a half shift there, you  
 25 know, pick up when I could around childcare.

81

1 Q. Yes. All right, well, thank you for that.  
 2 Earlier I said that we would turn to something else  
 3 which was your own experience of maternity services  
 4 during the pandemic when you had your baby. So you say  
 5 you found out you were pregnant towards the end of the  
 6 first lockdown. That's in paragraph 56 onwards.  
 7 A. Yes.  
 8 Q. And you gave birth sort of around early in the third  
 9 lockdown I think. But you say in paragraph 57 that the  
 10 maternity experience, in your own words, was absolutely  
 11 horrendous.  
 12 A. Yes.  
 13 Q. Yes. So do you want to say a little bit more about that  
 14 then. So when did your experiences with the maternity  
 15 services begin? Obviously you became pregnant. You  
 16 knew you were pregnant in June 2020, but when did you  
 17 start to have your visits to the maternity service?  
 18 A. So there was a bit of a lack of visits with maternity,  
 19 so that was one thing that I think that was pretty bad  
 20 and because it was my first pregnancy as well, so I  
 21 didn't really know what I was doing, didn't feel like  
 22 I had adequate support, and I was going to scans on my  
 23 own.  
 24 And then the maternity services in terms of what I'm  
 25 talking about is after I've actually had my child, I did

82

1 not get the support that I needed. I was going to be —  
 2 I was trying to breastfeed. During the pandemic there  
 3 wasn't actually any services available on how to  
 4 breastfeed. You could normally attend classes and that  
 5 before the pandemic. There was nothing like that.  
 6 There was no online classes or anything that I could  
 7 have attended. So I kind of really struggled with  
 8 breastfeeding after because I had a C—section. So  
 9 trying to ask for support from maternity services on me  
 10 breastfeeding was really, really difficult. And the  
 11 hospitals and the healthcare centres there was a severe  
 12 lack of it.  
 13 So I was really struggling, so I had actually  
 14 contacted a volunteer service breastfeeding support like  
 15 cafe in my area and if it wasn't for that service being  
 16 available, who were actually volunteers, I don't think  
 17 I would have been able to breastfeed and I ended up  
 18 breastfeeding for two years, so that service was  
 19 absolutely amazing, but I feel like that service should  
 20 have been available from the hospital and from the  
 21 staff. It just wasn't there. And also I dealt with  
 22 postpartum anxiety and depression and I didn't get any  
 23 support with that whatsoever.  
 24 Q. But you also describe your — the period of labour as  
 25 being very difficult while in the hospital. It was long

83

1 and difficult.  
 2 A. Yes, so I was in the hospital for ten days. I would  
 3 probably say it was the worst experience of my life,  
 4 because we weren't allowed to go outside in those ten  
 5 days, so no fresh air for ten days was absolutely  
 6 horrendous. We weren't allowed to leave the rooms. We  
 7 were stuck inside the room for the first six days whilst  
 8 I tried to have a natural birth. We weren't allowed to  
 9 go walking about the hospital or anything like that. We  
 10 weren't allowed visitors.  
 11 If my partner at the time wanted to leave the  
 12 hospital, he was told he wouldn't be allowed back in, so  
 13 he couldn't leave to get like any food or anything like  
 14 that. If we needed new clothes, family had to come to  
 15 the door, drop off the clothes and then the staff would  
 16 go downstairs and pick it up and then bring it up to us.  
 17 I think it got to the point where like after I had  
 18 had my little girl after my section one of the porters  
 19 or the janitors, I can't remember the name of the staff,  
 20 he had actually come to take me for one of my MRI scans  
 21 and I remember being so excited because he went the long  
 22 way around the hospital so I could actually see air and  
 23 other people. I just felt like I was losing my mind and  
 24 I think when you were so vulnerable after you have just  
 25 given birth I really think that had a massive impact on

84

1 me.

2 Q. And you say towards the end of this section that

3 postnatal care was, in your opinion, poor?

4 A. It was very poor. They didn't — you could tell the

5 staff was under pressure, you could tell that they were

6 short staffed, you could tell that they were being run

7 into the ground and as a careworker, I get it.

8 I understood how they felt. But as a patient I felt

9 neglected and I felt like my needs or, you know,

10 anything that I needed to ask them wasn't prioritised,

11 they didn't really have a person-centred care. It was

12 just as quick as they could get in and get out.

13 Q. You don't expressly deal with this in your statement,

14 but what do you want to say about care after you left

15 the hospital, for example, health visiting services,

16 children's visiting services?

17 A. So that was really difficult. I had barely seen a

18 health visitor. I actually had to contact the health

19 visitor in order to ask when they were going to be

20 coming out to see my little girl, because obviously her

21 development was really important to me. I wasn't

22 getting her weighed. I wasn't getting — they weren't

23 coming out to tell me anything.

24 I was a first-time mum so I didn't really have any

25 experience of how it was meant to work before, but

85

1 I know from my sister giving birth previously that she

2 had seen a health visitor quite regularly after she gave

3 birth and I had barely seen — I had maybe seen her

4 once, twice, maybe even three times during my aftercare.

5 Q. And this would be during the third lockdown in the first

6 part of 2021?

7 A. Yes, but it also continued — it was up to me to be able

8 to contact the services, not the other way around.

9 Q. Well, thank you. You then turn finally to the lessons

10 you would like to be — you would like to think will be

11 learned from what you've described and I suppose there

12 are two parts to this. There's the lessons to be

13 learned from what you've been saying about your

14 experience as a careworker in a care home and then,

15 secondly, the lessons to be learned from what you've

16 just described about maternity services.

17 So if you want to deal with the first one first.

18 What would you hope would be the lessons that will be

19 learned?

20 A. Well, I'm really hoping that when the government are

21 doing the national care service and the registered care

22 work that they're going to hold private care homes

23 accountable. And what I mean by this I think they need

24 to start listening to staff that are on the floor,

25 rather than the people who own these private care

86

1 companies. I think it's important for careworkers to be

2 able to share the experiences in order to be able to

3 actually improve policies and procedures in the future.

4 I think that involvement with trade unions is

5 really, really important in care homes, because no one

6 is holding private care companies accountable at the

7 moment and I think careworkers need a voice and they

8 need someone to hear them, regardless of who the union

9 is, and I think it's important that they have someone to

10 advocate for them, because a lot of staff aren't aware

11 of their rights and if it wasn't for me knowing my

12 rights already, I probably would have been treated a lot

13 worse than I already was. So I think it's really

14 important if we're going to introduce a national care

15 service and fair work scheme that we actually have fair

16 work procedures put in place and the government really,

17 really learn from the mistakes that was made and I also

18 think — sorry just to add in — that all of these COVID

19 inquiries and people like me talking it's really good

20 that the public can hear how transparent we are being,

21 because they didn't actually know a lot of what actually

22 went on in the care homes. So it's good to hear from

23 people like me and people who worked in the care homes,

24 because they can see what actually went on.

25 Q. You do say in paragraph 67 that you think especially in

87

1 terms of not following correct procedures, I mean you

2 have referred to protocols and a handbook of procedures

3 and so on, but I mean are you — is the implication from

4 that what you want to say is that, yes, there were

5 procedures and guidance books and so on, but I think you

6 said once you had to go and look at it yourself and the

7 books there, but there's a difference between the

8 guidance book and the protocols being in place and

9 actually being followed; is that what you're saying?

10 A. Yes, correct. I mean I was a union rep so I kind of

11 knew what I was doing and talking about, but what about

12 people who don't have a union rep in the care homes?

13 How do they — how do care home providers be held

14 accountable for following these policies and procedures

15 if there's no one there to help them be accountable.

16 It's down to the government to make sure that they

17 are following correct procedures and policies and

18 protocols and make sure they are held accountable if

19 they don't.

20 Q. Hm—hmm. And is there anything specifically you want to

21 say about lessons to be learned from what you

22 experienced in relation to maternity services?

23 A. I think, you know, a lot of the hospital staff were

24 actually the same. We have the same experiences as well

25 in the care homes, in terms of they're absolutely run

88

1 into the ground, so I think we need a lot more mental  
 2 health support in the hospitals.  
 3 I think there needs to be a lot more training in  
 4 terms of aftercare when it comes to maternity services.  
 5 I definitely think there needs to be better training  
 6 when it comes to breastfeeding and more services  
 7 provided for mothers who haven't breast-fed before and,  
 8 yes, I just think that the government need to be looking  
 9 at how care is provided in a hospital after birth,  
 10 because it's just so important when someone so  
 11 vulnerable that they get person-centred care, rather  
 12 than just treated like a number.  
 13 Q. Yes. Well, thank you very much. Is there anything else  
 14 you would like to say to the Inquiry?  
 15 A. I think I have said most of what I wanted to say in my  
 16 statement and today. I just hope that, you know, that  
 17 lessons can be learned from this and I do — I hope that  
 18 there is positive change when it comes to private care  
 19 homes, because I feel like we have been forgotten for  
 20 quite a bit now and it's time that care is prioritised,  
 21 social care is prioritised as much as the hospitals are.  
 22 Q. Well, thank you for your evidence and the effort you  
 23 have put in both today and to your statement. Once  
 24 again, thank you.  
 25 MR EDWARDS: My Lord, that concludes the evidence of this

89

1 witness.  
 2 THE CHAIR: Yes, thank you very much indeed and can I just  
 3 thank the witness very much. Very good. 12.30, I think  
 4 you're taking the next witness — 1.30, I think you're  
 5 taking the next witness, Mr Edwards.  
 6 MR EDWARDS: Yes.  
 7 THE CHAIR: Thank you.  
 8 MR EDWARDS: Thank you.  
 9 (12.16 pm)  
 10 (Luncheon adjournment)  
 11 (1.31 pm)  
 12 THE CHAIR: Now, good afternoon, Mr Edwards.  
 13 MR EDWARDS: Good afternoon, my Lord. This evidence session  
 14 is evidence from Mr Neil Craig, who has worked for many  
 15 years as a porter at the Glasgow Royal Infirmary and  
 16 he's giving his evidence as a union representative for  
 17 Unite.  
 18 THE CHAIR: Very good. Thank you. And good afternoon,  
 19 Mr Craig.  
 20 THE WITNESS: Good afternoon, my Lord.  
 21 THE CHAIR: Yes, Mr Edwards.  
 22 EVIDENCE OF NEIL CRAIG  
 23 Examination-in-chief by MR EDWARDS  
 24 MR EDWARDS: Yes, thank you, my Lord.  
 25 Mr Craig, could you give your full name to the

90

1 Inquiry?  
 2 A. Neil Thomson Craig.  
 3 Q. And you have worked as a porter at Glasgow Royal  
 4 Infirmary for 25 years; is that right?  
 5 A. That's right.  
 6 Q. That's right. And you're also a union representative  
 7 for Unite?  
 8 A. That's right.  
 9 Q. Yes, that's right. Now, do you have a copy of your  
 10 statement in front of you online? Good.  
 11 A. Not yet. It's not on yet.  
 12 Q. Is it not. It is now.  
 13 A. Thank you.  
 14 Q. Good, so you have that in front of you. Have you had an  
 15 opportunity to read over it?  
 16 A. Yes.  
 17 Q. Yes, and you are happy for that statement to be  
 18 published?  
 19 A. Yes.  
 20 Q. Yes, and for your evidence today to be recorded and  
 21 published?  
 22 A. Yes.  
 23 Q. Yes. The reference for Mr Craig's witness statement is  
 24 SCI-WT0118-000001.  
 25 Now, if you could begin, Mr Craig, with just

91

1 describing briefly what your duties are or indeed what a  
 2 porter's duties are in a hospital, as you do in  
 3 paragraph 3 of your statement?  
 4 A. So my main duties is taking patients from department to  
 5 department for x-rays, theatres, collecting blood  
 6 samples, collecting waste, delivering prescriptions,  
 7 basic left and lay between the departments and the  
 8 hospital.  
 9 Q. And those were the duties that a porter would have had  
 10 before the pandemic?  
 11 A. Yes, same duties.  
 12 Q. Yes. And more or less continued afterwards?  
 13 A. Yes.  
 14 Q. Yes, and you worked as a porter at the Glasgow Royal  
 15 Infirmary throughout the pandemic?  
 16 A. Yes.  
 17 Q. But you — and sorry — when did you become a Unite  
 18 representative?  
 19 A. So I became a Unite representative in the January 2020.  
 20 Q. Right, so just before?  
 21 A. Just before COVID.  
 22 Q. Right, very good. Now your witness statement, as most  
 23 of them are, are organised around a number of themes and  
 24 what we are going to do is just look at some of those  
 25 themes and the first theme is the first learning about

92

1 COVID and the sort of first impact of it when began to  
 2 see what was happening abroad and when it first hit  
 3 Scotland. And then we'll move on to issues around PPE,  
 4 which we'll spend some time on.  
 5 So I mean can you remember when you first learned of  
 6 the outbreak of the pandemic?  
 7 A. Probably just in the news. In Italy I think was at  
 8 first. We'd learned about it in the media.  
 9 Q. Now ---  
 10 A. It was probably February.  
 11 Q. Yes, February 2020, but in paragraph 6 of your statement  
 12 you describe the sort of first response of the hospital  
 13 that you remember when a COVID-positive patient arrived.  
 14 A. So the first patient I remember in the GRI was a patient  
 15 that had been on holiday and had been transferred to the  
 16 GRI. So when that first patient came in, they came in  
 17 off the ambulance. There's everybody round about them  
 18 had serious PPE masks, like Hazmat suits. No, we  
 19 couldnae be clear. The only thing we had to do was make  
 20 sure that the corridors and the lifts that that patient  
 21 was going to be through to get to the ward was all  
 22 clear. So we didn't need to go near that patient at all  
 23 at first.  
 24 Q. So there was definitely a sort of response to the  
 25 unknown, if you like?

93

1 A. Yes, it's like made you feel safe at the time, because  
 2 of the precautions they were taking.  
 3 Q. But things quickly changed you say in paragraph 7?  
 4 A. Yes. So in that ward that that patient was he was in a  
 5 side room, they were in a side room, the door was always  
 6 closed and then gradually through the week the door was  
 7 open to his room, the PPE that staff had on going into  
 8 his room sort of reduced to like a surgical mask and  
 9 then sometimes none.  
 10 Q. Now, that brings us to PPE which you begin discussing at  
 11 paragraph 8 so at the --- before the pandemic, what sort  
 12 of PPE would a porter normally have, if any?  
 13 A. Before --- usually for a patient had say for an MRSA you  
 14 wear a mask and gloves and apron just for that patient  
 15 if they were confirmed, but then for any other patient  
 16 we wouldnae use any PPE at all.  
 17 Q. Yes. And at the beginning of the first lockdown, so  
 18 March 2020, did that change?  
 19 A. So at the beginning it sorta you would wear a mask. PPE  
 20 it was changing day-to-day at first and then it was  
 21 changing if you had a patient it was confirmed COVID and  
 22 it was contact COVID, so basically you didnae really  
 23 know at first if the patient had COVID, so you didnae  
 24 wear PPE, only when it was COVID.  
 25 Q. You say at paragraph 9 in the initial periods --- after

94

1 this first experience when great precautions were taken  
 2 then it relaxed and now we're moving into the initial  
 3 period sort of March 2020. You say in paragraph 9 that  
 4 the default position was that patients were getting  
 5 treated as if they did not have COVID?  
 6 A. Yes, aye, nae symptoms, if you had nae symptoms, you  
 7 didn't have COVID  
 8 Q. Yes, and obviously there was no testing at this time?  
 9 A. No, testing, no.  
 10 Q. Now, in paragraph 10 you say you remember collecting a  
 11 patient from a ward to take them to x-ray and you say  
 12 they were feeling sick and you gave them a sick bowl.  
 13 Now, did they think they had COVID or what do you  
 14 remember about that?  
 15 A. Well, I don't know if at the time any of the staff  
 16 thought that patient had COVID, but I had to take that  
 17 patient fae the ward to x-ray and they didn't have any  
 18 PPE. I didn't have any PPE, because obviously they were  
 19 getting treated as somebody who didnae have COVID  
 20 confirmed, they werenae confirmed it, PPE at the time.  
 21 Q. Yes. And what you say in the next paragraph is that you  
 22 remember this because the hospital opened a COVID ward  
 23 the next day?  
 24 A. So the next day that's when normal --- we had normal  
 25 wards and then in that day there's been the first

95

1 experienced a particular ward getting open for COVID  
 2 patients, COVID patients only. And that patient was one  
 3 that I'd pushed the first day was the first patient in  
 4 that ward, so obviously I was a bit upset about that.  
 5 Q. Because you thought you would now ---  
 6 A. I thought there was a great risk of me catching COVID  
 7 because of the contact I had with the person.  
 8 Q. Now, you explain that you live with your family, you  
 9 live with your partner and your daughter, and in  
 10 paragraph 12 you raise the issue of provision that was  
 11 made or not made for staff that might not want to go  
 12 home to their family?  
 13 A. Aye, so at that time, at that time I was aware that ---  
 14 so there was the opportunity for surgeons and nurses  
 15 they get put up in a hotel. Instead of going home to  
 16 their families at the time, they could put up at a  
 17 hotel, but that never extended, my knowledge and as I  
 18 remember in my experience, it never extended to porters  
 19 and facility staff, domestics at the time.  
 20 Q. If I could just explore that with you for the moment.  
 21 What you're saying is --- it is one of the themes of your  
 22 statement that there was an unequal treatment of certain  
 23 staff compared to others and, at the moment, we're  
 24 focusing on the beginning of the pandemic for the first  
 25 lockdown, but what you're saying in paragraph 12 is that

96

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

97

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

98

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

99

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

100



1 A. Yes, James was, yes. James was obviously a full time  
 2 Esther was a convenor at the time, so they're senior  
 3 reps to me. That's where I was getting my advice,  
 4 getting asked to support management, because obviously  
 5 it settled staff's minds if they have the union rep  
 6 there to support the manager and they're agreeing with  
 7 they're getting told.  
 8 Q. And so what was the follow-on from this meeting then?  
 9 A. So that meeting went well on the Friday. As I say, I  
 10 just basically just was there to support the management  
 11 at the time and back up everything they were saying and  
 12 then the follow-up was the Friday night some porters  
 13 were getting told they didnae need.  
 14 So when I went in to work the next day, the Saturday  
 15 morning, I couldnae understand why there was a change  
 16 when I had spent the full day, the Friday, supporting  
 17 management to tell them we need to wear the masks at all  
 18 times now, gloves and aprons, and then it was changing.  
 19 But then that Saturday I quickly phoned James,  
 20 contacted James, and James got it all cleared up that  
 21 the guidance hadnae changed and the porters will  
 22 definitely still wearing masks. From that day on, we  
 23 always wore masks with every patient.  
 24 Q. What you explain in paragraph 17 is that following the  
 25 meeting on a Friday a porter had experienced been told

101

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

102

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

103

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

104

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

105

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

106

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

107

1 pandemic on shift patterns, so work shift patterns and  
 2 we just wind the clock back a little bit to the outbreak  
 3 and the beginning of the first lockdown. So you begin  
 4 in paragraph 28 by describing the pre-pandemic situation  
 5 that certainly in your case you would work about 48  
 6 hours per week, albeit some of that was --- ten hours or  
 7 so of that was overtime. That was the routine position.  
 8 A. Aye.  
 9 Q. And you say that, interestingly, that as you remember it  
 10 at first your colleagues as porters were not getting  
 11 COVID or not catching it.  
 12 A. Not at first, because when --- at the start a lot of the  
 13 porters, because we were essential workers, we were  
 14 going to work, where lots of people were going to work,  
 15 obviously you're reading media and it was like a, well  
 16 done, you're going to work, this is your duty. So a lot  
 17 of porters were going in and working and the managers  
 18 didn't know the impact of COVID at first, how the  
 19 capacity in patients that was going to be. So thought  
 20 the workload was going to be higher and so we were all  
 21 there and we could be there as long as we wanted to be  
 22 really, because people weren't sure if you were going to  
 23 be needed, but it turns out we weren't really needed.  
 24 Q. So people were coming to work, they weren't getting  
 25 COVID at the beginning and the shift patterns at first

108

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

109

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

110

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

111

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

112

1 Q. Right. So the practice then was to put all patients  
 2 into a bag and then shortly after to double bag  
 3 patients?  
 4 A. Aye.  
 5 Q. Deceased persons. Yes. But that didn't continue  
 6 consistently either, did it?  
 7 A. No, that did not, because there was a time where  
 8 patients were coming --- they were just in the one bag,  
 9 they werenae double bagged and we'd take them down to  
 10 the mortuary. We would be asked to take them down to  
 11 the mortuary, but the mortuary attendant was asking us  
 12 to like can you make sure they're double bagged, because  
 13 funeral directors --- the guidance was still --- the  
 14 guidance by now was to double bagged and the funeral  
 15 directors wouldnae take the patient from the mortuary  
 16 unless they were double bagged, so that meant the  
 17 mortuary attendant --- she was double bagging them and  
 18 she was putting them in the bag herself so --- which is  
 19 quite a hard task to do.  
 20 Q. Yes. So at some point the practice or the  
 21 recommendation to double bag a deceased person wasn't  
 22 being followed?  
 23 A. Wasnae.  
 24 Q. And the porters were taking that person to the mortuary  
 25 and it was up to the mortuary attendant to do that?

113

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

114

1 A. That didnae actually happen for long. That was --- that  
 2 only went for a week and probably the fact that  
 3 mortuary --- funeral directors wouldnae take the patient  
 4 and we then porters wouldnae leave the ward without the  
 5 patient double bagged probably helped, but then, aye, so  
 6 that was --- that was only for a week.  
 7 Q. That was only for a short period?  
 8 A. A short period of time.  
 9 Q. Right. You then turn to the exposure for porters to  
 10 COVID and what you said earlier was in the first  
 11 lockdown there didn't seem to be a significant incidence  
 12 of COVID amongst porters where you were working?  
 13 A. Aye, because then again we didnae have --- we didnae have  
 14 the latter flow test or anything like that. We  
 15 didnae --- people --- you could have COVID and be  
 16 asymptomatic, so there was nae porters at the time  
 17 turning up to work with symptoms with COVID up until  
 18 probably, as I say there, the end of July, August.  
 19 Q. Sorry. Go on. I was just going to turn to paragraph  
 20 41, but I think you were going to anyway.  
 21 A. Aye, so my first recollection of a porter turning up to  
 22 work with COVID was in August 2020 and this porter was  
 23 actually an agency staff, so he didnae work for one  
 24 department, he worked between two departments. So he  
 25 worked --- he worked with the casualty porters and he

115

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

116

1 A. Occupational health advice was to leave work, go home,  
 2 occupational health will contact you, go through their  
 3 checklist and see if you're all right to go back to  
 4 work.  
 5 Q. And is that what happened?  
 6 A. With the porters? No, we got asked to stay there and  
 7 occupational health would contact us that day. So my  
 8 advice at that time and we were asked to still push  
 9 patients until occupational health confirmed that you  
 10 could go home or stay. My advice that day was and  
 11 obviously speaking --- phoning James for James' advice on  
 12 it.  
 13 Q. That's James O'Connell?  
 14 A. Aye. We will no be pushing any patients until  
 15 occupational health confirmed that we were safely --- we  
 16 were to be still at work.  
 17 Q. Yes. And in paragraph 45 you maintain that generally,  
 18 so not always, but generally, porters were never sent  
 19 home if they had been in contact with an infected  
 20 colleague, whereas other departments were getting sent  
 21 home?  
 22 A. Aye. So in that incidence there, we had two porters  
 23 that were sent home that day, two porters. Probably  
 24 15/20 that came in contact with that porter had COVID  
 25 confirmed.

117

1 Q. And you say the decisions --- just to be clear, the  
 2 period we're talking about now is when there was an  
 3 increase incidents of COVID so this is the second half  
 4 of 2020?  
 5 A. Yes.  
 6 Q. You say in paragraph 46 that the practice of not sending  
 7 staff off-site was one --- well, was one that led to an  
 8 increased exposure to COVID?  
 9 A. Definitely, definitely. Because we were come in contact  
 10 with porters or domestics staff that had confirmed COVID  
 11 and we were nae getting so --- basically there was a  
 12 checklist that would ask you if you had been two metres  
 13 away, had your mask on, but then it's your manager  
 14 asking these questions, so there was an element --- for  
 15 me an element of staff maybe no telling the truth when  
 16 it came to, because they thought there might be  
 17 consequences.  
 18 But that's when definitely the rise in porters  
 19 catching COVID, that's when it came, but then we were  
 20 coming face-to-face with not just COVID, porters, staff  
 21 members, patients with COVID as well.  
 22 Q. Now, by this time of course there was more guidance on  
 23 shielding and risk assessments and so what you say in  
 24 paragraph 47 where you turn to this is that in  
 25 October --- in and after October 2020 there was a rise in

118

1 shielding porters?  
 2 A. Aye, returned --- rise in shielding porters back at their  
 3 work.  
 4 Q. There was a rise in shielding porters returning to work.  
 5 Why was that?  
 6 A. Because --- well, after the first lockdown it was like  
 7 the government guidance was like lockdown is over,  
 8 people that were shielding can return and go back  
 9 into --- go back to your work. So the staff members that  
 10 were shielding, they were --- it was --- guidance was that  
 11 they could return to work now. So they were back at  
 12 their work between probably October, November, I think.  
 13 Q. And there were COVID risk assessments in place by this  
 14 time?  
 15 A. So they would get risk assessed and they were meant to  
 16 come back at the end of lockdown and that was just a  
 17 phonecall off a manager. They say like --- ask a few  
 18 questions. They say are you okay? You come back.  
 19 You're all right to come back to work.  
 20 Q. What you're saying is the risk assessment was done by a  
 21 manager?  
 22 A. Yes.  
 23 Q. And not by an occupational health qualified person?  
 24 A. No, not at that --- no. That was in end August and  
 25 between August, start August and the end August, these

119

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

120

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

121

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

122

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

123

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

124

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

125

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

126

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

127

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

128

1 so that's it.  
 2 Q. We are very grateful for the evidence you have given and  
 3 for the effort you have put in to the preparation of  
 4 your statement and I thank you for that.  
 5 MR EDWARDS: My Lord, that completes Mr Craig's evidence.  
 6 THE CHAIR: Very good, thank you very much, Mr Craig.  
 7 Right. Well, we finished a little early,  
 8 Mr Edwards. I think --- I'm not sure if the next witness  
 9 is available yet, but if the next witness is available,  
 10 the last witness, we could start that witness at shall  
 11 we say quarter to --- I know Mr Gale is going to lead  
 12 that witness. We could start is at quarter to three if  
 13 that's possible.  
 14 MR EDWARDS: I can ask, my Lord.  
 15 THE CHAIR: Very good.  
 16 MR EDWARDS: If it's possible, my Lord, we'll inform you,  
 17 yes.  
 18 THE CHAIR: That's kind, super. Thank you very much indeed.  
 19 (2.27 pm)  
 20 (A short break)  
 21 (2.59 pm)  
 22 THE CHAIR: Now, good afternoon, Mr Gale.  
 23 MR GALE: Good afternoon, my Lord. The last witness today,  
 24 and indeed the last witness in this section of the  
 25 hearings is Ms Helen Goss. She is ---

129

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

130

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

131

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

132



1 you've confined your statement. But all that said, the  
 2 Inquiry is very mindful of the fact that your daughter's  
 3 condition and indeed your own is an ongoing one, so we  
 4 are very mindful of that.  
 5 Can I also indicate that in your statement you've  
 6 included a section headed "Educational Impacts" and I  
 7 think we find that --- it's not necessary to show it at  
 8 this stage --- but we can find that at paragraphs 134 to  
 9 155. It's quite a lengthy passage in your statement.  
 10 Now, we've obviously read what you've said in that  
 11 section, Ms Goss, but as you know my colleagues in  
 12 the Inquiry, working in what we call P4, are involved in  
 13 considering the impacts on children and young people and  
 14 their education and they have been in touch with you and  
 15 it's my understanding that they have taken or are taking  
 16 a statement from you to inform their investigations. Is  
 17 that the position that you understand?  
 18 A. Yes, it is, yes.  
 19 Q. Yes. So today it's not my intention with a couple of  
 20 exceptions to look at that section of your statement,  
 21 but the one area that I will ask you a little about is  
 22 the extent to which absence from school has been an  
 23 isolating factor for your daughter and we'll come to  
 24 that in due course.  
 25 Now, as I have said, you provided a detailed

133

1 progression of your daughter's condition up to the end  
 2 of 2022 and this began with you, your then partner and  
 3 your daughter contracting COVID just prior to the first  
 4 lockdown in 2020. And you tell us about that in your  
 5 statement beginning at paragraph 8 and following and as  
 6 I understand it, you kept --- with the knowledge of that  
 7 infection, you kept your daughter off school at that  
 8 time; is that right?  
 9 A. Yes, we didn't know exactly what it was, but I had a  
 10 suspicion that it could have been COVID-19.  
 11 Q. Right. And do you remember for how long you kept your  
 12 daughter off school?  
 13 A. It was only a week because then we went into lockdown.  
 14 Q. Yes.  
 15 A. So ---  
 16 Q. That took over?  
 17 A. Sorry.  
 18 Q. I'm sorry. I'm saying that lockdown then took over.  
 19 A. Yes, yes, that's right.  
 20 Q. Yes. As you say at paragraph 14 of your statement, your  
 21 daughter's symptoms were initially mild, because I think  
 22 both you and your then partner contracted COVID at the  
 23 same time?  
 24 A. He had it first, and then my daughter started to feel a  
 25 bit unwell and it wasn't until a few days after that

134

1 that I started to feel unwell. So it was like a  
 2 succession of getting knocked down.  
 3 Q. Dominoes. Yes. Okay. But if one was looking at it in  
 4 a comparative way, her initial symptoms were milder than  
 5 yours, as I understand it?  
 6 A. Much so. Oh goodness, yes. If it had been in  
 7 isolation, we would have barely thought she was unwell  
 8 at all. She just felt a bit under the weather. She was  
 9 still able to do some school work and play a bit. It  
 10 was very mild for her.  
 11 Q. And in order to get a little context, and you do refer  
 12 to certain of this information in paragraph 23 and 24,  
 13 prior to this, can I put it bluntly, was your daughter a  
 14 sickly child?  
 15 A. No, not particularly. She had had childhood illnesses  
 16 in the past, but she had always recovered just fine, so  
 17 I wouldn't have called her a sickly child, no.  
 18 Q. Was she active?  
 19 A. Oh very, yes, very active. She would --- she loved  
 20 swimming, she had swimming lessons all the time, we went  
 21 swimming a lot. We played tennis occasionally. She  
 22 loved that, but her main hobby, the thing that she  
 23 misses the most, is that she has been horse riding since  
 24 she was about, gosh, four or five years old, so she  
 25 can't do that anymore.

135

1 Q. Right. And could you also tell us about her school  
 2 attendance, was that relatively normal prior to this ---  
 3 A. It wasn't --- yes, prior to the pandemic, yes, it was  
 4 relatively normal. We did have a small bit of  
 5 difficulty in her primary 2. It turned out that she had  
 6 a condition called PANDAS which we didn't know at the  
 7 time, which actually interestingly got triggered again  
 8 by COVID. But you know she had a lovely friend group.  
 9 She really liked the school. She was always quite happy  
 10 there. Yes, there were no concerns.  
 11 Q. Okay. Now, what you do tell us in paragraph 14 is that  
 12 your daughter three to four weeks post infection took a  
 13 very sudden turn for the worse. Can you just describe  
 14 what that turn was?  
 15 A. Oh, my goodness. This --- that was honestly the scariest  
 16 time of my entire life and that is not even an  
 17 exaggeration. I remember we were just in the sitting  
 18 room watching TV and all of a sudden she just gets up  
 19 and says "I'm not feeling well" and then took herself  
 20 upstairs to bed. That was really weird for her.  
 21 Anyway, and it happened really quickly. Within a few  
 22 hours, she had a wild temperature and she was feeling  
 23 feverish, hot and cold. She was feeling really, really  
 24 unwell and it came so out of the blue, I had no idea  
 25 what on earth was going on.

136

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

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

137

1           temperature down.  
2 Q. Sorry. Can I just interrupt there. You did seek advice  
3 from NHS 24 I think?  
4 A. Yes, I did. I didn't delay that. I did seek advice  
5 from them. They didn't seem too concerned and I was  
6 trying to emphasise how severe this was, whatever this  
7 was and you have to remember as well back in that sort  
8 of era, I suppose, right at the beginning of the  
9 pandemic, it was very much an environment of fear. We  
10 were told, you know, don't go to your GP surgery. Don't  
11 go to the hospital. Save the NHS. You know, all of  
12 these buzz words and slogans. So I was frightened to  
13 take her anywhere so, yes, I called 911 and I described  
14 all of her symptoms and everything and they said, oh,  
15 can we see if she can go to the bathroom. I was I  
16 really don't think she can, but they were insistent she  
17 had to go to the bathroom and my daughter was --- she was  
18 almost delirious at that point. She was --- there were  
19 some times when I couldn't even rouse her from her  
20 sleep. It was so frightening.  
21           Anyway, I tried to encourage her to get up, said  
22 it's really important that we try, that we try to go to  
23 the bathroom. She was you know complaining and saying  
24 "I don't need to go to the bathroom, I don't feel well.  
25 Let me sleep." Anyway, she did ---

138

1 Q. Can we just ---  
2 A. She got up with some help.  
3 Q. Can I just interrupt. Can we just get this in a little  
4 context. This came on three or four weeks after the  
5 initial contracting of COVID that you've told us about.  
6 In the period between contracting COVID and this onset  
7 had your daughter recovered or apparently recovered from  
8 COVID?  
9 A. Yes, yes, when we had COVID it was really mild for her.  
10 Q. Hm---hmm.  
11 A. She was --- she was fine.  
12 Q. Yes.  
13 A. We thought we had got off lightly, you know. I was  
14 almost glad that we had had it. I was, oh, well, maybe  
15 that's it over and done with and we all came through the  
16 other side, thank goodness.  
17 Q. I don't mean this as a criticism or an insult, was there  
18 any chance in your mind that your daughter was conning  
19 you about her condition? You're laughing. I think  
20 I can take it your answer ---  
21 A. It's such a ridiculous thing to say. No, of course she  
22 wasn't. She was incredibly sick when she had, you know,  
23 four weeks after and we had COVID, the acute infection.  
24 The reason we knew it was COVID was because of me, my  
25 symptoms were really awful. I had a horrible cough,

139

1 I couldn't breathe, my oxygen stats were down at 91, 92  
2 sometimes even 90. I mean there was no mistaking that  
3 it was COVID at all. We didn't need a test to tell us  
4 that even though there was no testing.  
5 Q. You do tell us at paragraph 18 of your statement that  
6 that you came across some information about a condition  
7 named Paediatric Inflammatory Multisystem Syndrome. It  
8 was temporarily linked to SARS-Cov-2. It's called  
9 PIMSTS. This from what you say was information which  
10 was reflected in the condition that your daughter was  
11 suffering; is that correct?  
12 A. Yes.  
13 Q. You did eventually obtain a diagnosis of this. You  
14 refer to this in paragraph 19, and this was a diagnosis  
15 provided I think by Royal Aberdeen Children's Hospital,  
16 but it was qualified with the word "suspected"?  
17 A. Yes.  
18 Q. Did you gain, albeit two years later, some satisfaction  
19 of obtaining that diagnosis?  
20 A. I wouldn't say satisfaction because of what they have  
21 put us through the last four years. I mean I knew  
22 that's what she suffered from and because they were  
23 hesitant to admit her and so she wasn't assessed, you  
24 know, they said, well, we can't backdate her diagnosis,  
25 because she wasn't assessed, and I said, well, that's

140

1 absolutely reasonable, but the reason she wasn't  
 2 assessed is because, you know, we were told not to come  
 3 in at one point. I think that will forever be burned  
 4 into my memory: under no circumstances should you turn  
 5 up at the hospital with your daughter. That's insane.  
 6 If she was so ill like that right now, I would call  
 7 an ambulance. That's how sick she was. So I wouldn't  
 8 say it was satisfying. It was frustrating. It was  
 9 infuriating. I'm glad it's on her record now, but I get  
 10 no satisfaction out of that, because she was so ill. I  
 11 honestly thought I might lose her.  
 12 Q. You do tell us at paragraph 21 that she had --- if your  
 13 daughter had become horrifyingly unwell now, you  
 14 wouldn't hesitate but to take her to hospital; is that  
 15 correct?  
 16 A. Yes.  
 17 Q. Now, I would like to ask you a little of what you say in  
 18 paragraph 20. This may be of some significance for the  
 19 Inquiry. You refer to an FOI request submitted by a  
 20 member of the public and also evidence gathered by the  
 21 UK Covid Inquiry, revealing that organisations including  
 22 the NHS and the government, by which I assume that is a  
 23 reference to the UK Government, were very well aware of  
 24 this condition, this is the condition PIMS-Ts, but had  
 25 chosen not to inform the public so as not to panic

141

1 parents. Now, can you just expand on that a little,  
 2 please?  
 3 A. They in their ivory towers decided that they weren't  
 4 going to tell the public that this condition even  
 5 existed, which I think is just stupid, because if I had  
 6 known, if I had known what she was suffering from,  
 7 I would have taken her straight there. I wouldn't have  
 8 hesitated. You know, the context of fear around that  
 9 time, don't go near the hospital, don't --- save the NHS,  
 10 I would have just completely ignored all of that and  
 11 taken my kid to get medical treatment. I'm just so ---  
 12 sorry --- it's really traumatic remembering it.  
 13 Q. No, no, take your time. Do you feel able to go on?  
 14 A. I just think if they had informed parents then I would  
 15 have taken her in and it's very possible that she with  
 16 treatment early maybe she wouldn't be so sick now.  
 17 Q. Right. You do say in paragraph 20 that the  
 18 institutions, including the government, had chosen not  
 19 to inform the public so as not to panic parents. Is  
 20 that something that you have seen in writing or is that  
 21 a supposition that you have made?  
 22 A. Yes. I'm pretty sure it's in the emails between people  
 23 like Dr --- oh, I can't say their names, can I?  
 24 Q. No, if you don't mind.  
 25 A. I'm pretty sure it's in writing in emails between

142

1 high-level decision-makers in healthcare and policy and  
 2 all of those areas.  
 3 Q. Right, okay. Can we move on, please, to --- are you all  
 4 right? Can we move on to the period that you describe  
 5 in paragraphs 22 and following of your daughter's  
 6 symptoms during the summer of 2020.  
 7 Again, we can read what you say. Can we just again  
 8 go back to --- well, perhaps go to two expressions that  
 9 you use, one in paragraph 23 and the other in paragraph  
 10 24. The expression in paragraph 23 is in the last  
 11 sentence and you say that your daughter had "no fuel in  
 12 the tank", and then in paragraph 24, you say that "there  
 13 was no spark in her."  
 14 Again, can you just give us an indication, given her  
 15 condition and the symptoms that she was displaying  
 16 during this period, what you mean by those two  
 17 expressions?  
 18 A. She was just really, really lethargic. She was  
 19 exhausted all the time. She didn't want to do anything.  
 20 I mean, you know, we're lucky enough to have a back  
 21 garden, she didn't want to come out in the back garden  
 22 to do anything, even anything really simple. I did  
 23 manage to get her out a couple of times, but she would  
 24 just sit in the shade with her coat on and it was warm,  
 25 it was summer, and she just looked like such a sad and

143

1 exhausted figure. There was nothing to her.  
 2 When I say "there was no spark in her", she was  
 3 just, you know, she was quiet, she was withdrawn, she  
 4 was --- she wasn't herself.  
 5 Q. Yes. And you give an indication in paragraph 24 of a  
 6 number of sensory difficulties that she was  
 7 experiencing, including that she couldn't have a bath  
 8 because the water hurt her and also that she was  
 9 sensitive to sunlight.  
 10 A. Yes.  
 11 Q. These were conditions that were impeding her obvious  
 12 enjoyment of life?  
 13 A. Yes, that's right and it's difficult to as a --- I don't  
 14 want to say as a healthy person, but as somebody who  
 15 doesn't experience these symptoms, it's really hard to  
 16 understand how light and noise can actually be painful,  
 17 physically painful, and I have experienced it myself  
 18 with my Long COVID. Luckily, I don't get it very often,  
 19 but she gets it still everyday and it is very, very  
 20 common in Long COVID and also PANS which she was later  
 21 diagnosed with. So quite often --- you know quite often  
 22 she has to stay in a dark quiet room, very little  
 23 sensory input. You know, it's no life for a kid. It's  
 24 very difficult to deal with.  
 25 Q. Now, and paragraph 26, and I don't think it's necessary

144

1 to look at the circumstances that gave rise to you  
 2 asking for advice from a GP, but you tell us that the GP  
 3 attributed her behaviour to the fact that she had not  
 4 been at school and she was suffering from an  
 5 accumulation of isolation and anxiety and you go on to  
 6 say that the GP was very dismissive of her symptoms.  
 7 Now, before we go on, the — one of the points  
 8 I think you want to make through your evidence is the  
 9 extent to which your daughter's condition was readily  
 10 attributed to the effects of isolation and anxiety and  
 11 that any other cause of your daughter's symptoms were  
 12 dismissed by certainly some health professionals. Is  
 13 that what you want to convey to the Inquiry?  
 14 A. Most professionals. In fact, pretty much all of them,  
 15 except one. It was a ridiculous time. Right from the  
 16 beginning I think people thought we were imagining it,  
 17 making it up, that perhaps it was the effect of  
 18 isolation and anxiety. None of us felt isolated or  
 19 anxious at that time. It was a ridiculous conclusion to  
 20 come to quite honestly and I didn't believe that was the  
 21 case when the GP was suggesting that this is what the  
 22 problem was, but I didn't argue with it. I know better  
 23 now, but at the time I thought, well, maybe they're  
 24 right. Maybe they're right.  
 25 Q. Presumably these interactions with the GP were through

145

1 you and remotely; would that be right?  
 2 A. On the phone.  
 3 Q. Yes.  
 4 A. On the phone.  
 5 Q. There was not a physical examination of your daughter?  
 6 A. No, no not at that time. There was later on when she  
 7 had much more severe symptoms.  
 8 Q. Okay. Now, the next period that you talk about in your  
 9 statement is at paragraphs 28 and following and this is  
 10 the period between August 2020 and the end of the year  
 11 2020, and you tell us that your daughter became very ill  
 12 again in August 2020 and you tell us the symptoms of  
 13 that. And you then took her to the GP, your GP, and  
 14 subsequent to that her condition worsened and the GP  
 15 sent her directly to hospital, the Royal Aberdeen  
 16 Children's Hospital; is that right?  
 17 A. Yes, that's right.  
 18 Q. And one of the issues that you were confronted with then  
 19 was that there had not been a diagnosis or a positive  
 20 test of COVID at the outset of the pandemic in  
 21 March 2020 and, therefore, the — those who were  
 22 interacting with your daughter indicated that you and  
 23 they could not be sure that it was COVID in the absence  
 24 of a test. How did you feel about that?  
 25 A. Oh, it was so infuriating and, you know, this attitude

146

1 lasted for years. Oh, you didn't have a test so you  
 2 can't know it was COVID, you know, basically completely  
 3 undermining our entire experience. You know we had —  
 4 I had been very sick with the acute infection and then  
 5 my daughter had been unbelievably sick with PIMS and not  
 6 treated and then we go to seek help when she's really  
 7 quite unwell again and they're saying, no, we don't  
 8 believe — we don't believe what you're saying  
 9 essentially. It's infuriating.  
 10 THE CHAIR: Can I ask you a question, please? Sorry to  
 11 interrupt and I'm not seeking to be confrontational, but  
 12 I want to be very clear. The language that you've just  
 13 used and you use in the final sentence of paragraph 28  
 14 and you say:  
 15 "The hospital did not believe that we had COVID—19  
 16 in March."  
 17 Now, I fully understand if that's the case your  
 18 irritation, anger, frustration in relation to the  
 19 attitude, but I think you accept that it's a fact that  
 20 there was no test, because there wasn't one, in  
 21 March 2020.  
 22 Now, from a clinician's point of view, do you accept  
 23 that in the absence of a test, a positive test for  
 24 COVID, the clinician would be — I'm not suggesting this  
 25 is what happened, but I just want to be clear about

147

1 that — there would be nothing wrong with a clinician  
 2 saying, well, you report that you or your daughter had  
 3 COVID in March, but in the absence of a positive test,  
 4 we cannot be definitively sure and we have to in  
 5 considering her condition at the moment proceed on the  
 6 basis that there is an undiagnosed report or an  
 7 unconfirmed, I beg your pardon, report of COVID some  
 8 months ago.  
 9 Now, can I be clear, that wasn't the approach they  
 10 took; is that your evidence?  
 11 A. Yes, that's not the approach they took. They were  
 12 completely resistant.  
 13 THE CHAIR: They were completely resistant.  
 14 A. And I mean —  
 15 THE CHAIR: Do you accept that I am right that there would  
 16 be nothing wrong with them saying we can't be absolutely  
 17 sure that she had or we can't proceed on the basis that  
 18 she definitely had COVID without a positive test.  
 19 You're saying that they didn't believe you, which is  
 20 obviously a different thing. That's your position, is  
 21 it?  
 22 A. Yes, they didn't believe.  
 23 THE CHAIR: That's fine.  
 24 MS BAHRAMI: I was clinically diagnosed albeit over the  
 25 phone based on my symptoms —

148

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

149

1 A. Mm—hm.  
 2 Q. Is that correct?  
 3 A. Yes.  
 4 Q. And the clinicians that you spoke to at the hospital,  
 5 were they made aware of that?  
 6 A. I said that, yes.  
 7 Q. Yes, okay. Now, can I take you on, please, to paragraph  
 8 35 of your statement. You mention there that your  
 9 daughter's teacher raised certain concerns with you  
 10 about what's described as "uncharacteristic behaviour".  
 11 Now, just to understand the situation, when this  
 12 occurred, do I take it that your daughter was back at  
 13 school?  
 14 A. Yes, so after that illness in the August I pushed her  
 15 regrettably to go back into school, and she was trying  
 16 her best and it was really difficult. Everyday was very  
 17 difficult trying to get her into school. She wasn't  
 18 feeling well. She didn't want to go, but I was pushing  
 19 her for the sake of attendance, which is — I wouldn't  
 20 do that now, but at the time it felt very important to  
 21 get her back to school after lockdown and be with her  
 22 friends and — but then, yes, I by chance met her past  
 23 teacher in the community here and she said "I'm  
 24 really — it's such a shame, it's such a shame to see  
 25 her, she's so different, she's just not able to engage

150

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

151

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

152

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

153

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

154

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

155

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

156

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

157

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

158

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

159

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

160

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

161

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

162

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

163

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

164



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

165

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

166

1 Q. You feel that was done reluctantly?  
 2 A. Oh, gosh, yes, very reluctantly and we're not the only  
 3 ones. There are so many kids out there who quite  
 4 clearly have Long COVID and are not been diagnosed with  
 5 it, despite all conditions being excluded. There's a  
 6 big reluctance to diagnose Long COVID in children.  
 7 Q. So only other point I want to take from you in relation  
 8 to that section of your statement is that you have an  
 9 ongoing legal action against NHS Grampian which began  
 10 earlier this year. We don't need to go into any more  
 11 detail than that, but just as a matter of fact you have  
 12 begun a legal action in relation to the conduct of  
 13 NHS Grampian.  
 14 A. Yes.  
 15 Q. You've given us the section on the impact on your  
 16 daughter and indeed on yourself. Now, this is paragraph  
 17 123 and following. You mention in paragraph 124  
 18 something that I have already asked you about, that your  
 19 savings are gone and, as you put it, you're skint?  
 20 A. Yes.  
 21 Q. And you live paycheck to paycheck.  
 22 A. Yes.  
 23 Q. This has been while we're talking about obviously  
 24 principally the impact on your daughter, this had had a  
 25 very significant impact on you?

167

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

168

1 better, get infected again, the cycle continues and each  
 2 time you get infected, your baseline gets lowered, which  
 3 is why I think I had such a horrible time trying to  
 4 write this statement is because after a fourth infection  
 5 my brain is shot, just I can't process things anymore, I  
 6 feel really dumb all the time, and, you know, we don't  
 7 want to get reinfected a fifth time so we do all we can  
 8 to avoid it. We still wear masks. Well, she can't  
 9 leave the house but when I need to go out, maybe go to  
 10 the shop, I'll wear a mask to try and lower my risk.  
 11 But, you know, she can't leave the house anyway so we  
 12 don't really see very many people. We have to rely on  
 13 people coming to us but turns out people don't do that.  
 14 Q. We're coming to the end of the period of time we have  
 15 for your evidence, Ms Goss. There are just a few points  
 16 I would like to just ask you about further. Paragraph  
 17 131 of your statement, you talk about a disconnect  
 18 between what the Scottish Government is saying and what  
 19 is happening on the ground and you say that the  
 20 government is adamant that children are being seen and  
 21 treated and you say they are not. They're also saying  
 22 that they provided adequate funding to Long COVID  
 23 services and you have said that the funding has been  
 24 tokenistic and not guaranteed long-term so recruitment  
 25 has been extremely challenging. There are currently no

169

1 functioning Long COVID services for children and young  
 2 people in Scotland. Has that always been the case?  
 3 A. Yes. They talk a good game but actions speak louder  
 4 than words and, you know, where are these services that  
 5 we were promised in 2021? Don't have them.  
 6 Q. The other point I would like to ask you about is  
 7 vaccinations which you refer to in paragraph 132 and  
 8 133. Your daughter hasn't been vaccinated; is that  
 9 right?  
 10 A. She hasn't.  
 11 Q. No, and I think you took that decision having taken the  
 12 view of the immunologist that you have been --- who has  
 13 been treating your daughter who didn't necessarily ---  
 14 A. Yes, I asked for his opinion.  
 15 Q. He didn't necessarily say that it shouldn't happen but  
 16 cautioned against it, I think is possibly the way to  
 17 describe it.  
 18 A. Well, yes but it was a discussion, weighing up the risks  
 19 and the benefits. He suggested that perhaps it might be  
 20 a bit taxing on her immune system at that given time so  
 21 maybe just wait a bit until she's feeling a wee bit  
 22 better, but vaccination eligibility for her age group  
 23 was very short-lived so even if I wanted to get her a  
 24 vaccination now, I don't think I could.  
 25 Q. Right. You have provided us at the end of your

170

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

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

19 A. They knew that in March 2020.

20 Q. Yes.

21 A. This isn't new.

22 Q. Yes.

23 A. It just wasn't communicated.

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

171

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

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

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

25 MR GALE: Thank you, my Lord.

172

1 THE CHAIR: Indeed, Ms Goss, there is absolutely no need for  
 2 you to feel embarrassed, thank you very much indeed and  
 3 that's all of your evidence.  
 4 That brings us to the end of the evidential hearings  
 5 in relation to the Health and Social Care Impact  
 6 Section, portfolio 3 in this Inquiry. Mr Gale, I would  
 7 like to thank you for leading your team throughout this  
 8 long period of evidence which has spanned I think about  
 9 seven or eight months now, I'm very grateful for all  
 10 your efforts, but I'm also very grateful to your team,  
 11 both counsel and solicitors for all their efforts in  
 12 this time and also to the paralegals and witness takers  
 13 and all the other backroom staff who assisted you in  
 14 putting together which has been an exceptionally  
 15 complicated and lengthy piece of evidence, which I'm  
 16 very happy to say, so far as I'm concerned, has  
 17 proceeded essentially without a blemish, my thanks to  
 18 all of you.  
 19 MR GALE: Thank you very much, my Lord, and we are similarly  
 20 very grateful to your Lordship for his guidance and his  
 21 attention that he has paid throughout the evidence that  
 22 we have led.  
 23 THE CHAIR: Thank you all. That's this part of the evidence  
 24 hearings finished. The next hearing will be the hearing  
 25 on Mr Gale's submission in relation to this evidence

173

1 which is set for, I think is it the 27 June, Mr Gale?  
 2 MR GALE: 27, my Lord, yes.  
 3 THE CHAIR: So until 27 June that's adjourned.  
 4 MR GALE: Thank you, my Lord.  
 5 (4.25 pm)  
 6 (The hearing was adjourned to 27 June 2024)  
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 14  
 15  
 16  
 17  
 18  
 19  
 20  
 21  
 22  
 23  
 24  
 25

174

1 INDEX  
 2 1EVIDENCE OF EMMA McCONNACHIE  
 1 Examination—in—chief by MS BAHRAMI  
 3 47EVIDENCE OF HSCO249  
 47Examination—in—chief by MR EDWARDS  
 4 90EVIDENCE OF NEIL CRAIG  
 90 Examination—in—chief by MR EDWARDS  
 5130EVIDENCE OF HELEN GOSS  
 130Examination—in—chief by MR GALE  
 5  
 6  
 7  
 8  
 9  
 10  
 11  
 12  
 13  
 14  
 15  
 16  
 17  
 18  
 19  
 20  
 21  
 22  
 23  
 24

175

**A**

**aberdeen (3)** 140:15 146:15 163:10

**ability (3)** 29:22,23 41:18

**able (33)** 6:22 10:3,20 11:5 12:21 14:2 15:17 16:1 17:25 18:9,16 26:7 27:20 28:10,13 30:18 44:20 53:13 62:14 63:11 73:2 83:17 86:7 87:2,2 126:17 135:9 142:13 150:25 159:13,22,23 162:5

**above (2)** 37:2 53:4

**above (1)** 93:2

**absence (6)** 67:11 73:16 133:22 146:23 147:23 148:3

**absent (1)** 68:3

**absolute (1)** 43:16

**absolutely (17)** 12:19 36:12 56:19 68:24 75:10 82:10 83:19 84:5 88:25 141:1 148:16 152:21 153:22,25 155:18 158:3 173:1

**absorbed (1)** 13:9

**abuse (1)** 8:13

**abusive (1)** 8:3

**accept (4)** 27:19 147:19,22 148:15

**acceptance (1)** 171:14

**accepted (2)** 27:20 171:14

**accepting (2)** 31:23,25

**access (21)** 26:23 29:16,21 30:11 42:18,19 43:3,8,10,23 44:5,20 46:11 54:2,8,9,16,22 57:19,25 59:4

**accessing (5)** 2:14 3:6,9 32:25 152:22

**accidental (1)** 62:18

**accord (1)** 66:8

**according (1)** 137:13

**accordingly (1)** 31:3

**account (1)** 163:11

**accountable (5)** 86:23 87:6 88:14,15,18

**accumulated (1)** 79:17

**accumulation (1)** 145:5

**accurate (2)** 4:15 9:21

**accurately (1)** 9:25

**accuse (1)** 163:18

**accused (2)** 164:16,25

**accusing (1)** 165:21

**acetate (1)** 37:17

**acquired (1)** 149:22

**across (8)** 5:17 28:11 38:4 69:1 140:6 153:10,11 171:17

**acted (2)** 7:16 8:15

**action (1)** 56:15

**acting (2)** 167:9,12

**actions (1)** 170:3

**active (5)** 6:17 24:10 25:13 135:18,19

**actively (1)** 43:8

**activities (4)** 61:2,4,12,13

**actual (1)** 69:12

**actually (77)** 4:11,23 14:1 15:17 18:6,19 25:19,22 28:8 33:1,10 36:17,18 40:23 42:11 43:14 49:12 53:13 55:13 57:6,11,22,25 58:5 59:4 65:7 67:1,20,23 68:19 70:12,16 73:2 74:9 76:24 78:12 79:6,12 82:25 83:3,13,16 84:20,22 85:18 87:3,15,21,21,24 88:9,24 104:16,23 105:2,12 106:13,23 115:1,23 120:22 127:4 132:9 136:7 137:24 144:16 154:7,9 155:4 159:22 160:16 161:14,15 162:7 163:8 165:10,22

**acute (2)** 139:23 147:4

**acutely (1)** 34:14

**acuteonset (1)** 154:19

**adamant (2)** 154:1 169:20

**aid (5)** 24:16 46:13 64:10 87:18 128:23

**added (1)** 104:9

**additional (5)** 12:25 20:10 53:17 64:10,11

**address (2)** 42:5 63:14

**adds (1)** 24:13

**adequate (2)** 82:22 169:22

**adhd (1)** 41:5

**adhered (1)** 34:18

**adjourned (2)** 174:3,6

**adjournment (1)** 90:10

**admin (2)** 2:10 30:1

**administrative (1)** 27:21

**administrator (6)** 54:7,10,18,25 55:13,21 84:4,6,8,10,12 126:12

**admissions (1)** 110:3

**admit (1)** 140:23

**admitted (1)** 110:16

**admittedly (1)** 81:18

**adults (2)** 48:19,24

**advance (1)** 33:4

**advances (25)** 8:25 9:4,7,8 16:13 32:6,13,13 35:14,25 36:1 101:3 102:16 116:9,12,13 117:1,8,10,11 138:2,4 145:2 152:12 163:6

**advisable (1)** 68:15

**advised (5)** 32:16 37:2 67:1 69:3 75:23

**advocate (1)** 87:10

**ae (1)** 104:18

**aerosol (1)** 171:15

**affect (1)** 18:3

**affected (2)** 19:7 24:18

**afford (3)** 77:5,24 80:22

**after (44)** 6:15 30:20 32:19 33:22 39:23 73:1 77:4 79:8,22,23 80:2,4,17 81:18 82:25 83:8 84:17,18,24 85:14 86:2 89:9 94:25 98:16 107:5 113:2 118:25 119:6 120:8 123:6,7 128:1,2 132:24 134:25 139:4,23 150:14,21 153:25 154:14 162:17 166:15 169:4

**aftercare (2)** 86:4 89:4

**afternoon (9)** 90:12,13,18,20 100:7 111:5 129:22,23 130:1

**afterwards (2)** 70:25 92:12

**again (54)** 12:10 14:2 15:22 20:4 21:6 24:6 32:13 37:5,8,21 40:5 44:2 45:18 48:13 54:5 69:13 71:24 81:2 89:24 97:17 111:21 115:13 120:5,21,24 121:13,25,25 123:14 127:18 128:19 131:19 136:7 137:20 143:7,7,14 146:12 147:7 151:3,4,8 154:5 155:21 157:20 159:16 160:21,24 165:23 166:10 168:3,24 169:1 171:24

**against (5)** 62:2 63:12 79:19 167:9 170:16

**age (4)** 10:8 121:6,10 170:22

**agencies (4)** 44:7 45:20 78:14,15

**agency (13)** 77:21,24 78:11,13,17,18 115:23 122:13,14,16,19,21,23

**agitated (1)** 20:21

**ago (5)** 14:1 33:1 137:19,20 148:8

**agree (3)** 61:21 62:1 155:18

**agreeable (1)** 47:10

**agreed (1)** 32:4

**agreeing (1)** 101:6

**agreement (3)** 49:5 122:15,20

**ahead (4)** 4:6,10,16 21:19

**aid (1)** 162:7

**aids (1)** 162:21

**air (5)** 12:18 38:23 84:5,22 163:2

**airborne (1)** 171:9

**aired (1)** 37:10

**albeit (3)** 108:6 140:18 148:24

**alcohol (1)** 36:19

**alert (3)** 35:6 36:2,3

**alive (1)** 126:14

**allied (1)** 5:25

**allocating (1)** 54:19

**allocation (1)** 103:11

**allow (1)** 14:17

**allowed (13)** 8:23 22:4 28:15 30:19 49:13 59:2 73:4 84:4,6,8,10,12 126:12

**almost (3)** 63:1 138:18 139:14

**alone (6)** 9:22 17:17 73:5 77:18 78:25 80:23

**along (3)** 63:9 100:23 128:21

**alongside (1)** 46:6

**already (7)** 40:2 52:9 87:12,13 100:20 127:8 167:18

**also (56)** 1:6 5:15 9:2 11:16,18,20 12:25 13:6 14:15,20 16:16 17:21 18:7 19:2 25:7,13 28:3 34:14 35:14 37:16 40:16,17 44:6 47:20 49:3,15 55:23 59:7 60:24 62:11 75:12 77:3 79:20 83:21,24 86:7 87:17 91:6 102:11 122:10 123:14 125:3,19 131:14 132:6 133:5 136:1 141:20 144:8,20 152:17 161:24 169:21 172:3 173:10,12

**altered (3)** 11:9,10 17:15

**alternative (1)** 4:5

**although (4)** 11:17 159:10 162:12 163:7

**always (15)** 4:15 10:9 11:22 14:7 59:14 60:12 94:5 101:23 106:12 117:18 124:22 128:4 135:16 136:9 170:2

**amazing (3)** 41:10 83:19 158:3

**amazon (1)** 3:23

**ambulance (3)** 93:17 141:7 158:22

**amongst (7)** 58:18 115:12 116:6 120:6 124:12,18 171:14

**amount (10)** 8:13 13:21 24:1 40:8 103:15 106:24 109:2,23 122:18,25

**amounts (1)** 15:23

**amplification (1)** 130:18

**amputations (1)** 20:25

**amusing (1)** 25:21

**anecdotally (1)** 15:21

**anger (1)** 147:18

**angry (2)** 98:12 102:25

**announced (1)** 39:19

**announcement (2)** 26:3 35:5

**announcements (1)** 22:1

**annoyed (1)** 98:14

**annual (1)** 79:16

**anonimised (2)** 46:25 47:9

**another (14)** 38:23 48:19 53:20 63:11 79:12 102:1 105:24,25,25 122:4,9 155:19 162:4 165:10

**answer (3)** 139:20 161:12 166:24

**answered (1)** 35:16

**antibiotics (1)** 2:23

**anticipation (1)** 6:10

**antirheumatic (1)** 32:9

**antiviral (3)** 33:14,17,24

**antivirals (1)** 33:25

**anxieties (3)** 125:10,17 165:14

**anxiety (11)** 81:1 83:22 104:9 145:5,10,18 151:5 152:1,7 163:23,24

**anxious (3)** 125:15 145:19 152:11

**anybody (9)** 2:25 3:1 6:7,15 19:21 33:10 34:9 65:3 102:19

**anymore (9)** 23:25 55:1 77:1,12 81:23 103:4 135:25 159:24 169:5

**allocating (1)** 54:19

**allocation (1)** 103:11

**allow (1)** 14:17

**allowed (13)** 8:23 22:4 28:15 30:19 49:13 59:2 73:4 84:4,6,8,10,12 126:12

**almost (3)** 63:1 138:18 139:14

**alone (6)** 9:22 17:17 73:5 77:18 78:25 80:23

**along (3)** 63:9 100:23 128:21

**alongside (1)** 46:6

**already (7)** 40:2 52:9 87:12,13 100:20 127:8 167:18

**also (56)** 1:6 5:15 9:2 11:16,18,20 12:25 13:6 14:15,20 16:16 17:21 18:7 19:2 25:7,13 28:3 34:14 35:14 37:16 40:16,17 44:6 47:20 49:3,15 55:23 59:7 60:24 62:11 75:12 77:3 79:20 83:21,24 86:7 87:17 91:6 102:11 122:10 123:14 125:3,19 131:14 132:6 133:5 136:1 141:20 144:8,20 152:17 161:24 169:21 172:3 173:10,12

**altered (3)** 11:9,10 17:15

**alternative (1)** 4:5

**although (4)** 11:17 159:10 162:12 163:7

**always (15)** 4:15 10:9 11:22 14:7 59:14 60:12 94:5 101:23 106:12 117:18 124:22 128:4 135:16 136:9 170:2

**amazing (3)** 41:10 83:19 158:3

**amazon (1)** 3:23

**ambulance (3)** 93:17 141:7 158:22

**amongst (7)** 58:18 115:12 116:6 120:6 124:12,18 171:14

**amount (10)** 8:13 13:21 24:1 40:8 103:15 106:24 109:2,23 122:18,25

**amounts (1)** 15:23

**amplification (1)** 130:18

**amputations (1)** 20:25

**amusing (1)** 25:21

**anecdotally (1)** 15:21

**anger (1)** 147:18

**angry (2)** 98:12 102:25

**announced (1)** 39:19

**announcement (2)** 26:3 35:5

**announcements (1)** 22:1

**annoyed (1)** 98:14

**annual (1)** 79:16

**anonimised (2)** 46:25 47:9

**another (14)** 38:23 48:19 53:20 63:11 79:12 102:1 105:24,25,25 122:4,9 155:19 162:4 165:10

**answer (3)** 139:20 161:12 166:24

**answered (1)** 35:16

**antibiotics (1)** 2:23

**anticipation (1)** 6:10

**antirheumatic (1)** 32:9

**antiviral (3)** 33:14,17,24

**antivirals (1)** 33:25

**anxieties (3)** 125:10,17 165:14

**anxiety (11)** 81:1 83:22 104:9 145:5,10,18 151:5 152:1,7 163:23,24

**anxious (3)** 125:15 145:19 152:11

**anybody (9)** 2:25 3:1 6:7,15 19:21 33:10 34:9 65:3 102:19

**anymore (9)** 23:25 55:1 77:1,12 81:23 103:4 135:25 159:24 169:5

**allocating (1)** 54:19

**allocation (1)** 103:11

**allow (1)** 14:17

**allowed (13)** 8:23 22:4 28:15 30:19 49:13 59:2 73:4 84:4,6,8,10,12 126:12

**almost (3)** 63:1 138:18 139:14

**alone (6)** 9:22 17:17 73:5 77:18 78:25 80:23

**along (3)** 63:9 100:23 128:21

**alongside (1)** 46:6

**already (7)** 40:2 52:9 87:12,13 100:20 127:8 167:18

**also (56)** 1:6 5:15 9:2 11:16,18,20 12:25 13:6 14:15,20 16:16 17:21 18:7 19:2 25:7,13 28:3 34:14 35:14 37:16 40:16,17 44:6 47:20 49:3,15 55:23 59:7 60:24 62:11 75:12 77:3 79:20 83:21,24 86:7 87:17 91:6 102:11 122:10 123:14 125:3,19 131:14 132:6 133:5 136:1 141:20 144:8,20 152:17 161:24 169:21 172:3 173:10,12

**altered (3)** 11:9,10 17:15

**alternative (1)** 4:5

**although (4)** 11:17 159:10 162:12 163:7

**always (15)** 4:15 10:9 11:22 14:7 59:14 60:12 94:5 101:23 106:12 117:18 124:22 128:4 135:16 136:9 170:2

**amazing (3)** 41:10 83:19 158:3

**amazon (1)** 3:23

**ambulance (3)** 93:17 141:7 158:22

**amongst (7)** 58:18 115:12 116:6 120:6 124:12,18 171:14

**amount (10)** 8:13 13:21 24:1 40:8 103:15 106:24 109:2,23 122:18,25

**amounts (1)** 15:23

**amplification (1)** 130:18

**amputations (1)** 20:25

**amusing (1)** 25:21

**anecdotally (1)** 15:21

**anger (1)** 147:18

**angry (2)** 98:12 102:25

**announced (1)** 39:19

**announcement (2)** 26:3 35:5

**announcements (1)** 22:1

**annoyed (1)** 98:14

**annual (1)** 79:16

**anonimised (2)** 46:25 47:9

**another (14)** 38:23 48:19 53:20 63:11 79:12 102:1 105:24,25,25 122:4,9 155:19 162:4 165:10

**answer (3)** 139:20 161:12 166:24

**answered (1)** 35:16

**antibiotics (1)** 2:23

**anticipation (1)** 6:10

**antirheumatic (1)** 32:9

**antiviral (3)** 33:14,17,24

**antivirals (1)** 33:25

**arranged (1)** 161:5

**arrangements (4)** 72:1 102:12 120:17 161:8

**arrive (1)** 53:20

**arrived (4)** 5:7 53:24 72:14 93:13

**arriving (1)** 13:25

**arthritis (2)** 31:2 32:8

**artificial (1)** 131:14

**ask (27)** 23:10 35:20 36:16 54:5,25 55:5 61:19 63:10 65:7 68:20 73:21 83:9 85:10,19 118:12 119:17 129:14 131:19 133:21 141:17 147:10 157:20 160:17 169:16 170:6 172:6,10

**asked (28)** 25:8,8,19 30:9,10 32:2 33:10 35:11 52:25 53:4,5,6 66:7 68:25 73:24 74:10 81:4,7 101:4 103:2 109:21 113:10 114:20 117:6,8 121:8 167:18 170:14

**asking (12)** 1:12 23:10 26:4 30:19 55:3 79:9 80:14 98:20 113:11 118:14 145:2 155:23

**aspects (1)** 34:3

**assessed (4)** 119:15 140:23,25 141:2

**assessment (14)** 73:21 74:3,6,14,19,23 75:23 119:20 120:2,11,23,24 121:8,9

**assessments (8)** 73:16,25 118:23 119:13 121:24 122:1 127:10 128:6

**assigned (1)** 40:20

**assistance (1)** 2:15

**assistant (1)** 48:23

**assistants (1)** 48:22

**assisted (1)** 173:13

**assume (3)** 141:22 149:8 163:17

**assumption (1)** 10:7

**assumptions (1)** 44:7

**asymptomatic (1)** 115:16

**attack (4)** 77:15 78:1 79:12 154:25

**attacks (5)** 19:23,25 76:23 160:15,15

**attend (2)** 22:10 83:4

**attendance (4)** 123:24,25 136:2 150:19

**attendant (4)** 113:11,17,25 114:12

**attended (1)** 83:7

**attending (1)** 45:7

**attention (1)** 173:21

**attitude (3)** 52:14 146:25 147:19

**attributed (2)** 145:3,10

**audiologists (1)** 43:21

**august (14)** 40:3 106:11,11 115:18,22 116:5 119:24,25,25,25 146:10,12 150:14 156:18

**augustseptember (2)** 107:12 120:22

**autism (1)** 39:13

**autistic (1)** 41:4

**automatically (1)** 127:19

**availability (7)** 50:19 57:3,20 58:15 102:4,9 105:6

**available (25)** 11:2,24 19:4 21:12 51:9 55:12 57:4 58:5,8,12,13 69:12 70:24 73:25 78:15,19 83:3,16,20 105:3,8 129:9 162:14 172:4

**average (2)** 28:12 38:9

**aviemore (2)** 161:5,10

**avoid (1)** 169:8

**aware (14)** 22:17 31:10 34:14 50:3 51:5 73:23

**71:10 96:13 105:14 132:16 141:23 150:5 160:22 171:17**

**awareness (1)** 160:10

**away (13)** 40:13 60:18 70:21,24 71:18,20 73:5 118:13 121:24 122:1,9 159:19 164:23

**awful (3)** 1:12 25:23 139:25

**aye (39)** 95:6 96:13 98:20 99:16 102:3,14 104:11 106:10,20 108:8 109:9 110:1,5,10 111:14 113:4 115:5,13,21 116:13 117:14,22 119:2 120:7 121:3,7,21,23 122:14,23 123:6,11,23 124:13 125:1,7,7,24 127:15

**B**

**babies (1)** 161:21

**baby (7)** 75:2 77:3 80:4 82:4 160:25 161:1,24

**back (65)** 4:24 36:10 37:8,15 38:1,13,15,17,22 41:21 46:16 55:5 59:20 67:3,4 68:17 69:4 79:7 80:23 84:12 101:11 103:17 107:2,4,6,7 108:2 114:10 117:3 119:2,8,9,11,16,18,19 123:6,14,19,23 124:15 123:14 124:10,15 125:9,14,16 138:7 143:8,20,21 150:12,15,21 157:10 158:15 159:16 160:5,20 161:19 164:16 166:18 168:24

**backiate (1)** 140:24

**background (2)** 1:18 128:8

**backlog (5)** 13:13,15,18 24:14 124:6

**backlogs (1)**

76:2,3,6,7,20 78:16  
 82:13,18 89:20 96:4  
 98:11,14 102:5,7,25  
 103:17 108:2 134:25  
 135:8,9 136:4 154:20  
 159:13 168:3,23,25  
 170:20,21,21

**blemish** (1) 173:17  
**block** (4) 46:4 109:12,13,15  
**blood** (1) 92:5  
**blows** (1) 165:21  
**blue** (2) 53:24 136:24  
**blunty** (1) 135:13  
**board** (3) 44:3,4,4  
**bodies** (1) 32:17  
**body** (11) 11:16,21 16:14  
 20:20 26:8 44:23 45:1  
 112:1,14,15 137:7  
**boiler** (1) 157:11  
**bones** (1) 155:4  
**book** (2) 42:5 88:8  
**books** (3) 8:19 88:5,7  
**boots** (1) 22:24  
**boring** (1) 168:10  
**born** (1) 161:7  
**borrow** (1) 4:13  
**both** (9) 11:21 30:12,13  
 89:23 132:2 134:22 163:4  
 165:10 173:11  
**botter** (2) 19:16 21:21  
**bottom** (1) 152:15  
**bought** (1) 162:14  
**bow** (1) 172:16  
**bowel** (1) 95:12  
**box** (1) 166:22  
**boxes** (2) 57:25 102:7  
**boy** (1) 41:9  
**brain** (2) 155:8 169:5  
**break** (3) 30:19 46:19 129:20  
**breakdown** (3) 6:9 14:10  
 17:16  
**breaking** (2) 15:8 76:25  
**breaks** (1) 38:19  
**breastfed** (1) 89:7  
**breastfeed** (3) 83:2,4,17  
**breastfeeding** (5)  
 83:8,10,14,18 89:6  
**breathe** (2) 140:1 149:3  
**briefly** (5) 81:17 92:1 151:21  
 153:14 172:10  
**brightness** (1) 160:2  
**bring** (7) 33:10 43:11 52:3  
 58:17 77:24 84:16 137:25  
**bringing** (2) 70:15 77:21  
**brings** (2) 94:10 173:4  
**broadcast** (1) 130:20  
**broadened** (1) 105:4  
**broke** (1) 157:11  
**broken** (2) 24:8 155:4  
**brought** (8) 6:7 28:10 37:16  
 70:8 71:10,15 74:20 78:22  
**bruised** (1) 38:3  
**bruising** (1) 38:4  
**budge** (1) 137:14  
**building** (1) 48:21  
**built** (1) 40:2  
**burden** (1) 157:1  
**burned** (1) 141:3  
**burst** (1) 165:22  
**bus** (1) 77:11  
**business** (11) 1:20 2:3 6:23  
 13:9 25:4,9 27:22 28:22  
 29:4,6 45:24  
**businesses** (3) 29:1,2 45:20  
**buttoned** (1) 11:7  
**buttons** (1) 11:6  
**buy** (3) 59:12 162:10,19  
**buzz** (1) 138:12

**C**

**cafe** (1) 83:15  
**call** (15) 10:10,17,19 11:13  
 22:22 33:6 56:25 97:2  
 102:24 116:1 133:12 141:6  
 151:3 158:21,21  
**callback** (2) 32:2 33:9

**called** (13) 6:1 22:22 26:10  
 32:4,18 33:6,8 42:22  
 135:17 136:6 138:13 140:8  
 153:12  
**calling** (1) 10:3  
**calls** (2) 10:20 14:3  
**calpol** (1) 137:12  
**came** (46) 3:13 5:24 7:13,21  
 9:14 12:6 16:21 18:2,18  
 29:11 35:10 36:9,18 40:2  
 42:4 45:12 55:9,15 58:1  
 59:15,20 60:5 61:2 71:6  
 84:20 93:16,16 104:3,21  
 105:16,25 117:24  
 149:1,12 163:1 173:1,23  
 118:16,19 121:10 125:9,9  
 126:2,9 136:24 139:4,15  
 140:6 153:10 158:4 164:5  
**camera** (2) 9:17 10:14  
**camhs** (4) 41:2,16 152:18  
 165:10  
**cancel** (2) 7:24 13:21  
**canceled** (9) 5:8 6:3,6 8:1,7  
 13:20 14:5 126:8,9  
**cancer** (2) 125:23,24  
**cannot** (3) 29:24 148:4  
 166:23  
**cant** (24) 60:22 63:12 72:10  
 78:2,3 84:19 126:25  
 135:25 140:24 142:23  
 147:2 148:16,17 149:3,8  
 157:12 158:17,17 161:20  
 164:11 166:19 169:5,8,11  
**capacity** (6) 13:14,15 107:3  
 108:19 109:4,17  
**card** (1) 35:13  
**care** (97) 2:13,19 3:1 4:3  
 6:16,16 14:20 16:4 17:5,24  
 18:11,12,25,25 19:6,8  
 20:24 21:2,3 22:20 23:20  
 24:10,10,11 28:1 29:22  
 32:25 39:10 42:17,21  
 44:19 47:19,22,24  
 48:4,9,14,22,23 50:21,23  
 51:9 55:16 57:23 58:7  
 59:9,17,25 60:2 66:25  
 67:17 68:21 69:19,23  
 70:4,8,15,18,19 71:2  
 72:9,24 73:3,6 75:4,13  
 76:17 78:3,17 79:1 80:18  
 81:13 85:3,11,14  
 86:14,21,21,22,25  
 87:5,6,14,22,23  
 88:12,13,25  
 89:9,11,18,20,21 109:7  
 125:23,23 173:5  
**careful** (2) 39:10 131:12  
**carer** (1) 47:19  
**carers** (2) 49:2 61:8  
**careworker** (2) 45:7 86:14  
**careworkers** (2) 87:1,7  
**caring** (3) 45:19 60:24,25  
**carpets** (1) 9:19  
**carried** (2) 137:4 161:20  
**carrier** (1) 68:22  
**carries** (1) 166:12  
**carrying** (1) 24:1  
**cars** (1) 22:24  
**cases** (6) 2:7 18:22 39:3  
 44:18 52:18 72:2  
**casualty** (1) 115:25  
**catching** (5) 31:20 96:6  
 107:17 108:11 118:19  
**categories** (2) 163:3,23  
**category** (3) 14:20 17:18  
 36:4  
**cats** (1) 163:8  
**caught** (1) 35:8  
**causative** (1) 165:8  
**cause** (6) 12:6 19:6 60:14  
 114:19 145:11 156:13  
**caused** (2) 63:4 195:7  
**causing** (2) 160:3,12  
**cautioned** (1) 170:16  
**cautious** (1) 39:6  
**cent** (5) 28:6,12,23 124:16  
 156:8

**centred** (1) 60:20  
**centres** (1) 83:11  
**certain** (16) 5:1 11:20  
 19:11,12 21:6 22:20 26:6  
 29:15 35:18 96:22  
 132:16,23 135:12 150:9  
 166:15 172:6  
**chain** (3) 4:21 45:14 53:5  
**chair** (28) 1:3,10,12 37:18  
 46:15,21 47:1 57:14  
 90:2,7,12,18,21  
 129:6,15,18,22 130:1  
 147:10 148:13,15,23  
 149:1,12 163:1 173:1,23  
 174:3  
**chairs** (1) 162:3  
**challenges** (3) 46:10 59:24  
 62:7  
**challenging** (2) 46:2 169:25  
**chance** (4) 33:16 128:24  
 139:18 150:22  
**chancellor** (1) 25:19  
**change** (22) 5:22 6:22 9:9,12  
 32:16 44:15,16  
 52:11,12,14,15 67:16  
 89:18 94:18 101:15 103:3  
 104:4,5 105:19 106:3,15  
 111:3  
**changed** (32) 4:25 5:23 7:11  
 17:18 19:4 23:17 24:22  
 32:14 35:9 40:1,15  
 57:1,5,16,18,20 61:5 64:8  
 94:3 99:22 100:5,6,14  
 101:21 102:17 103:5 104:6  
 105:25 110:17,21,22  
 112:11  
**changes** (4) 6:3 17:12 19:2  
 25:1  
**changing** (7) 5:16 63:25 64:1  
 94:20,21 101:18 111:3  
**charge** (12) 12:5 13:6 15:16  
 18:16 54:8,16,19,21  
 65:16,21 77:18 78:25  
**charity** (1) 42:16  
**checking** (1) 4:24  
**checklist** (2) 117:3 118:12  
**chemo** (1) 126:7  
**chemotherapy** (3)  
 126:1,10,18  
**child** (8) 40:10 82:25  
 135:14,17 152:17 154:22  
 162:23 164:23  
**childcare** (7) 29:8,16,17,21  
 80:22 81:22,25  
**childhood** (1) 135:15  
**children** (14) 29:24 30:2,20  
 39:24 40:9,11,13,16 41:12  
 133:13 165:1 167:6 169:20  
 170:1  
**childrens** (3) 85:16 140:15  
 146:16  
**choice** (1) 60:22  
**choose** (2) 23:15 32:5  
**chose** (10) 2:16 3:13 15:16  
 33:24 35:25 36:5 37:1,4  
 41:19 64:15  
**chosen** (4) 28:25 34:10  
 141:25 142:18  
**christmas** (4) 35:13 123:7,7  
 153:8  
**chronic** (2) 155:21 156:2  
**chuck** (1) 56:3  
**chunks** (1) 38:6  
**circulation** (1) 2:22  
**circumstances** (9) 11:1 16:4  
 22:20 34:12 35:18 68:24  
 106:2 141:4 145:1  
**clarification** (1) 79:9  
**clarified** (1) 26:19  
**clarify** (1) 15:17  
**class** (1) 160:2  
**classes** (3) 83:4,6 160:1  
**classification** (1) 7:10  
**classified** (4) 14:10  
 29:11,13,15  
**clean** (5) 105:20,22 106:1

127:23 128:3  
**cleaning** (4) 13:17,19 122:15  
 127:24  
**clear** (19) 10:24 16:13 26:14  
 35:3,11,17,24 41:22 56:9  
 63:6 78:10 93:19,22 97:6  
 100:19 118:1 147:12,25  
 148:9  
**cleared** (1) 101:20  
**clearly** (9) 22:7 35:12 123:12  
 149:16 153:20 156:1  
 166:4,6 167:4  
**clicked** (1) 5:4  
**clinic** (6) 11:4,11 19:25  
 25:5,6 110:12  
**clinical** (3) 26:11 30:3 97:1  
 146:6 153:10 148:24  
**clinician** (5) 147:24 148:1  
 158:4 165:10,11  
**clinicians** (2) 147:22 150:4  
**clinics** (2) 124:3,5  
**clock** (1) 108:2  
**close** (2) 122:6 128:23  
**closed** (1) 94:6  
**clothes** (4) 51:7 59:22  
 84:14,15  
**clued** (2) 64:16 66:9  
**coat** (1) 143:24  
**cobra** (1) 24:24  
**cognitive** (3) 11:9 132:8  
 159:21  
**coincidental** (1) 159:5  
**cold** (1) 136:23  
**collaborative** (1) 6:5  
**collapse** (1) 72:1  
**collapsed** (2) 161:22,25  
**colleague** (2) 117:20 121:20  
**colleagues** (7) 4:12 7:7  
 15:19,21 18:23 23:8 29:21  
 30:9 50:21 57:21  
**coloured** (2) 137:16 108:10  
 121:19 123:19 133:11  
**collecting** (3) 92:5,6 95:10  
**collective** (1) 12:9  
**collectively** (1) 13:5  
**college** (8) 1:7,22,22  
 24:18,21 25:9,15 26:9  
**combination** (1) 76:13  
**combined** (2) 73:12 171:25  
**come** (43) 4:11 5:2 6:13 9:5  
 11:3,21 14:4 16:20 17:20  
 18:4 21:25 22:4 24:25 25:1  
 46:16 50:14 56:14 58:23  
 59:10 62:14,24 63:11 65:7  
 66:25 68:10 18 76:24  
 84:14 103:11 104:2 107:6  
 119:9 119:16,18 119 120:2  
 121:8 133:23 137:11,14  
 141:2 143:21 145:20  
**comes** (5) 89:4,6,18 149:9  
 164:14  
**comfort** (3) 23:14 36:7 38:16  
**comfortable** (6) 10:11 21:8  
 23:9,12 56:14 162:19  
**conning** (3) 4:23 6:3,14,25  
 7:16 17:8 18:8 19:10 31:13  
 35:15 46:12 50:5,12 56:12  
 63:7,10 65:20 70:3,6,13  
 71:19 77:1 85:20,23  
 107:4,15 108:24 109:20  
 113:8 118:20 169:13,14  
**comment** (4) 21:13  
 155:22,25 156:1  
**committee** (2) 45:3,4  
**common** (2) 17:23 144:20  
**communal** (1) 61:15  
**communicate** (1) 25:19  
**communicated** (3) 111:4  
 171:10,23  
**communication** (7) 5:10  
 31:13 45:13 63:6 97:4,13  
 111:7  
**communications** (6) 1:6,23  
 22:14 35:2,3 166:15  
**community** (3) 150:23  
 152:13,17

**companies** (3) 27:14 87:1,6  
**company** (4) 27:16 28:4,17  
 43:14  
**comparative** (1) 135:4  
**compare** (1) 10:22  
**compared** (2) 52:9 96:23  
**comparison** (1) 14:23  
**competency** (1) 16:16  
**compensating** (2) 63:1 138:23  
**complaint** (2) 78:23 166:10  
**complaints** (1) 62:23  
**complete** (1) 17:18  
**completely** (11) 8:11 9:9  
 17:15 19:3 29:25 37:24  
 142:10 147:2 148:12,13  
 149:6  
**completes** (1) 129:5  
**complex** (3) 2:20,25 18:7  
**compliant** (1) 46:3  
**complicated** (1) 173:15  
**complication** (1) 14:15  
**complications** (2) 21:14,15  
**comply** (1) 132:20  
**compose** (1) 132:9  
**compromised** (1) 126:11  
**concentrate** (1) 159:25  
**concern** (2) 53:8 79:20  
**concerned** (11) 33:19 36:11  
 51:22 56:6 67:9 120:22  
 153:5 157:21 161:10  
 164:15 173:16  
**concerning** (1) 121:16  
**concerns** (12) 44:6 48:2  
 50:1,18 51:14,20 56:12,16  
 59:5 78:23 136:10 150:9  
**concludes** (1) 89:25  
**conclusion** (1) 145:19  
**conclusion** (24) 9:23 15:13  
 132:15,24 133:3 134:1  
**conclude** (1) 139:19 140:6,10  
 141:24,24 142:4 143:15  
 145:9 146:14 148:5 151:13  
 153:9 154:22 155:8,10  
 165:8,9  
**conditions** (11) 11:21  
 19:1,12,13 20:23 21:6  
 23:19 31:14 144:11 166:22  
 167:5  
**conduct** (1) 167:12  
**conference** (1) 10:19  
**confident** (1) 10:24  
**confined** (2) 132:17 133:1  
**confirm** (1) 124:9  
**confirmation** (1) 99:5  
**confirmed** (16) 41:5  
 94:15,21 95:20,20 97:20  
 98:1,3,7,22 99:6 111:1  
 117:9,15,25 118:10  
**confirming** (1) 98:4  
**confrontational** (1) 147:11  
**confronted** (1) 146:18  
**confusing** (1) 153:20  
**confusion** (2) 22:16 102:22  
**connecting** (1) 130:2  
**connections** (1) 41:18  
**conning** (1) 139:18  
**conscious** (1) 166:9  
**conscripted** (1) 6:1  
**consensus** (1) 163:22  
**consented** (1) 33:13  
**consequences** (1) 118:17  
**consequently** (1) 44:14  
**consider** (6) 13:2 46:6 69:23  
 120:17 149:13 151:9  
**considerable** (1) 156:25  
**consideration** (1) 20:11  
**considered** (1) 45:17  
**considering** (2) 133:13 148:5  
**consistency** (1) 63:4  
**consistently** (1) 113:6  
**constant** (2) 36:21 39:2  
**constantly** (2) 36:16 161:17  
**constitute** (1) 130:20  
**consultant** (1) 157:21  
**consultation** (1) 157:22  
**consultations** (2) 9:10 10:22

**contact** (26) 7:15 14:17 26:7  
 27:20 35:20 36:25 39:2  
 85:18 86:8 94:22 96:7  
 97:21 100:3 104:21 110:24  
 114:13,14 116:2,11,22,23  
 117:2,7,19,24 118:9  
**contacted** (4) 14:9 83:14  
 101:20 157:21  
**contacting** (2) 31:22 102:15  
**contacts** (1) 25:16  
**contagious** (1) 34:15  
**contained** (3) 35:11,14  
 132:21  
**content** (3) 8:2 130:16  
 156:11  
**context** (5) 49:4 131:3  
 135:11 139:4 142:8  
**contexts** (1) 50:17  
**continue** (5) 27:19 63:23  
 67:15 71:4 113:5  
**continued** (10) 3:18 8:19  
 16:7 56:20 71:6 75:18 86:7  
 92:12 102:4 151:23  
**continues** (1) 169:1  
**continuing** (2) 67:10 71:23  
**contract** (3) 33:5 74:18  
 81:21  
**contracted** (6) 32:21 38:25  
 45:7 131:4 134:22 159:6  
**contracting** (7) 20:2,4 33:20  
 51:22 134:3 139:5,6  
**contractors** (2) 12:9 43:22  
**contracts** (2) 3:15 45:20  
**contracting** (1) 163:6  
**contraindicators** (1) 163:23  
**contrary** (2) 152:3,5  
**contrasting** (1) 69:11  
**contributing** (1) 151:9  
**control** (15) 7:13 20:5 21:6  
 34:2,6,13,17 36:25 39:5  
 51:2 63:18 66:3 160:14,16  
 171:7  
**convenience** (1) 2:17  
**convenor** (1) 101:2  
**convey** (1) 145:13  
**convicted** (2) 153:22 154:15  
**cope** (2) 18:9 79:13  
**copy** (2) 47:15 91:9  
**corner** (1) 30:4  
**corona** (4) 5:24 7:5,14,20  
**correct** (3) 48:1,5,11  
 49:7,18,24 52:10 53:19,23  
 54:1,4 55:22 56:2,23 59:21  
 60:4,8 61:7,10 62:10 67:14  
 73:14 74:8 88:1,10,17  
 131:6 140:11 141:15 150:2  
 154:10  
**corrected** (1) 44:2  
**correctly** (1) 76:15  
**corridor** (1) 38:24  
**corridors** (1) 93:20  
**cost** (3) 13:9 80:22 162:12  
**costly** (1) 78:16  
**costs** (3) 12:13 18:19 29:6  
**cough** (2) 139:25 149:4  
**couldnae** (9) 93:19 101:15  
 124:3,4,9 126:15,19,22  
 127:4  
**couldnt** (28) 4:4 6:15  
 8:12,22 17:19 19:17 23:24  
 29:16 30:4 39:9 77:1,5,24  
 79:13,14 80:22 84:13  
 138:19 140:1 144:7 154:2  
 159:24,24,25 160:1,13,16  
 165:22

**council** (2) 2:1 45:19  
**counsel** (1) 173:11  
**countries** (2) 7:19 50:7  
**country** (1) 28:12  
**county** (1) 22:10  
**couple** (7) 32:15 71:19 76:5  
 124:7 125:25 133:19  
 143:23  
**course** (14) 3:9 37:22 38:18  
 62:12 69:18 73:13 103:7  
 111:15 118:22 127:7  
 128:12 133:24 137:13  
 139:21  
**courses** (2) 64:12 66:3  
**cover** (4) 12:13 29:7 41:8  
 80:2  
**covered** (3) 46:7,9 63:16  
**covering** (1) 38:5  
**covid** (147) 20:2,4 21:15  
 31:21 32:21 33:3,5,7,20  
 39:1,7,13 45:3,7,10,10  
 50:12 51:15 65:4,19,20  
 66:14,16,19,22 67:11  
 68:13 70:11,12 71:11  
 72:10,12 73:2 87:18 92:21  
 93:1 94:21,22,23,24  
 95:5,7,13,16,19,22  
 96:1,2,6 97:20  
 98:1,2,19,23 99:5  
 106:23,24,

136:12 138:17 139:7,18  
140:10 141:5,13 143:11  
146:5,11,22 147:5 148:2  
150:12 151:4,19,24  
152:6,16,25 153:5  
154:15,18 155:12  
156:6,10,23 157:24 158:15  
159:6 160:9 161:3,6,9  
163:10,22 165:12  
166:3,8,15 167:16,24  
168:14 170:8,13  
daughters (13) 132:15,24  
133:2 134:1,21 143:5  
145:9,11 150:9 151:13  
153:9 165:8,9  
day (36) 4:24 12:2 13:24  
25:6 33:2,3,24 38:4 50:10  
52:19,19 54:20 55:3 56:12  
59:20 61:24 65:4 73:11  
76:9 77:15,25 95:23,24,25  
96:3 101:14,16,22 104:6  
110:10,22 117:7,10,23  
137:5 149:13  
days (14) 39:8,9,18,24 45:11  
81:23 84:2,5,7 109:17  
112:8 124:13 134:25  
daytoday (1) 94:20  
deal (9) 2:18 13:13 25:7  
54:15 65:20 85:13 86:17  
144:24 159:19  
dealing (5) 25:3 60:11 62:7  
72:11 168:8  
deals (1) 154:12  
dealt (2) 25:12 83:21  
death (3) 33:16 71:16 72:22  
deceased (8) 111:17,23,24  
112:4,12,14 113:5,21  
december (2) 125:25 132:7  
decide (3) 27:23 31:6,8  
decided (3) 81:3,12 142:3  
decision (8) 6:5,5 12:10  
27:18 28:17,18 105:1  
170:11  
decisionmakers (1) 143:1  
decisionmaking (1) 16:15  
decisions (2) 14:24 118:1  
deconditioning (1) 162:24  
decontaminate (1) 12:18  
decontaminated (1) 12:20  
decontaminating (1) 12:4  
dedication (2) 26:25 27:3  
deemed (1) 125:16  
default (1) 95:4  
define (1) 161:12  
definitely (20) 89:5 93:24  
97:7,12 99:6 101:22 102:6  
104:11,11 109:4,9 110:21  
116:8 118:9,18 125:15  
148:18 152:22 156:7  
definition (1) 166:21  
definitively (1) 148:4  
delay (3) 114:18,19 138:4  
delayed (1) 39:13  
deliberate (1) 62:18  
delirious (1) 138:18  
deliver (1) 72:7  
delivering (1) 92:6  
delivery (5) 4:19,21 5:6  
42:8,12  
delta (2) 159:7,15  
demand (1) 18:21  
dementia (9) 20:12,12  
48:20,25 59:12 60:3,11  
75:25 76:4  
dentist (2) 2:24 43:21  
department (8) 32:18  
42:24,25 92:4,5 104:18  
111:25 115:24  
departments (4) 92:7 115:24  
116:21 117:20  
depended (2) 58:16 67:11  
dependence (1) 58:20  
dependency (1) 104:22  
depending (3) 48:23 49:1  
76:10  
depends (2) 97:20 112:9

depressed (2) 77:8,11  
depression (1) 83:22  
derecognise (1) 49:16  
dermatological (1) 32:11  
describe (13) 71:25 72:16  
76:12 83:24 93:12 104:12  
125:20 136:13 143:4 155:1  
158:18 163:9 170:17  
described (5) 78:24 86:11,16  
138:13 150:10  
describing (3) 92:1 108:4  
132:15  
description (1) 9:21  
designation (2) 110:16,20  
desperately (2) 25:17 137:17  
despite (4) 2:9 29:6 39:1  
167:5  
detail (1) 167:11  
detailed (4) 22:7 35:21  
130:13 133:25  
detailing (1) 20:8  
details (2) 48:6 130:10  
determined (2) 121:6 156:12  
detriment (1) 28:1  
developed (6) 17:13,24  
33:7,23 40:14 137:6  
development (1) 85:21  
developmental (1) 40:15  
developments (1) 50:1  
devolved (1) 42:13  
diabetes (1) 20:24  
diagnose (3) 166:20,24 167:6  
diagnosed (6) 125:24 144:21  
148:24 154:18 166:16  
167:4  
diagnosis (16) 10:25 19:14  
39:13 41:17  
140:13,14,19,24 146:19  
155:10,19,21 156:5,9,14  
166:25  
didnae (26) 94:22,23 95:19  
98:13,13 99:7 101:13  
103:3,4,13 108:18  
109:4,7,8 110:25 111:12  
114:17 115:1,13,17,15,23  
122:17 124:10 126:1 128:7  
didn't (113) 4:1,2,11 5:15 7:6  
8:3,4,5,8,8 12:23 13:5,8  
14:19 15:6,10,20 19:16,18  
21:1,25 22:2,15 23:12 26:1  
29:1,2 31:8,17 34:9  
35:8,20 36:14,19  
38:14,14,19 40:10,21  
42:1,9 43:9,24,24 51:15,17  
55:4,15 60:18 62:1,24  
65:1,5,13 66:21,24  
67:5,6,18 68:14 70:11,16  
73:25 75:9,15 77:3,12,13  
79:7 81:3,10 82:21,21  
83:22 85:4,11,24 87:21  
93:22 95:7,17,18 102:1  
103:11 110:17,19 112:12  
113:5 115:11 126:7 134:9  
136:6 137:21,23 138:4,5  
140:3 143:19,21 145:20,22  
147:1 148:19,22 150:18  
153:19,21 160:18 164:8  
166:24 170:13,15  
died (1) 111:15  
difference (4) 17:7 88:7  
162:25 163:2  
differences (2) 39:22,22  
different (20) 2:13,15 4:17  
9:24 11:19 15:23,23 25:10  
27:12 30:24 37:1 40:18  
44:17 48:17 50:6,17 55:3  
105:24 148:20 150:25  
differing (1) 171:13  
difficult (20) 9:18,21 28:18  
38:11 60:17,23 73:8 80:25  
83:10,25 84:1 85:17  
132:4,9 144:13,24  
150:16,17 158:8 168:8  
difficulties (7) 12:6 54:9  
60:6,10,15 144:6 154:4  
difficulty (5) 2:14,19 3:9

132:5 136:5  
dining (3) 61:16,18 62:3  
dinner (1) 61:20  
direction (2) 24:22 156:7  
directly (1) 146:15  
director (4) 1:25 24:21  
27:1,18  
directors (7) 113:13,15  
114:3,5,6,14 115:3  
dirty (1) 106:1  
disappointed (1) 15:5  
disbanded (2) 45:4,5  
discharged (3) 69:19 70:10  
109:6  
disclaimer (1) 11:24  
disconnect (2) 69:6 169:17  
discovered (1) 162:7  
discoving (1) 153:16  
discriminating (1) 79:19  
discuss (5) 24:25 62:11 80:5  
99:8 121:4  
discussing (2) 49:25 94:10  
discussion (2) 10:18 170:18  
disease (5) 8:4 16:12,12 32:8  
34:15  
disinfectant (1) 5:2  
dismissed (1) 145:12  
dismissive (3) 145:6 149:6  
151:8  
displayed (1) 149:19  
displaying (2) 68:6 143:15  
disposable (2) 51:4,7  
disrespect (1) 163:12  
distanced (1) 62:4  
distancing (4) 59:25 60:5  
61:2 65:25  
distinction (1) 30:5  
distress (1) 60:14  
distressing (3) 160:13  
166:6,8  
distributed (4) 42:19,20  
44:9,18  
district (1) 18:24  
diverted (1) 25:5  
divided (1) 132:13  
dividends (1) 28:21  
dmards (1) 32:9  
doctor (1) 102:18  
doctors (3) 19:17 43:19  
151:21  
documentation (1) 172:3  
documents (1) 172:7  
doesnae (1) 102:18  
doesnt (4) 144:15 157:12  
164:9,11  
doffing (1) 22:23  
doing (21) 20:6 23:8,9,12  
30:8 35:17 53:6 70:17  
81:22 82:21 86:21 88:11  
121:9 122:13,19  
123:14,16,17 132:11  
154:23 165:15  
domestic (4) 97:2 102:24  
122:13,19  
domestics (5) 96:19 97:5  
111:10 118:10 127:22  
domiciliaries (1) 23:7  
domiciliary (1) 22:19  
dominoes (1) 135:3  
donated (3) 59:6,7,9  
donations (3) 58:8,16,20  
done (22) 12:5 55:21  
6:5,8,11,11 70:8  
74:14,19,23 108:16 119:20  
120:11,12,25 121:1 122:2  
127:10 128:6,6 132:20  
139:15 167:1  
donning (1) 22:23  
dont (62) 10:13 21:11 23:6  
34:5 43:25 46:9,12 51:4  
52:1 60:13,14 64:24 65:5  
68:17 74:6 75:13 77:11  
78:22 83:16 85:13  
88:12,19 95:15 97:12,14  
102:19 110:18 121:5  
123:14 126:19 127:20

137:22 138:10,10,16,24,24  
139:17 142:9,9,24  
144:13,18,25 147:7,8  
151:15 158:22,24 160:20  
162:1 166:4,5 167:10  
168:9 169:6,12,13  
170:5,24 172:15,19  
door (7) 12:21,24 33:12  
38:22 84:15 94:5,6  
113:2,9,12,14,16,17,21  
114:4,5,8,17,18,21 115:5  
down (23) 4:21 16:21 24:8  
28:10 37:14 42:4 45:22  
76:7,25 88:16 113:9,10  
120:4 123:2,8 124:6 135:2  
137:11,14 138:1 140:1  
154:24 159:16  
downstairs (8) 48:20,24  
54:24 59:11 75:21 76:3,10  
84:16  
downtime (1) 110:2  
dr (1) 142:23  
drafted (1) 6:1  
dramatic (2) 51:25 52:4  
dramatically (1) 5:23  
drawing (1) 154:23  
dressed (1) 11:5  
dressings (2) 3:20,25  
dried (2) 11:8 59:19  
drink (1) 137:6  
drop (1) 84:15  
droplet (1) 171:16  
dropoff (1) 23:3  
dropped (1) 33:12  
droves (1) 71:20  
drug (1) 32:11  
drugs (1) 32:9  
due (2) 18:21 133:24  
dumb (1) 169:6  
during (43) 7:1,6 16:2 21:16  
22:18,20 23:11 24:18,20  
28:8,14 39:10 40:6,9 43:7  
47:23 52:13 54:10 55:3  
56:21 57:17 58:10 64:5,7  
71:14 73:1,17 75:2,18  
79:17 82:4 83:2 86:4,5  
98:7 120:9 123:9 125:3,3  
128:4 143:6,16 166:2  
dust (1) 42:21  
duties (8) 27:21 75:6,18  
92:1,2,4,9,11  
duty (4) 48:24 55:13 108:16  
110:1  
dying (2) 121:20 122:8  
dyspraxia (1) 41:6

E

earlier (10) 41:11 82:2  
105:15 115:10 149:18  
153:13 155:13 167:10  
171:2 172:1  
early (9) 3:12 24:20 68:4  
69:13 82:8 129:7 132:7  
142:16 155:10  
earn (1) 29:23  
earnings (3) 28:6,13,20  
earth (3) 136:25 137:18,21  
ease (2) 3:19 157:14  
eased (1) 17:1  
easiest (1) 10:15  
easy (1) 172:22  
eat (3) 38:19 61:20 137:5  
eating (2) 61:15,15  
edge (1) 164:21  
education (6) 39:18,20 41:19  
133:14 159:23 163:25  
educational (3) 40:20 133:6  
171:2  
edwards (21) 46:21,22  
47:5,6,7 57:15 89:25  
90:5,6,8,12,13,21,23,24  
129:5,8,14,16 175:3,4

effect (8) 19:15,19 24:14  
145:17 157:7,9 159:9  
161:16  
effectively (1) 168:18  
effectiveness (1) 55:24  
effects (1) 145:10  
effort (5) 49:16 89:22 129:3  
132:1,1  
efforts (2) 173:10,11  
eight (2) 47:25 173:9  
either (8) 56:7 59:10 98:13  
109:6 113:6 125:5 163:18  
165:7  
elderly (3) 17:17 60:3 76:1  
elearning (5) 63:17,20,24  
64:2,8  
elective (3) 109:8 110:11  
123:15  
element (2) 118:14,15  
eligibility (1) 170:22  
eligible (2) 28:5 42:23  
else (10) 2:18 34:9 53:18  
82:2 89:13 107:19,21  
127:11,12 128:22  
elses (2) 15:1 23:11  
email (10) 4:25 8:25 22:6  
42:5 43:10 68:17 69:1,4  
79:6,8  
emailed (1) 68:12  
emails (4) 25:2 80:14  
142:22,25  
embarrassed (2) 172:17  
173:2  
emergency (1) 50:4  
emergency (2) 23:20 110:14  
emerging (3) 9:15 30:23  
32:13  
emma (4) 1:5,15 20:16 175:2  
emotional (2) 73:10 172:15  
emotionally (1) 132:3  
emphasis (2) 138:6 172:12  
employed (2) 47:22 122:16  
employee (2) 27:17 74:20  
employees (1) 29:14  
employer (8) 23:17  
67:3,5,9,18,21 69:8,9  
employment (1) 123:22  
empty (1) 109:18  
enclosed (1) 37:25  
encourage (1) 138:21  
end (35) 17:10 19:22 36:9  
38:4 50:19 63:14 71:5,8  
72:25 73:7,17 78:8 82:5  
85:2 106:18 115:8  
119:16,24,25 123:6  
128:1,2 132:10,18,22,24  
134:1 146:10 149:13  
159:18 169:14 170:25  
171:3 172:10 173:4  
endanger (1) 160:24  
ended (6) 19:2 41:2 70:21  
80:17 83:17 159:20  
ends (1) 122:5  
engage (2) 150:25 156:21  
engaging (3) 21:8 61:4 164:3  
england (3) 35:19 36:1 42:14  
english (1) 36:1  
enhanced (2) 40:25 127:24  
enjoy (1) 61:23  
enjoyment (1) 144:12  
enough (14) 53:11 55:7,7  
56:4,14 58:13,25 59:7,13  
74:12 77:23 80:2 128:3  
143:20  
ensure (1) 38:22  
entered (1) 44:1  
entire (3) 23:6 34:15 72:2  
entire (2) 136:16 147:3  
entirely (1) 68:14  
entitled (2) 67:7,22  
environment (3) 34:16 80:7  
138:9  
episodes (1) 125:25  
equipment (1) 3:11  
equipped (1) 72:11  
equivalent (1) 28:9

era (1) 138:8  
erratic (1) 102:5  
escorted (1) 33:12  
especially (2) 61:23 87:25  
essential (2) 17:6 108:13  
essentially (4) 4:21 147:9  
162:15 173:17  
established (2) 112:23,25  
esther (2) 100:4 101:2  
estimates (1) 5:18  
eureka (2) 15:15,15  
even (37) 16:6 17:24 19:22  
20:9 22:3 37:9 38:17 40:25  
125:16 127:20 136:16  
137:16 138:19 140:2,4  
142:4 143:22 149:21  
158:14 159:14,20 160:6  
162:2 170:23  
evening (1) 33:4  
eventually (4) 43:10 81:12  
140:13 158:13  
ever (8) 3:25 9:8 10:13 17:22  
33:5 38:20 97:14 158:11  
every (29) 4:8 12:4,14 16:19  
36:24 43:6 50:10 52:19,19  
56:12 64:19 71:18,21 77:9  
97:22 98:21 99:20 100:12  
101:23 105:24 106:13  
116:20 126:23 157:13  
158:5 165:17 166:21  
168:20  
everybody (6) 5:3 15:22  
32:20 93:17 116:22 127:19  
everybodies (2) 8:9 14:22  
everyday (7) 3:21 76:22  
107:1 109:15 125:14  
144:19 150:16  
everyone (1) 102:24  
everything (15) 12:4,19  
26:19 58:1 66:9 70:1 80:25  
81:9 101:11 123:8 138:14  
149:8 155:5 164:14 165:15  
everywhere (1) 155:6  
evidence (51) 1:15  
evidence (1) 146:5  
46:6,22,25 47:4,8,11,18  
48:2 70:16 89:22,25  
90:13,14,16,22 91:20  
100:20 103:23,25 104:1  
125:18 128:21,22 129:2,5  
130:3,5,7,10,16,17,20,24  
131:20 141:20 145:8  
148:10 149:18 153:13  
156:24 169:15 171:12  
172:10,20  
173:3,8,15,21,23,25  
evidential (1) 173:4  
exact (1) 64:11  
fair (2) 87:15,15  
fall (5) 14:19 15:10 59:22  
109:2 157:10  
familiar (5) 9:16,20 114:23  
122:22 130:23  
families (5) 62:22 63:2 96:16  
154:3 164:24  
family (18) 27:25 30:17,19  
39:16 62:14,23 63:5,11  
65:25 73:4,13 84:14  
96:8,12 125:21 126:15  
131:15 149:24  
far (10) 4:6,16 13:14  
17:21,25 24:6 50:24 67:9  
161:9 173:16  
father (1) 125:23  
fatigue (2) 155:21 156:2  
fatigued (1) 159:13  
fault (2) 57:14 120:17  
favoritism (1) 62:21  
favourably (1) 103:12  
fear (8) 20:2,2,3,3,4 138:9  
142:8  
fears (2) 50:4 125:10  
february (3) 39:17 93:10,11  
februarymarch (2) 49:22  
151:12

expectancy (1) 19:7  
expectation (1) 5:9  
expectations (3) 68:2,11  
69:8  
expected (6) 5:6 7:14 25:22  
68:18 99:18 105:9  
expensive (1) 158:5  
experience (22) 7:3 32:24  
34:24 42:4,7 75:2,4 78:24  
81:19 82:3,10 84:3 85:25  
86:14 95:1 96:18 121:17  
125:20 128:25 144:15  
147:3 166:7  
experienced (8) 43:2 81:1  
88:22 96:1 101:25 121:20  
144:17 158:11  
experiences (4) 76:14 82:14  
87:2 88:24  
experiencing (6) 18:11 40:17  
41:12 144:7 154:4 158:6  
experimental (1) 33:15  
experts (2) 17:1 171:15  
explain (8) 9:25 47:18,22  
50:20 60:9 96:8 101:24  
109:11  
explained (4) 35:12 100:9  
131:21 149:16  
explaining (1) 70:3  
explore (1) 96:20  
exposure (2) 115:9 118:8  
expression (1) 143:10  
expressions (2) 143:8,17  
expressly (1) 85:13  
extended (3) 96:17,18 97:13  
extent (4) 29:5 133:22 145:9  
155:14  
extra (7) 11:2 20:11 25:3  
27:6 37:20,25 65:12  
extremely (3) 158:4,10  
169:25

F

fabricated (2) 163:19 164:3  
face (7) 37:13 38:2,8,8,11,12  
99:24  
facebook (1) 153:11  
faced (5) 18:17 36:14,20  
42:6,11  
facemask (3) 34:11,11,11  
facemasks (1) 34:7  
facetoface (3) 99:24 103:14  
118:20  
factory (3) 29:17 96:19 99:18  
factor (2) 133:23 151:10  
factual (1) 166:14  
fading (1) 137:10  
fae (2) 95:17 104:6  
failed (1) 2:16  
failing (1) 4:14  
fair (2) 87:15,15  
fall (5) 14:19 15:10 59:22  
109:2 157:10  
familiar (5) 9:16,20 114:23  
122:22 130:23  
families (5) 62:22 63:2 96:16  
154:3 164:24  
family (18) 27:25 30:17,19  
39:16 62:14,23 63:5,11  
65:25 73:4,13 84:14  
96:8,12 125:21 126:15  
131:15 149:24  
far (10) 4:6,16 13:14  
17:21,25 24:6 50:24 67:9  
161:9 173:16  
father (1) 125:23  
fatigue (2) 155:21 156:2  
fatigued (1) 159:13  
fault (2) 57:14 120:17  
favoritism (1) 62:21  
favourably (1) 103:12  
fear (8) 20:2,2,3,3,4 138:9  
142:8  
fears (2) 50:4 125:10  
february (3) 39:17 93:10,11  
februarymarch (2) 49:22  
151:12



feel (39) 9:23 10:24 16:8,24  
21:9 23:9,12 35:15,21 36:3  
45:12 52:17 80:6 81:1  
82:21 83:19 89:19 94:1  
102:25 106:16 134:24  
135:1 138:24 142:13  
146:24 149:3 151:10  
152:19,19 155:12 156:5  
158:1 164:20 165:4 167:1  
169:6 172:11,19 173:2  
feeling (9) 2:21 8:10 95:12  
136:19,22,23 150:18  
168:23 170:21  
feet (10) 2:15,22,22,24 9:19  
17:12 20:17 26:13  
37:12,19  
fell (1) 153:25  
felt (30) 5:17 6:7 7:22 13:5  
16:17 32:1,3 35:2,7,10,12  
36:6,19 37:1 56:14,14 62:5  
76:21 84:23 85:8,9  
109:25 123:16 135:8  
145:18 150:20 163:22  
165:5,6  
feverish (1) 136:23  
few (18) 6:8 24:11 31:9 32:7  
33:11,17 38:17 48:13  
70:21 78:14 112:10,13  
119:17 134:25 136:21  
158:14 162:4 169:15  
fp2 (4) 34:11,12 37:4,9  
fp3 (2) 104:13,14  
fifth (2) 33:22 169:7  
fight (1) 67:22  
figure (5) 29:6 30:1 137:17  
144:1 154:2  
figured (1) 15:3  
fil (1) 163:19  
film (1) 30:4  
final (1) 147:13  
finally (5) 86:9 127:6 131:16  
152:21 166:15  
financial (7) 13:4 27:9  
28:1,24 29:2,5 157:1  
financially (1) 18:13  
find (13) 24:15 25:21 34:1  
36:10 38:10 42:22,22  
44:21 78:18 133:7,8  
157:13,15  
finding (3) 78:11,12 132:9  
findings (1) 10:18  
fine (4) 135:16 139:11  
148:23 153:23  
finish (3) 79:24 80:2 172:12  
finished (4) 106:10,12 129:7  
173:24  
finishes (1) 126:24  
first (91) 1:4 3:19 8:20 12:22  
13:19 14:11,11 19:24,25  
30:14 31:9 32:7 33:23  
35:4,13 38:1 39:1,21  
41:1,6 47:24 49:25 50:3  
51:15 52:16,23 53:21  
54:15,22 56:21,21 58:10  
64:5,7 66:18 70:2 71:4  
73:18 76:14,15 82:6,20  
84:7 86:5,17,17 92:25,25  
93:1,2,5,8,12,14,16,23  
94:17,20,23 95:1,25  
96:3,3,24 106:10,10,18  
107:5 108:3,10,12,18,25  
111:11 112:11 115:10,21  
119:6 120:8,10 123:1  
125:25 126:4,5 131:3,4  
134:3,24 149:19 153:6,6  
firsttime (1) 85:24  
fit (4) 38:11,12 59:8 104:15  
fitted (3) 38:2 104:16 162:13  
fittested (2) 104:19,24  
fitting (1) 104:13  
five (5) 2:12 7:21 33:21  
39:24 135:24  
fiveten (1) 79:23  
fix (2) 24:3,13  
flareup (1) 81:2  
flexible (2) 80:20,24

flinging (1) 164:5  
floor (1) 26:4  
floor (1) 86:24  
floor (2) 38:23 115:14  
flu (4) 7:1,6,11 43:3  
fluctuated (1) 153:1  
fluid (1) 104:5  
flying (1) 25:2  
focus (4) 10:23 156:23  
159:24 163:24  
focusing (1) 96:24  
foi (1) 141:19  
fold (1) 38:11  
folder (4) 65:7,17,22 74:17  
follow (4) 23:1 35:25 36:5  
160:1  
followed (2) 88:9 113:22  
following (15) 44:6 54:7 74:7  
88:1,14,17 101:24 131:24  
134:5 143:5 146:9 156:18  
161:2 163:21 167:17  
followon (1) 101:8  
followup (1) 101:12  
food (2) 11:8 84:13  
foot (7) 2:13,19 10:14,21,23  
11:19 17:24  
footwear (1) 11:5  
force (1) 60:6  
forcefully (1) 128:17  
foresee (1) 6:25  
foreseen (1) 17:19  
forever (1) 141:3  
forgotten (2) 45:13 89:19  
form (2) 41:16,18  
formal (3) 39:20 41:16  
102:20  
formally (1) 102:20  
form (1) 45:3  
forth (1) 33:2  
fortunate (1) 44:25  
fortunes (1) 25:13  
forward (3) 6:7 35:8 152:20  
forwards (1) 25:2  
found (9) 18:6 40:6 41:3  
67:4 77:25 82:5 132:4  
154:3 164:7  
four (21) 1:24 2:12 5:5,11,13  
13:19 14:1 48:22 81:23  
122:14,20 132:6 135:24  
136:12 137:19 139:4,23  
140:21 151:15 164:15  
168:19  
fourth (1) 169:4  
fouryear (1) 41:16  
frail (1) 76:1  
frame (1) 37:17  
free (3) 18:16 38:22 110:2  
frequently (2) 35:11 164:17  
fresh (2) 84:5 163:2  
friction (1) 63:5  
friday (6) 99:9 100:6  
101:9,12,16,25  
friends (4) 35:19,25 150:22  
168:7  
frightened (1) 138:12  
frightening (1) 138:20  
front (4) 12:21 47:15  
91:10,14  
frontline (5) 29:10 39:2  
42:15 43:17 45:14  
96:3,3,24 106:10,10,18  
107:5 108:3,10,12,18,25  
111:11 112:11 115:10,21  
119:6 120:8,10 123:1  
125:25 126:4,5 131:3,4  
134:3,24 149:19 153:6,6  
firsttime (1) 85:24  
fit (4) 38:11,12 59:8 104:15  
fitted (3) 38:2 104:16 162:13  
fittested (2) 104:19,24  
fitting (1) 104:13  
five (5) 2:12 7:21 33:21  
39:24 135:24  
fiveten (1) 79:23  
fix (2) 24:3,13  
flareup (1) 81:2  
flexible (2) 80:20,24

funded (1) 122:20  
funding (5) 53:11,13,17  
169:22,23  
funeral (8) 113:13,14  
114:2,5,6,14,16 115:3  
fungal (1) 17:13  
funny (1) 162:21  
furlough (4) 12:22  
27:19,20,24  
furloughed (3) 13:7 74:10  
79:20  
furloughing (1) 27:15  
further (6) 52:9 72:20  
112:16,18 151:24 169:16  
future (1) 87:3

**G**

gain (1) 140:18  
gale (13) 129:11,22,23  
130:2,4 149:17 172:25  
173:6,19 174:1,2,4 175:4  
gales (1) 173:25  
game (1) 170:3  
games (1) 61:12  
gap (1) 12:17  
garden (2) 143:21,21  
gathered (1) 141:20  
gave (15) 7:11 16:9 19:7  
37:25 70:1 82:8 86:2 95:12  
130:6,16 145:1 158:14  
166:25 171:2 172:1  
gel (1) 36:19  
general (12) 3:20 6:15 8:25  
9:4 10:7,18 24:10 43:24  
46:11 104:9 109:16 112:7  
generally (5) 15:5 23:23  
27:17 117:17,18  
generate (1) 43:13  
get (96) 3:22 4:4,10,13 8:21  
9:21,24 10:13,20 15:12,12  
19:17 20:4 22:15 26:3  
28:11 29:1,21 31:16,17  
35:8 43:10 44:2 50:15  
51:21 53:11,12  
54:21,21,24 55:6 59:23  
62:2,24 64:12 65:9  
66:21,24 67:2,23 73:10  
74:5 76:9 77:10,13 83:1,22  
84:13 85:7,12,12 89:11  
93:21 96:15 98:22 99:4,23  
100:4 102:20 104:16  
110:22 111:12 114:15  
119:15 123:11 124:3,4  
126:1,7,17 127:24 135:11  
137:20 138:21 139:3 141:9  
142:11 143:23 144:18  
150:17,21 151:6 156:12  
159:18 161:14 162:1,20  
168:22,22,24,25 169:1,2,7  
170:23 171:17  
gets (3) 136:18 144:19 169:2  
getting (45) 33:18 45:2 46:4  
57:24,25 63:1 74:2 77:22  
79:10 80:13 85:22,22  
95:4,19 96:1 98:6 99:19  
101:3,4,7,13 102:14 103:2  
104:20 107:13,16  
108:10,24 117:20 118:11  
120:1,23,25 121:1,25  
122:2,15 124:7,7 128:6,6  
135:2 152:10 154:5 163:2  
girl (2) 84:18 85:20  
give (17) 9:6,8 10:10 29:19  
33:24 49:15 57:8 69:22  
125:15 126:15 130:13  
90:25 128:25 130:18 131:3  
137:23 143:14 144:5  
156:14 157:14  
given (21) 4:15 5:9,19 28:12  
45:2,9 46:5 53:12 58:22  
84:25 100:20 129:2 130:5  
143:14 151:15 163:12,20  
167:15 170:20 171:3  
172:21  
giving (7) 10:24 47:18 86:1  
90:16 125:18 130:24  
137:12

glad (2) 139:14 141:9  
glasgow (3) 90:15 91:3 92:14  
169:22,23  
glass (1) 137:9  
glove (2) 51:3 100:13  
gloves (9) 34:8 51:6 58:1  
94:14 99:20 101:18 105:13  
106:13 127:20  
gmb (1) 47:20  
goal (1) 165:16  
god (4) 137:8 158:5 161:1  
162:2  
goes (3) 63:12 105:15 166:1  
going (65) 5:10 19:2 21:10  
24:9 26:1,5 41:21 53:7,9  
55:3 56:13 57:8 66:9 68:24  
71:17 76:16,22 77:6,8  
79:25 81:9,22 82:22 83:1  
85:19 86:22 87:14 92:24  
93:21 94:7 96:15 98:22  
100:9 103:17 105:2 107:13  
108:14,14,16,17,19,20,22  
111:11 112:14 115:19,20  
120:4 121:18 123:15  
126:10 129:11 131:19  
136:25 142:4 158:15  
160:20 161:10,21  
162:8,18,23 164:22 168:3  
172:16  
gold (1) 42:21  
gone (10) 5:4 10:16 17:25  
19:13 24:6 109:17 112:13  
157:4,10 167:19  
gonnae (1) 128:14  
good (30) 1:3,4,10,11,12  
46:16 21:22 47:6,7 51:24  
55:10 87:19,22  
90:3,12,13,18,18,20  
91:10,14 92:22 105:1  
129:6,15,22,23 130:1  
170:3  
goodness (5) 135:6 136:15  
139:16 154:21 158:14  
gosh (3) 135:24 154:6 167:2  
goss (15) 129:25  
130:1,3,5,15 131:9 133:11  
149:17 158:25 165:25  
169:15 172:9,19 173:1  
175:4  
government (20) 22:14  
26:3,17 31:13 34:22 41:22  
42:13 44:7,12 52:22 86:20  
87:16 88:16 89:8 119:7  
141:22,23 142:18  
169:18,20  
governments (1) 44:23  
gp (19) 31:16,18,22,23 32:5  
43:3 138:10  
145:2,6,21,25  
146:13,13,14 151:3,8,23  
152:8  
gps (1) 151:20  
graciously (1) 172:16  
gradually (2) 94:6 110:7  
graduation (1) 2:2  
grandpian (3) 166:10  
167:9,13  
grandparents (1) 30:17  
grant (1) 29:3  
graphically (1) 77:14  
grateful (9) 128:24 129:2  
132:11,25 149:16 172:20  
173:9,10,20  
great (10) 34:20 51:14 95:1  
96:6 102:10 106:24  
122:18,23,24 126:15  
greater (2) 21:19 107:9  
greatly (2) 4:22 21:18  
grf (2) 93:14,16  
ground (3) 85:7 89:1 169:19  
group (6) 136:8 149:24  
153:12,16 154:3 170:22  
guaranteed (1) 169:24  
guess (2) 152:11 161:13  
guidance (53) 9:14  
26:6,8,14,17 34:7,17,21,25  
35:10,15 36:5,6 42:12

44:8,8,15,16,17 63:25 64:1  
65:1,6,17 68:14,20  
69:4,11,12 70:7 88:5,8  
99:18 100:4,5 101:21  
102:17 104:4,6 105:16  
113:13,14 114:5,7  
116:14,14,20 118:22  
119:7,10 121:11 152:12  
139:2 147:6 157:14 160:17  
162:8  
guidances (1) 45:12  
guidelines (3) 63:13 65:18,24

**H**

hadnae (2) 100:6 101:21  
hadnt (13) 5:7 14:16 17:25  
18:13 19:21 32:2 39:19  
40:5 43:25 44:1 50:7,8  
55:21  
hair (2) 38:5,6  
half (12) 1:21,24 5:3 12:5  
77:19 79:1 81:24,24  
109:12,18,18 118:3  
hand (1) 106:1  
handbook (1) 88:2  
handle (2) 12:21 165:22  
hands (3) 11:20 36:18  
122:15  
happen (12) 15:20 26:5 30:4  
50:14,16 62:17 70:19,23  
74:7 75:9 115:1 170:15  
happened (9) 15:13 44:21  
79:10 81:7 98:10 117:5  
136:21 147:25 164:23  
happening (11) 7:12,18 21:3  
26:2 74:11 93:2 154:7,8  
160:14 164:9 169:19  
happy (7) 34:3 41:9 60:24  
62:25 91:17 136:9 173:16  
hard (8) 14:24 26:14 77:9  
113:19 144:15 159:19  
160:22 165:20  
hardcore (1) 161:16  
hardest (1) 131:11  
hasnae (1) 102:17  
hasnt (2) 170:8,10  
havent (5) 17:9 46:7 89:7  
172:11,17  
having (21) 18:12,17 21:2  
24:15 28:17 36:16,23  
37:14 40:13 41:2 57:18  
72:7 75:2 78:12 97:2 98:18  
149:24 158:16 161:17  
163:23 170:11  
hazmat (1) 93:18  
hcp (1) 6:1  
head (3) 38:13 42:24,25  
43:3 138:10  
headaches (1) 161:17  
headed (1) 133:6  
health (46) 2:20 5:25 19:7  
42:25 43:1,5,5 44:3,4,4  
45:12,16 68:19,23  
69:2,7,12 72:17 73:9  
74:8 76:13 85:15,18,18  
86:2 89:2 117:1,2,7,9,15  
119:23 120:14,20  
123:19,21 124:25 125:5  
127:11 128:5,16 145:12  
152:18 168:6 173:5  
healthcare (32) 7:1,16 11:13  
17:1 18:16,19 19:21 21:8  
22:14 23:10 29:10 30:13  
31:10 34:18 36:13 37:3  
39:2 41:23 42:9,15  
43:17,19 44:8,14,16,17  
45:14,18 83:11 125:21,22  
143:1  
healthwise (1) 125:7  
healthy (1) 144:14  
hear (6) 50:9,12 79:7  
87:8,20,22  
heard (5) 14:16 34:23 42:3  
97:4 171:12  
hearing (5) 50:11 130:19  
173:24,24 174:6  
hearings (3) 129:25 173:4,24  
heart (1) 38:1

heel (1) 24:11  
heightened (1) 3:18  
held (5) 47:24 88:13,18  
160:19,19  
helen (3) 129:25 130:3 175:4  
help (17) 10:4 11:12 19:11  
25:15 26:11 27:4 30:21  
41:3,14 80:14 88:15 124:1  
139:2 147:6 157:14 160:17  
162:8  
helped (2) 22:9 115:5  
hence (2) 33:24 41:19  
here (11) 15:4 33:5 40:22  
50:9,14 51:12 81:24 103:1  
131:1,21 150:23  
heres (2) 166:20,21  
herself (3) 113:18 136:19  
144:4  
hes (4) 40:10,23 90:16  
126:10  
hesitant (1) 140:23  
hesitate (1) 141:14  
hesitated (1) 142:8  
hi (1) 20:16  
hide (1) 55:17  
high (5) 3:1 14:10 69:18  
104:22 121:25  
higher (4) 78:19 108:20  
124:14,14  
hundred (1) 14:14  
highlevel (1) 143:1  
highlight (3) 46:8 66:15  
171:6  
highlighted (3) 31:25  
74:18,21  
highly (3) 31:20 34:15 158:4  
hindsight (2) 30:24 149:21  
hire (1) 43:14  
hired (2) 77:22 81:6  
hiring (1) 78:17  
historically (1) 105:7  
history (3) 16:22 149:23  
158:11  
hit (4) 39:19 76:6 77:10 93:2  
hmhmm (5) 80:17 88:20  
102:22 139:10 157:19  
hobby (1) 135:22  
hoist (1) 75:19  
hold (2) 5:7 86:22  
holding (1) 87:6  
holiday (1) 93:15  
holistic (1) 11:14  
home (72) 6:12 10:4 21:22  
22:17,19 23:11 25:4 30:1  
36:3 47:19 48:4,9,10,14  
49:5,16 50:22,23 51:3,9  
53:7,15 55:14,16 56:2 58:7  
59:9,17,25 60:2 61:4,12  
62:12,13,15 63:21 68:9,21  
70:4,8,13,18,19 71:2,18  
75:4,22 76:17  
77:1,18,19,21,24 78:13  
79:1 80:18 81:8,13 86:14  
88:13 96:12,15 97:2 109:7  
117:1,10,19,21,23 130:2  
161:19 163:1  
homes (17) 53:5,6 57:23  
69:19,23 70:16 74:15  
78:17 86:22 87:5,22,23  
88:12,25 89:19 109:7  
125:3  
honestly (6) 136:15 141:11  
145:20 149:3 161:18  
172:14  
honour (1) 3:14  
hope (8) 47:14 86:18  
89:16,17 127:13 157:12  
165:16 172:17  
hoped (1) 162:17  
hopefully (1) 172:17  
hopes (2) 171:4,24  
hoping (2) 25:17 86:20  
horrendous (2) 82:11 84:6  
horrible (2) 139:25 169:3  
horrifying (1) 155:7  
horrifyingly (1) 141:13

horse (1) 135:23  
hospital (57) 32:22,25  
33:2,11,11 34:1,15,19  
43:19 70:11 71:20  
83:20,25 84:2,9,12,22  
85:15 88:23 89:9 92:2,8  
93:12 95:22 100:23 106:25  
107:2,3,8,13,15,18  
109:5,6,25 110:4,13,16  
111:16 122:16,22  
127:3,18,23 128:3 138:11  
140:15 141:5,14 142:9  
146:15,16 147:15 150:4  
151:21 163:18 166:3  
hospitals (15) 59:8 69:20,23  
70:2,4,6 71:9 72:14 74:11  
77:22 83:11 89:2,21  
122:13 125:2  
hotel (2) 96:15,17  
hour (4) 5:3 12:4 33:9 81:23  
hours (7) 27:7 33:12,17  
hesitate (1) 141:14  
house (7) 121:12 154:24  
155:5 157:11 168:14  
169:9,11  
however (2) 32:10 76:7  
hr (4) 53:4 79:6,8,16  
hsc0249 (2) 47:4 175:3  
humans (1) 60:21  
hundred (1) 25:16  
hundreds (1) 149:10  
hurt (2) 144:8 158:19  
husband (2) 30:12 39:25  
hyde (1) 154:25  
hygienic (1) 56:7

**I**

ibuprofen (3) 137:16,22,25  
icu (5) 104:22 111:25 112:1  
122:5,9  
id (4) 43:10,12,15 96:3  
idea (2) 136:24 153:19  
identify (2) 61:1 125:3  
ids (2) 43:13,14  
ignore (1) 23:24  
ignored (5) 23:24,24 24:6  
79:8 142:10  
iir (4) 34:7,10,11 37:2  
il (10) 11:19 54:5 125:5  
131:11 137:2 141:6,10  
146:11 165:1 169:10  
illhealth (1) 124:8  
illness (3) 150:14 163:19  
164:4  
illnesses (1) 135:15  
im (51) 11:18 15:14  
im (10) 11:19 54:5 125:5  
65:9 66:10 74:7,8 79:25  
82:24 86:20 110:18 124:22  
128:10,24,24 129:8  
134:18,18 136:19 141:9  
142:11,22,25 147:11,24  
149:16 150:23 152:10  
154:6 155:23,24 157:7,9  
164:15 165:14 166:9 168:3  
172:9,14,14,16,19  
173:9,10,15,16  
image (1) 10:21  
imagining (1) 145:16  
immediate (1) 137:7  
immune (4) 31:3,12 126:11  
170:20  
immunologist (1) 170:12  
immunology (1) 157:22  
impact (33) 8:5 13:4 20:21  
23:20 28:24 30:11,22  
33:19 39:8,15 40:12 41:17  
44:13 70:9 72:17,23 73:9  
84:25 93:1 102:23 107:25  
108:18 123:19 124:12  
126:19 128:14,14 131:2  
167:15,24,25 168:5 173:5  
impacted (2) 79:22 102:25  
impacting (1) 76:21  
impacts (10) 27:9 49:21  
63:19 76:13 80:9 124:25

125:5 133:6,13 171:2  
**impairment** (1) 11:9  
**impeding** (1) 144:11  
**implement** (1) 67:19  
**implementation** (1) 7:20  
**implemented** (1) 22:6  
**implication** (2) 64:17 88:3  
**implications** (2) 57:10 74:6  
**importance** (1) 127:9  
**important** (15) 16:10,18  
 21:9 29:12 62:6 74:5 85:21  
 87:1,5,9,14 89:10 138:22  
 150:20 162:20  
**importantly** (1) 55:23  
**impossible** (1) 155:1  
**impressed** (1) 34:21  
**improve** (2) 87:3 159:12  
**inappropriate** (1) 29:25  
**inaudible** (3) 49:8 79:17  
 126:16  
**incidence** (2) 115:11 117:22  
**incidents** (5) 71:11 116:6  
 118:3 120:6 122:6  
**include** (2) 27:22 75:19  
**included** (4) 12:20 42:9  
 66:23 133:6  
**including** (6) 33:15 59:16  
 97:3 141:21 142:18 144:7  
**income** (3) 13:8 27:24 28:16  
**inconsistent** (1) 63:13  
**increase** (12) 4:10 23:25  
 107:12,14,16,17 110:7  
 118:3 122:12 123:21  
 127:22 162:24  
**increased** (6) 18:21 110:4,6  
 116:6 118:8 120:6  
**increasing** (2) 6:21 71:12  
**incredible** (2) 158:15 168:5  
**incredibly** (2) 132:4 139:22  
**independent** (2) 42:16  
 128:15  
**index** (1) 175:1  
**indicate** (6) 49:15 53:8 133:5  
 151:18 157:19 172:5  
**indicated** (3) 146:22 156:24  
 157:3  
**indication** (2) 143:14 144:5  
**individual** (1) 157:20  
**induced** (2) 163:19 164:4  
**inevitably** (2) 66:13,14  
**infected** (3) 117:19 169:1,2  
**infection** (22) 6:9 7:13 17:13  
 20:5 34:2,6,13,17 39:5  
 51:2,2 63:17 66:3 134:7  
 136:12 139:23 147:4  
 153:24,24 168:22 169:4  
 171:7  
**infections** (1) 168:20  
**infectious** (1) 51:7  
**infirmary** (4) 90:15 91:4  
 92:15 163:10  
**inflammation** (1) 155:8  
**inflammatory** (1) 140:7  
**inform** (7) 11:13 67:19,21  
 129:16 133:16 141:25  
 142:19  
**information** (15) 5:15  
 11:2,23 25:18,23 26:5  
 46:1,1,11 66:11 69:7 104:2  
 135:12 140:6,9  
**informed** (3) 69:3 73:24  
 142:14  
**infuriating** (3) 141:9 146:25  
 147:9  
**ingrown** (2) 18:5 24:2  
**initial** (7) 5:21 49:21 50:1  
 94:25 95:2 135:4 139:5  
**initially** (5) 50:18 53:24 68:7  
 134:21 162:16  
**inpatient** (1) 166:3  
**inperson** (1) 10:22  
**input** (1) 144:23  
**inquires** (1) 87:19  
**inquiry** (22) 89:14 91:1  
 100:21 124:24 125:19  
 128:22 130:5,11,12,21

133:2,12 141:19,21 145:13  
 171:4,12,25 172:5,8,23  
 173:6  
**inquiries** (1) 132:21  
**insidiously** (1) 70:21  
**insane** (2) 141:5 158:16  
**inside** (3) 62:12 84:7 163:1  
**insight** (3) 7:12 25:18 26:4  
**insist** (1) 152:10  
**insistence** (1) 151:4  
**insistent** (1) 138:16  
**insisting** (1) 151:25  
**insofar** (2) 102:22 103:7  
**instance** (2) 15:16 30:14  
**instead** (5) 12:19 18:6,7  
 33:24 96:15  
**instincts** (1) 154:9  
**institutions** (1) 142:18  
**instruction** (1) 31:9  
**instructions** (2) 100:18  
 137:13  
**instrumental** (1) 100:23  
**insult** (1) 139:17  
**intended** (1) 26:13  
**intention** (1) 133:19  
**interacting** (1) 146:22  
**interaction** (1) 40:14  
**interactions** (1) 145:25  
**interest** (2) 128:10,13  
**interested** (1) 161:3  
**interesting** (2) 50:19 160:7  
**interestingly** (2) 108:9 136:7  
**internally** (2) 52:25 53:3  
**interrupt** (4) 57:19 138:2  
 139:3 147:11  
**intervention** (3) 18:1 154:13  
 156:16  
**into** (59) 4:23 5:2 6:2 7:12  
 11:1 20:10 23:11 24:17  
 29:11 30:2 33:13 48:17  
 50:12 54:24 61:18 62:3  
 68:21,25,25 70:3,8,13,15  
 71:2 78:1 85:7 89:1 94:7  
 95:2 104:21 105:20,23,25  
 107:6,13,15 110:1,18,25  
 111:11 112:10,13,15,19  
 113:2 114:15 119:9 123:11  
 132:13 134:13 141:4  
 150:15,17 154:5 157:4,4  
 158:24 165:23 167:10  
**intranet** (1) 42:20  
**intravenous** (1) 33:14  
**introduce** (1) 87:14  
**introduction** (1) 151:25  
**investigations** (1) 133:16  
**involutarily** (3)  
 168:12,13,19  
**involved** (5) 2:1 24:23  
 131:17 132:1 133:12  
**involvement** (2) 87:4 154:14  
**irritation** (1) 147:18  
**isae** (1) 102:20  
**isnt** (8) 23:2 24:10 34:23  
 43:19 46:1 78:6,8 171:21  
**isolated** (2) 60:16 145:18  
**isolating** (2) 133:23 168:10  
**isolation** (6) 33:13 135:7  
 145:5,10,18 152:7  
**issued** (5) 26:8 98:17 99:1  
 100:9 104:14  
**issues** (29) 2:21 12:25  
 17:5,24 21:18,20 29:8  
 40:5,14 41:13 44:10 54:2  
 55:24 56:8,9 58:19 61:1  
 62:11,13 63:3 66:16 73:15  
 93:3 104:8 105:5,10 111:7  
 120:20 146:18  
**italy** (1) 93:7  
**item** (1) 5:11  
**items** (1) 4:5  
**its** (88) 9:20 10:14 17:18  
 21:14 23:9,14 26:23 29:18  
 30:23 33:1 51:22 56:7  
 60:12,17 63:12 74:5 77:8  
 78:4 81:2,14  
 87:1,9,13,19,22 88:16

89:10,20 91:11 94:1  
 102:19 103:14 118:13  
 120:8 125:12,13 126:25  
 127:21 128:9,13 129:16  
 133:7,9,15,19 138:22  
 139:21 140:8 141:9  
 142:12,15,22,25  
 144:13,15,23,23,25  
 147:9,19 149:4 150:24,24  
 151:1 154:8,25  
 155:1,1,6,7,8 156:2,18  
 159:17,19 162:22,23,25  
 163:11 164:12,23 165:3,14  
 168:9,10,21,22 172:22  
**itself** (1) 53:16  
**iv** (2) 33:17,24  
**ive** (5) 1:19 82:25 107:3  
 157:10 171:1  
**ivory** (1) 142:3

---

**J**

---

**james** (9) 100:3  
 101:1,1,19,20,20  
 117:11,11,13  
**janitors** (1) 84:19  
**january** (4) 1:20,21 92:19  
 154:13  
**jekyll** (1) 154:25  
**job** (4) 47:24 102:13 103:13  
 109:22  
**jobs** (2) 13:8 122:13  
**joined** (1) 1:21  
**judgment** (4) 16:9,15,16,23  
**july** (5) 31:4 56:22 58:11  
 115:18 126:25  
**julyaugust** (1) 106:17  
**june** (9) 82:16 126:25 154:13  
 156:17 158:2 159:10  
 174:1,3,6  
**justified** (1) 30:6  
**justify** (2) 16:17,19

---

**K**

---

**keen** (1) 25:10  
**keep** (11) 7:22 12:24 38:7  
 55:8 56:5 60:16,24 61:19  
 62:24 74:4 105:18  
**keeping** (5) 63:25 66:10  
 128:3,10,13  
**kept** (7) 71:17 74:1 126:14  
 134:6,7,11 161:21  
**key** (8) 29:10,11,13,15,19  
 40:14 46:10 127:2  
**kid** (2) 142:11 144:23  
**kids** (5) 130:8 153:12 154:3  
 164:24 167:3  
**kill** (1) 36:22  
**kind** (15) 5:16 7:20 25:17  
 56:14 63:8 65:25 73:6  
 74:4,5 76:8 83:7 88:10  
 129:18 154:8 168:7  
**kindly** (1) 59:6  
**knew** (15) 7:15 31:19 36:15  
 74:24 77:4 82:16 88:11  
 98:22 103:5 106:14 139:24  
 140:21 153:25 158:5  
 171:19  
**knife** (1) 164:21  
**knocked** (1) 135:2  
**knockon** (3) 19:14,19 24:14  
**know** (134) 7:10 9:6 10:13  
 11:1,12,23 12:12 14:23  
 15:20 16:6,11,25 21:14  
 22:21,25 23:3,10 26:1  
 30:15,22 36:14,21 37:10  
 41:13 42:15 43:24,24  
 44:21 45:9 51:20  
 60:12,19,21 61:3 63:8,18  
 64:15,16,24 65:5,5,19  
 66:10 70:11 71:17 72:9  
 73:5,8,25 74:2,4,6 78:25  
 81:1,1,25 82:21 85:9 86:1  
 87:21 88:23 89:16 94:23  
 95:15 108:18 111:10,15  
 120:19 123:14 125:6

126:19 128:7,14 129:11  
 131:13 133:11 134:9  
 136:6,8  
 137:1,9,12,18,18,21  
 138:10,11,23 139:13,22  
 140:24 141:2 142:8 143:20  
 144:3,21,23 145:22 146:25  
 147:2,2,3 149:9,20,21  
 153:19,21 154:6 155:3  
 156:1,8,8,11,20 157:11  
 158:20,22 159:22 160:18  
 161:23 162:18,19,25  
 164:13,20,21,23  
 168:7,21,22 169:6,11  
 170:4 171:8 172:9,13  
**knowing** (1) 87:11  
**knowledge** (7) 16:22 39:7  
 96:17 100:6 121:1 131:24  
 134:6  
**known** (5) 1:25 32:9 130:11  
 142:6,6

---

**L**

---

**labour** (1) 83:24  
**lack** (12) 17:4 19:6 20:24  
 42:4,10 43:18 72:3 73:2  
 75:13 82:18 83:12 103:1  
**language** (3) 9:24 20:20  
 147:12  
**laptop** (1) 10:14  
**larbert** (1) 33:2  
**large** (1) 32:19  
**largely** (2) 132:17 159:4  
**larger** (1) 11:13  
**last** (15) 126:1,1,6,7,18  
 129:10,23,24 130:6,16  
 131:21 132:6,7 140:21  
 143:10  
**lasted** (2) 147:1 149:5  
**later** (20) 8:11 28:21 32:15  
 33:12 56:24 64:18 75:1  
 77:13,16 78:6,7 99:21  
 100:14 106:4 112:19  
 137:7,24 140:18 144:20  
 146:6  
**latter** (1) 115:14  
**laughing** (1) 139:19  
**lay** (1) 92:7  
**lazy** (1) 162:23  
**lead** (2) 20:24 129:11  
**leader** (1) 130:8  
**leading** (1) 173:7  
**learn** (3) 9:23 87:17 127:15  
**learned** (14) 4:17 73:20  
 86:11,13,15,19 88:21  
 89:17 93:5,8 127:13,13  
 171:4,6  
**learning** (4) 10:1 20:9 39:22  
 92:25  
**learnt** (1) 127:23  
**least** (2) 39:8 68:6  
**leave** (20) 23:3 59:3 72:10  
 77:4,6 79:16 80:13,17,19  
 81:12 84:6,11,13 114:21  
 115:4 117:1 165:23 168:14  
 169:9,11  
**leaves** (1) 31:2  
**leaving** (1) 17:21  
**led** (7) 6:5 17:5,15 54:8  
 66:14 118:7 173:22  
**leeway** (1) 16:9  
**left** (10) 17:14 22:13 23:23  
 24:3 55:18 59:16 80:12  
 85:14 92:7 121:12  
**leg** (1) 11:18  
**legal** (2) 167:9,12  
**length** (5) 100:1 103:21,22  
 105:18 121:15  
**lengthy** (4) 130:12 133:9  
 163:11 173:15  
**less** (6) 75:25 78:25 81:20  
 92:12 109:12 159:12  
**lession** (1) 127:16  
**lessons** (11) 86:9,12,15,18  
 88:21 89:17 127:6,13  
 135:20 171:4,5

**let** (3) 11:22 57:18 138:25  
**lethargic** (1) 143:18  
**lets** (1) 160:24  
**letter** (6) 31:15,16,17  
 32:1,15 43:13  
**letters** (2) 35:1 80:15  
**letting** (1) 51:20  
**level** (17) 14:7,8 16:25 18:24  
 23:14 25:22 28:10  
 29:13,15,19 30:8 34:13  
 36:8 37:2,20,25 40:1  
**levels** (6) 38:16  
 124:12,15,18,19 131:18  
**lied** (2) 15:2,13  
**life** (10) 6:18 19:7 72:25  
 73:8 84:3 136:16  
 144:12,23 157:15 158:25  
**lifealtering** (1) 19:12  
**lifechanging** (1) 19:13  
**lifting** (1) 75:19  
**lifts** (1) 93:20  
**light** (2) 144:16 159:18  
**lighter** (1) 75:6  
**lightly** (1) 139:13  
**like** (104) 2:6,23 4:3 16:15  
 17:22 23:3,25 27:13 28:11  
 39:3 42:21 46:8 50:8,13,15  
 51:2,5,18,22 54:22 55:19  
 56:15 58:3 59:14 61:8  
 64:10,10,12 65:17 68:23  
 71:21,25 72:22 74:23  
 75:19 76:23 77:9 79:23,24  
 80:16 81:2,7,8 82:21  
 83:5,14,19  
 84:9,13,13,17,23 85:9  
 86:10,10 87:19,23  
 89:12,14,19 93:18,25  
 94:1,8 100:5,11 102:8  
 103:23 107:20 108:15  
 109:9,15 111:10 112:20  
 113:12 115:14 119:6,7,17  
 120:1 124:1 127:4,13  
 128:4,5,23 135:1 137:19  
 141:6,17 142:23 143:25  
 149:3 154:23 159:14,19  
 162:1 163:14 164:20 165:5  
 169:16 170:6 172:12 173:7  
**liked** (1) 136:9  
**likely** (2) 41:4 78:7  
**limited** (7) 5:5 27:14,16  
 28:4,17 42:7 75:21  
**line** (3) 25:21 34:6 45:21  
**linear** (1) 168:21  
**lines** (3) 21:3 22:10 25:5  
**linked** (1) 140:8  
**list** (4) 31:7,19,23 32:6  
**listening** (1) 86:24  
**literally** (1) 158:18  
**litteral** (40) 3:17 6:20 8:6,21  
 9:4 11:11 15:22 21:7  
 22:11,16 24:7,16 27:8 41:9  
 50:15 52:21 54:13 64:18  
 74:24 75:1 76:2,3,20 78:16  
 82:13 84:18 85:20 103:17  
 106:4 108:2 129:7 131:13  
 133:21 135:11 139:3  
 141:17 142:1 144:22  
 154:20 159:13  
**live** (3) 96:8,9 167:21  
**lived** (1) 126:22  
**livelihood** (1) 27:25  
**livelihoods** (1) 25:25  
**lives** (1) 17:17  
**living** (4) 9:22 29:23 61:3  
 126:21  
**local** (1) 33:5  
**lock** (1) 158:18  
**lockdown** (54) 3:13 5:24  
 6:11,14 13:20 39:19  
 52:16,23 56:21,21,24  
 57:17 58:10 64:6,7 71:5,7  
 73:18 82:6,9 86:5 94:17  
 96:25 106:5,12,19 107:6  
 108:3 112:11 115:11 116:4  
 119:6,17,16 120:3,8,9,10  
 122:12 123:10,12

126:2,4,5,9,12,13,24  
 128:1,2 134:4,13,18  
 150:21  
**lockdowns** (1) 106:10  
**locked** (3) 12:24 54:24 55:15  
**logically** (1) 14:13  
**lone** (1) 13:1  
**long** (33) 5:13 13:10 38:15  
 79:22 83:25 84:21 108:21  
 109:21 112:4 115:1 125:8  
 130:8 131:2,22 134:11  
 144:18,20 149:5 153:7,12  
 154:16 155:14 156:9,13  
 158:14 164:24 166:16,20  
 167:4,6 169:22 170:1  
 173:8  
**longer** (8) 8:14 17:22 19:13  
 52:13 99:23 110:24 124:5  
 126:23  
**longest** (1) 14:14  
**longterm** (3) 124:13,15  
 169:24  
**look** (12) 9:6 30:16,20 37:13  
 48:12 88:6 92:24 105:19  
 124:15 133:20 149:1  
 152:10  
**looking** (3) 73:1 143:25  
 159:14  
**looking** (15) 11:14,17,18,20  
 25:15 26:6 30:24 32:19  
 37:11,12 65:1 77:4 89:8  
 128:10 135:3  
**lordship** (1) 173:20  
**lose** (2) 11:16 141:11  
**losing** (1) 84:23  
**lost** (10) 2:21 11:15,22 13:8  
 26:1 39:23 40:8 168:6,6  
 146:3  
**lot** (39) 9:18 11:2,15 18:7  
 20:5 25:1,23 27:5 36:19  
 52:17 53:10 59:3 61:24  
 62:20 63:4 65:5,5 70:14  
 71:15 75:14 77:20 78:16  
 80:12 81:20 87:10,12,21  
 88:23 89:1,3 108:12,16  
 109:5,5 116:1 124:14  
 135:21 166:17  
**lots** (4) 24:16 25:2 108:14  
 110:2  
**louder** (1) 170:3  
**loved** (2) 135:19,21  
**lovely** (1) 136:8  
**lower** (3) 17:10 75:24 169:10  
**lowered** (1) 169:2  
**luck** (1) 81:11  
**luckily** (2) 15:20 144:18  
**lucky** (1) 143:20  
**ludicrous** (1) 165:14  
**lunch** (3) 38:19,19,21  
**luncheon** (1) 90:10

---

**M**

---

**main** (2) 92:4 135:22  
**mainly** (1) 62:22  
**maintain** (1) 117:17  
**makes** (1) 35:24  
**making** (14) 11:1 22:17 35:4  
 36:17 37:10 55:20  
 65:22,23 145:17 154:7  
 159:20 164:25 165:14,21  
**maliciousness** (1) 44:1  
**man** (1) 38:9  
**manage** (4) 59:23 60:23  
 67:23 143:23  
**managed** (3) 161:14,15  
 162:3  
**management** (35) 24:25  
 51:13,14,19,24 52:8,14,24  
 53:10 56:17 57:4 59:5  
 60:15,24 61:19  
 62:1,3,19,21 63:5 73:24  
 74:4,20,21 75:13 76:8  
 79:4,7 101:4,10,17 104:3  
 123:24,25 128:7  
**managements** (1) 116:18  
**manager** (12) 68:12 69:2  
 81:4,5 99:17 100:12 101:6

118:13 119:17,21 120:12  
 121:9  
**managers** (3) 100:10,10  
 108:17  
**managing** (2) 6:19 60:6  
**mandatory** (1) 24:13  
**manifestations** (1) 156:3  
**manned** (1) 12:23  
**manner**



14:8,12,14 16:21 17:1  
19:11,18 22:3,4,10,12  
32:25 37:23 109:12,13,15  
121:1 128:7 131:17 142:11  
149:7,14 154:12 156:16,22  
163:17  
**medically (2)** 14:6 164:7  
**medication (2)** 31:11,11  
**medicine (1)** 109:16  
**meet (6)** 2:16 8:9 15:6  
16:19,23 43:15  
**meeting (10)** 81:4 99:17  
100:8,11,24 101:8,9,25  
165:13,23  
**meetings (4)** 24:24 25:3  
99:17 124:1  
**melt-down (1)** 160:17  
**melt-downs (2)** 158:16  
160:14  
**member (10)** 2:1 56:9,11,16  
63:11 65:13 102:1  
116:21,23 141:20  
**members (21)** 25:11 26:22  
27:3 30:17 38:21,25 51:17  
62:14,23 63:6 65:25 67:23  
73:4,13 105:4 107:4  
118:21 119:9 123:25  
131:15 149:24  
**memory (1)** 141:4  
**meningitis (1)** 137:8  
**mental (8)** 72:17 73:9 76:13  
89:1 124:25 125:5,7  
152:17  
**mention (6)** 46:8 53:10  
121:19 150:8 161:2 167:17  
**mentioned (6)** 6:24 7:24  
10:2 22:15 23:18 57:24  
**message (1)** 21:21  
**messages (1)** 80:16  
**met (5)** 34:10 81:5 150:22  
165:11,11  
**method (1)** 33:14  
**metres (2)** 38:24 118:12  
**mid (1)** 160:17  
**night (24)** 5:11 11:6,12,17  
17:8 18:1 21:14,15 30:17  
52:21 59:19 68:21 73:5  
76:6 96:11 100:21 102:7  
118:16 137:16 141:11  
162:24 168:7 170:19  
172:14  
**mild (3)** 134:21 135:10 139:9  
**milder (1)** 135:4  
**mind (5)** 84:23 121:12  
139:18 142:24 165:21  
**mindful (2)** 133:2,4  
**minds (1)** 101:5  
**mingle (1)** 125:14  
**mingling (1)** 125:14  
**minimised (2)** 105:1 151:20  
**minimum (2)** 28:20,23  
**minister (2)** 35:4,13  
**minor (2)** 2:23 24:1  
**minute (2)** 154:22,23  
**minutes (4)** 12:3,4,14 79:23  
**missed (1)** 40:14  
**misses (1)** 135:23  
**mistakes (1)** 87:17  
**mistaking (1)** 140:2  
**mstmm (3)** 150:1 152:2  
153:3  
**mobile (1)** 25:5  
**mobility (3)** 18:3 162:7,21  
**modifying (1)** 32:9  
**module (1)** 64:11  
**moment (12)** 41:5 74:3 87:7  
96:20,23 98:25 100:18  
107:20 148:5 153:15,15,17  
**monday (3)** 6:12,14 33:8  
**money (1)** 67:12  
**month (5)** 9:11 33:22 112:19  
122:7 137:19  
**months (11)** 5:13 19:22  
38:17 39:24 71:19 99:15  
148:8 153:18 158:14  
162:18 173:9

**more (70)** 2:20 7:25 8:21  
10:18 11:14 13:6 15:22  
17:5,6 18:7 20:21 21:4  
23:18,23 24:15 32:10  
34:12 36:6,7,15 44:13  
50:10,11,11 52:17,18,18  
53:13 55:1,5 57:4,19,25  
58:5 59:13 64:15 66:18  
67:18 71:5 74:24 75:14  
76:1,1,2,3,20 78:16,24  
81:14,19 82:13 89:1,3,6  
92:12 105:3 107:8 110:15  
118:22 120:10 123:16  
124:22 146:7 152:1 159:13  
163:21 164:13 166:8  
167:10 171:17  
**morning (14)** 1:3,4,5,10,11  
33:6,8 46:21,22 47:6,7  
77:9 101:15 111:4  
**mortgage (1)** 77:6  
**mortality (18)** 111:24  
112:3,5,9  
113:10,11,11,15,17,24,25  
114:9,10,11,11,12,15 115:3  
**most (14)** 3:10,23 29:12  
41:4 48:2 56:21 89:15  
92:22 96:6 109:17 111:1  
121:16 135:23 145:14  
**mostly (1)** 168:13  
**mothers (1)** 89:7  
**motor (1)** 41:7  
**mouth (1)** 110:18  
**move (8)** 63:24 93:3 107:21  
111:17 143:3,4 152:23  
156:15  
**moved (4)** 10:2 36:2,2  
104:23  
**moving (2)** 95:2 111:22  
**mri (1)** 84:20  
**msa (2)** 94:13 105:16  
**msa (24)** 1:3,4,13,13,14,16,17  
100:20,20 129:25  
130:1,5,15 131:9 133:11  
148:24 149:17 158:25  
165:25 169:15 172:9,19  
173:1 175:2  
**much (3)** 5:23 6:19 13:9  
16:9 18:19 29:1  
46:14,15,17 54:23 59:21  
61:20 64:9 78:4 89:13,21  
90:2,3 129:6,18 135:6  
138:9 145:14 146:7 151:16  
164:17 168:6 172:18,23  
173:2,19  
**multiple (1)** 2:9  
**multisystem (1)** 140:7  
**multis (3)** 85:24 126:22,22  
**munchausens (2)** 163:18  
164:3  
**must (4)** 16:11 32:8 70:18  
80:15  
**myself (17)** 8:15 27:13  
31:8,21 34:11 39:25  
51:16,19 55:16 68:19,19  
74:9 102:16 144:17 154:7  
158:18 172:17

**N**

**nae (6)** 95:6 102:14 115:16  
118:11 120:3  
**name (7)** 4:7,9 18:6  
**name (7)** 65:3 84:19 90:25  
131:10,15,19 157:20  
**named (1)** 140:7  
**names (1)** 142:23  
**narrative (2)** 132:14,17  
**national (2)** 86:21 87:14  
**nations (3)** 42:14 122:15,20  
**natural (1)** 84:8  
**naturally (1)** 75:5  
**near (4)** 93:22 105:2 110:10  
142:9  
**nearly (2)** 56:12 161:19  
**necessarily (2)** 170:13,15  
**necessary (5)** 7:22,22 20:25  
133:7 144:25

**need (50)** 10:4,12 14:12,25  
15:1 19:8 21:19 23:19  
24:10 51:21 52:1,8,14 56:5  
57:11 65:13 73:16 80:1  
86:23 87:7,8 89:1,8 93:22  
99:7,23 100:13 101:13,17  
102:15,17,19 103:3,4  
107:23,24 110:13,13  
114:13,14,14,16 123:23  
138:24 140:3 156:21  
167:10 169:9 172:19 173:1  
**needed (19)** 2:15,18,25 3:25  
53:14 55:1 59:1 79:16 83:1  
84:14 85:10 104:25  
108:23,23 127:16,17,17,24  
151:6  
**needing (2)** 57:23 103:18  
**needs (14)** 2:19 8:6,8 15:2  
20:9,10 25:12 41:4 60:19  
62:6 75:14 85:9 89:3,5  
**negative (1)** 20:21  
**neglected (1)** 85:9  
**neil (4)** 90:14,22 91:2 175:4  
**neither (1)** 30:14  
**nervewracking (2)** 36:12,20  
**nervous (2)** 40:16 51:17  
**network (2)** 25:11 45:1  
**neuropsychiatric (1)** 154:19  
**never (19)** 45:8 64:2,8 81:5  
96:17,18 97:4,21  
104:19,21,25 105:14  
117:18 121:12 162:2 164:5  
165:11,11 168:21  
**news (7)** 50:9 52:19 57:24  
156:15  
**next (20)** 6:8 26:2 46:22  
59:20 63:24 90:4,5  
95:21,23,24 101:14 111:20  
121:18 129:8,9 137:2,5  
146:8 154:23 173:24  
**nhs (47)** 2:16 3:2,15,16 6:2  
7:8,8 17:4  
18:10,11,15,21,23 19:4  
21:3 23:15,21 29:13,14  
30:5,9,10 42:5,8,16,20,24  
43:9,9,11,12,22 44:8,9,19  
45:6,17 138:3,11 141:22  
142:9 154:12 155:13  
157:17 166:10 167:9,13  
**nhss (1)** 124:6  
**night (15)** 6:14 26:19,22  
33:7 54:9,11  
55:9,10,10,17,20 99:21  
100:15 101:12 137:2  
**nights (1)** 55:14  
**nine (3)** 65:6 70:12 153:18  
**nobody (2)** 6:19,20  
**noise (3)** 40:4 144:16 160:1  
**none (2)** 94:9 145:18  
**nonessential (3)** 6:4,6,12  
**nonexecutive (1)** 1:25 24:21  
**normal (16)** 17:4 27:6 61:2  
95:24,24 106:25 107:1,1  
110:9,10 116:20 123:14,16  
124:19 136:2,4  
**normality (2)** 123:3,6  
**normally (5)** 10:12 18:1 83:4  
94:12 112:4  
**norovirus (1)** 51:3  
**nose (1)** 38:4  
**noses (1)** 36:15  
**note (1)** 132:25  
**noted (2)** 19:9 34:5  
**notes (1)** 165:12  
**nothing (8)** 83:5 103:5 144:1  
148:1,16 152:1 157:10  
158:11  
**notice (3)** 11:6,12 17:7  
**noticed (2)** 39:23 40:5  
**noticing (1)** 11:10  
**notification (2)** 33:4 35:6  
**notifies (1)** 74:20  
**onus (1)** 23:13  
**notify (1)** 67:5  
**notifying (1)** 68:16  
**november (8)** 56:25  
106:7,9,18 119:12 121:22

130:6 152:18  
**number (17)** 1:8 6:21 32:19  
33:6 42:22 45:11 89:12  
92:23 107:16 122:12  
127:7,8 128:18 131:17  
144:6 160:8 163:15  
**numbers (2)** 42:19 106:23  
**numerous (1)** 152:25  
**nurse (5)** 48:21 77:17  
78:1,25 102:18  
**nursery (3)** 39:18,23 40:3  
**nurses (2)** 43:19 96:14  
**nursing (3)** 18:24 48:10  
98:11

**O**

**observation (1)** 163:10  
**obtain (2)** 15:2 140:13  
**obtaining (1)** 140:19  
**obvious (1)** 144:11  
**obviously (47)** 50:6,15 52:18  
55:2 56:6,13 59:1,5,21  
61:21 67:6,17 68:20 70:15  
71:8 72:25 73:24 74:17  
79:25 82:15 85:20 95:8,18  
96:4 101:1,4 103:5 105:9  
108:15 109:5 117:11  
122:16,25 124:6 125:10  
126:2,9,10 128:5  
130:11,23 132:16 133:10  
148:20 149:7 167:23 171:5  
**occasion (2)** 4:25 130:16  
**occasionally (1)** 135:21  
**occasions (1)** 163:16  
**occurrences (1)** 163:16  
**occupational (16)** 42:25  
43:1,4,5 117:1,2,7,9,15  
119:23 120:14 127:10,11  
128:5,16 163:3  
**occurred (2)** 43:25 150:12  
**oclock (2)** 26:17,18  
**occonnell (2)** 100:20 117:13  
**october (4)** 116:5 118:25,25  
119:12  
**offer (5)** 10:9 14:10 23:15  
34:14 97:4  
**offered (11)** 6:9 8:25 19:1  
41:2 63:16 64:12  
97:1,7,14,18,25  
**offering (1)** 56:25  
**officer (5)** 1:7,23 64:18  
65:4,8  
**official (1)** 28:22  
**officially (1)** 49:13  
**offsite (2)** 116:24 118:7  
**often (15)** 4:16 11:19 13:23  
15:20 18:23 25:14 34:23  
35:19 43:22 44:15 106:14  
144:18,21,21 160:16  
**oh (20)** 9:4 30:16 32:16  
35:24 63:12 135:6,19  
136:15 137:8 138:14  
139:14 142:23 146:25  
147:1 154:6,21 158:14  
161:1 162:1 167:2  
**ohara (1)** 100:20  
**okay (17)** 22:2 24:9 52:20  
57:11 69:5 119:18 121:15  
135:3 136:11 137:10 143:3  
146:8 150:7 159:5 160:20  
165:6 166:19  
**old (1)** 135:24  
**older (2)** 10:3,6  
**once (8)** 3:4 5:20 15:3 17:3  
36:9 86:4 88:6 89:23  
**ones (7)** 4:13 62:25 63:1  
78:15,19 103:2 167:3  
**ongoing (3)** 133:3 167:9  
168:17  
**online (6)** 47:16 83:6 91:10  
159:22 160:2 165:13  
**onset (1)** 139:6  
**onus (1)** 23:13  
**onwards (5)** 80:5 82:6  
151:24 152:13 163:9  
**open (6)** 6:17 21:4 30:9  
38:22 94:7 96:1

**P**

**opened (2)** 30:15 95:22  
**openminded (2)** 154:16,17  
**operated (1)** 28:4  
**operating (1)** 45:8  
**operation (1)** 13:22  
**opinion (9)** 25:8,9 42:10  
85:3 112:8 120:18 122:2  
163:3 170:14  
**opinions (1)** 35:22  
**opportunity (4)** 39:21 91:15  
80:5 81:17 82:6,9 87:25  
**opposed (1)** 36:1  
**opticians (1)** 43:21  
**option (2)** 10:10 24:5  
**oral (2)** 33:25 46:6  
**order (14)** 3:14 4:16 5:7  
14:13 16:12 46:23 47:9  
53:13 85:19 87:2  
105:12,17,18 135:11  
**orders (2)** 4:11,13  
**ordinarily (1)** 24:8  
**organisation (6)** 1:25 2:2 7:9  
26:21 27:1 130:7  
**organisations (1)** 141:21  
**organised (1)** 92:23  
**organising (1)** 100:24  
**original (1)** 32:4  
**others (8)** 15:22 21:19 29:22  
42:3 62:15 66:13 96:23  
125:6  
**ourselves (3)** 15:9 20:14  
37:17  
**outbreak (5)** 49:20 51:11  
93:6 108:2 112:10  
**outcomes (1)** 155:11  
**outset (2)** 49:21 146:20  
**outside (4)** 27:6 39:6 84:4  
163:1  
**over (18)** 8:25 28:6 37:18  
47:25 52:13 54:13 64:4  
69:23 91:15 119:7 132:6  
134:16,18 139:15 148:24  
151:6 164:15 171:1  
**overanxious (2)** 151:11,14  
**overreacting (1)** 151:13  
**overrule (2)** 27:2 108:7  
**overwhelmed (1)** 40:7  
**overwhelming (1)** 160:3  
**own (43)** 1:19 2:15,20 8:9  
14:22 19:9 21:1,5 23:7,14  
25:4 28:3 30:12 34:8,16  
36:25 38:25 44:5,22 45:24  
52:2,3 54:5 58:17 59:13  
61:5 63:21 66:8 71:24  
74:22,25 75:2,17 76:13  
81:21 82:3,10,23 86:25  
125:5 126:21 131:24 133:3  
**owned (2)** 28:4 105:23  
**owner (1)** 25:9  
**oxygen (2)** 104:21 140:1

**papers (5)** 144:20 154:20,21  
155:1 159:11  
**paper (2)** 74:21 165:17  
**paragraph (110)** 6:24 8:24  
12:1 13:11 31:1 34:20  
39:12 41:21 42:7 48:6,12  
49:3 50:20 52:22,24 53:25  
56:8 58:6 62:11 64:1 68:3  
69:22 70:2 71:23 72:13,16  
74:13 75:5 77:14 78:21  
80:5 81:17 82:6,9 87:25  
92:3 93:11 94:3,11,25  
95:3,10,21 96:10,25 97:24  
99:8,16 101:24 102:11  
103:17,17 104:8,12 105:5  
106:4 108:4 109:11,20  
115:19 116:9 117:17  
118:6,24 120:16 121:5  
125:20 128:19 134:5,20  
135:12 136:11 140:5,14  
141:12,18 142:17  
143:9,9,10,12 144:5,25  
147:13 150:7 151:5,18,23  
152:15 153:9 154:12,14  
155:9 156:18 157:19 160:8  
161:2 162:11 163:9,21  
166:1,1,11,12,14  
167:16,17 168:11 169:16  
170:7  
**paragraphs (7)** 54:7,14 76:11  
123:20 133:8 143:5 146:9  
**paralegals (1)** 173:12  
**pardon (1)** 148:7  
**part (2)** 151:11,14  
**parents (3)** 142:1,14,19  
**park (2)** 161:4 162:3  
**parlor (1)** 114:16  
**part (11)** 28:14 51:4 58:22  
75:22 86:6 114:2 132:2  
160:7 166:17 173:23  
**parties (1)** 37:11  
**particular (6)** 22:2 35:21  
36:2 135:15 158:8 171:17  
**partly (2)** 75:11 109:11  
**partner (6)** 80:21 84:11 96:9  
134:2,22 159:1  
**partnerships (1)** 27:14  
**parts (4)** 11:19 86:12 137:7  
156:20  
**pass (3)** 71:18 73:5 109:21  
**passage (1)** 133:9  
**passed (5)** 70:21,23 121:24  
122:1 171:1  
**passes (1)** 32:7  
**passing (3)** 71:20 72:23  
122:9  
**past (5)** 26:20 45:4 135:16  
150:22 164:15  
**patient (63)** 9:24 11:23  
12:15 16:17 17:11 28:1  
32:3 36:25 37:10,20 39:9  
85:8 93:13,14,14,16,20,22  
94:4,13,14,15,21,23  
95:11,16,17 96:2,3  
97:20,22  
98:1,3,4,5,10,12,13,15,18,21  
99:5,21 100:14 101:23  
103:14 106:13 110:23  
111:24 112:1,17,22 113:15  
114:15,21 115:5,5 121:14  
127:5,17,20,21,21  
**patients (92)** 3:25 6:6  
7:23,25 8:1,13,14,14,20  
9:17 10:3,6,7 12:10  
13:13,20,25  
14:2,5,7,9,15,19,25  
15:2,12,18,24 19:10,20,23  
20:7,9 21:5,23 22:7  
27:21,23 36:16 37:23 39:9  
44:14 69:19 70:3,6,10  
71:19 92:4 95:4 96:2,2  
98:6,22 99:25 103:19  
104:20,22,23

105:2,15,16,23 106:24,25  
107:1,2,8,14 108:19  
109:5,6,16 110:4,15,25  
111:1,18,23 112:12,14,22  
113:1,3,8 114:7 116:11  
117:9,14 118:21 121:14  
127:3  
**patterns (3)** 108:1,1,25  
**pay (19)** 15:14 18:17  
28:10,20 53:16  
66:16,19,23  
67:2,7,10,10,22,23 77:6  
78:14,19 157:16  
**paycheck (2)** 167:21,21  
**paying (1)** 12:7  
**payment (1)** 28:6  
**payslips (2)** 43:11,11  
**pediatric (2)** 154:19 157:24  
**pediatrician (4)** 152:24  
153:2 154:15 155:20  
**pediatrics (6)** 151:24  
**pediatric organisation (1)** 163:3  
**penny (2)** 157:13 158:5  
**penney (116)** 2:14,18 6:21  
8:7 9:16 13:7 14:23 15:23  
17:21 18:4,10 19:19 19:24  
20:2,3,3,12 21:17,20 23:23  
24:2 25:10,14,17,25,25  
26:1,4,10,20 27:4 28:11  
30:16,21 32:19 34:14  
36:4,14,19,21 37:6 38:16  
39:3 40:4,8,13,17 48:25  
49:25 50:14 53:4 56:11  
60:16,21 61:3,5,17,19  
62:3,8 63:7 66:13 71:9,21  
72:5,12,14,24 73:1 75:25  
78:4 80:12,16 84:23 86:25  
87:19,23,23 88:12 100:13  
104:15 105:1,8,10  
107:12,17 108:14,22,24  
109:20,25 110:12 111:15  
114:3 115:15 119:8 120:9  
122:3,4 123:24 124:1  
125:2,7,15 133:13 142:22  
145:16 154:8 156:8 161:23  
168:7 169:12,13,13 170:2  
**per (7)** 5:5 28:6,12,23 108:6  
124:16 156:8  
**perceived (2)** 14:7 16:25  
**percentage (1)** 124:14  
**percentile (1)** 41:7  
**perception (2)** 19:17 30:7  
**perform (1)** 2:23  
**performance (1)** 28:22  
**perhaps (7)** 21:5 26:21 143:8  
145:17 160:7 170:19 172:6  
**period (29)** 3:18 28:7,13  
52:13 58:11 64:4 83:24  
95:3 106:17,21,22 109:21  
115:7,8 118:2 120:5,19  
121:24 132:17 139:6  
143:4,16 146:8,10 163:9  
166:2 169:14 173:8  
**periods (2)** 94:25 132:16  
**permitted (1)** 22:19  
**perplexing (1)** 164:6  
**person (22)** 9:13,22 10:25  
11:4,15 14:13 17:17 23:5,5  
24:16 38:23 60:19 63:9  
65:15 96:7 112:4  
113:21,24 119:

phoned (1) 101:19  
 phoning (2) 77:20 117:11  
 photo (1) 43:15  
 photograph (1) 9:9  
 photographs (3) 9:11 10:12 35:23  
 physical (4) 43:13 146:5 160:15 163:4  
 physically (3) 23:4 132:2 144:17  
 physiotherapists (1) 43:20  
 pick (5) 20:20 65:3 81:25 84:16 163:14  
 picked (3) 21:20 40:18 41:11  
 picking (1) 81:21  
 picture (3) 8:11 9:17 11:22  
 pictures (4) 9:19 10:15 20:8,14  
 piece (1) 173:15  
 pims (1) 147:5  
 pinsts (2) 140:9 141:24  
 pinafore (2) 51:1 59:16  
 pinafores (5) 58:20,22,24 59:6,13  
 place (20) 2:8 3:5 5:21 11:25 20:11 22:22 32:5 37:18 49:5 62:7 65:18 76:14,15,16,17 87:16 88:8 119:13 123:1 157:23  
 placed (6) 3:11 7:7 31:6,18,23 33:16  
 places (3) 4:17 109:7 128:18  
 plan (6) 4:6,10,16 42:12 157:23 158:12  
 play (2) 40:11 135:9  
 played (1) 135:21  
 pleasant (1) 149:4  
 please (11) 1:17 14:17 32:24 34:24 52:5 131:14 142:2 143:3 147:10 150:7 154:20  
 pleased (1) 172:9  
 plummeted (1) 159:21  
 pm (7) 6:13 26:22 90:9,11 129:19,21 174:5  
 podiatrist (5) 1:5,19 9:5 17:11 20:17  
 podiatrists (12) 2:10,12 12:8 14:6 16:14 22:17 27:12 28:16,25 29:9,13 43:20  
 podiatry (15) 1:7,22,22 2:6 3:3 6:18 16:5 21:4 23:2,20 26:9 27:10 29:24 30:5,6  
 points (7) 42:19 127:7,8 145:7 163:15 166:13 169:15  
 police (2) 22:8 158:22  
 policies (11) 63:7 65:1,6,18,24 74:16,17,22 87:3 88:14,17  
 policy (3) 74:18,25 143:1  
 poolroom (1) 116:1  
 poor (2) 85:3,4  
 pop (1) 30:3  
 population (1) 21:11  
 porter (26) 90:15 91:3 92:9,14 94:12 99:22 101:25 106:6 109:21 114:23 115:21,22 116:2,19,23 117:24 121:13,20,24 122:11,4,7,9,9 123:5 128:25  
 porters (53) 84:18 92:2 96:18 97:3,5,13,18,25 98:16 99:3,4,22 101:12,21 102:15 103:11,13,18 104:17,24 105:7 108:10,13,17 109:2 110:6 111:9,17 113:24 115:4,9,12,16,25 116:1,6,10,15,15 117:6,18,22,23 118:10,18,20 119:1,2,4 120:6 124:12,18 128:11  
 portfolio (1) 173:6  
 position (11) 18:15 47:24 49:19 50:21 95:4 108:7

116:18 128:9 133:17 148:20 149:15  
 positive (26) 20:19 33:3 45:10 66:24 67:2,8 68:1,4,13 69:14 70:12 72:2,6,10,12 81:19 89:18 111:6 116:10 146:19 147:23 148:3,18 152:20,22,23  
 possibility (4) 97:15 151:12 154:17 164:22  
 possible (13) 9:13 13:23 26:15,23 27:5 60:12,20 61:20 78:5 97:24 129:13,16 142:15  
 possibly (5) 13:10 149:20 152:7 160:24 170:16  
 post (1) 136:12  
 posters (1) 56:2  
 postlockdown (1) 123:19  
 postnatal (1) 85:3  
 postpandemic (1) 123:18  
 postpartum (1) 83:22  
 posts (1) 122:17  
 potentially (2) 36:22 159:14  
 pounds (3) 12:12 157:5,6  
 ppe (8) 31:1,6,20 7:10 22:23 30:3 34:2,10 36:14,17 37:1 38:18 46:11 50:18,19,22 51:1,13,17 52:9,15,25 53:11,14,20 54:8,9,16,19,21,22 55:1,7,12,15,17 57:1,8,23 58:2,4 63:18 72:11 93:3,18 94:7,10,12,16,19,24 95:18,18,20 97:17,19,22,25 98:2,11,15,17,21 99:18,20 100:9 103:8 104:9 105:3,6,12,15,17 106:3,5,13 107:20,22,23 123:12 127:16  
 ppeclad (1) 33:13  
 practical (1) 121:4  
 practice (19) 1:6 2:6,10 5:21 6:23 11:14 12:8 21:1 23:7 29:9 37:24 38:25 42:1 43:4 44:11 112:11 113:1,20 118:6  
 practices (4) 4:12 12:12 15:25 56:25  
 practise (1) 16:1  
 practitioner (1) 45:23  
 practitioners (3) 16:1 23:13 44:20  
 pre2020 (1) 19:1  
 precautions (2) 94:2 95:1  
 preferred (1) 34:12  
 pregnancy (8) 73:15 74:19 75:18 77:13,16 78:7 79:17 82:20  
 pregnant (18) 28:8 73:17,18,20,22,23 74:1,11 75:7,17 76:16 78:2 79:14,19 82:5,15,16 161:4  
 premises (1) 23:6  
 prepandemic (4) 12:14 43:2 108:4 124:19  
 preparation (1) 129:3  
 prepare (2) 7:3 20:7  
 prepared (2) 9:8 53:16  
 preparedness (1) 7:8  
 preparing (1) 109:13  
 prescription (1) 23:4  
 prescriptions (1) 92:6  
 present (1) 153:6  
 presentation (2) 18:2 164:6  
 presented (1) 24:4  
 presenting (1) 149:2  
 preshielding (1) 38:16  
 pressing (1) 149:12  
 pressure (5) 72:18 77:7 81:20 85:5 157:1  
 pressures (1) 76:18  
 presumably (1) 145:25  
 pretty (7) 5:23 6:19 64:9

82:19 142:22,25 145:14  
 prevalence (3) 107:7 120:21 121:25  
 prevalent (1) 120:3  
 preventative (4) 16:6 17:5 19:6 20:24  
 prevention (3) 34:2 66:3 171:8  
 previous (2) 33:3 79:13  
 previously (3) 30:18 73:12 86:1  
 prices (1) 12:11  
 primary (4) 40:23,24,25 136:5  
 principally (2) 131:1 167:24  
 printing (1) 65:21  
 prior (15) 1:24 2:7,11 9:2,3,7 13:21 14:4 39:20 40:5 134:3 135:13 136:2,3 153:23  
 prioritisation (1) 103:9  
 prioritise (2) 7:25 51:24  
 prioritised (5) 69:23 75:14 85:10 89:20,21  
 prioritising (1) 75:16  
 priority (1) 29:19  
 private (30) 1:6 2:17 3:14 6:18 7:1 17:4 18:12,19 22:17 23:13,20 25:16 27:9,11 28:25 29:9,14 30:6,13 42:9,15 43:18,22 44:10,14,19 45:13 47:19 48:3,3,9 81:14 86:22,25 87:6 89:18 156:16,22 158:25  
 privately (1) 41:3  
 privileged (1) 18:15  
 probable (1) 124:22  
 probably (30) 5:17 8:20 32:15 38:17 68:16 84:3 87:12 93:7,10 98:5 105:14 107:17 109:24 112:8,9,19 114:18 115:2,5,18 116:14 117:23 119:12 123:8 124:13,14,16 126:14 127:15 160:11  
 problem (7) 58:23 78:11,12 114:25 145:22 160:10,11  
 problems (8) 3:5 56:20 63:25 66:19 73:13 103:7 122:21 162:22  
 procedure (2) 22:25 111:22  
 procedures (12) 20:6 63:7 65:2,18 74:22 87:3,16 88:1,2,5,14,17  
 proceed (2) 148:5,17  
 proceeded (1) 173:17  
 process (4) 40:12 64:22 130:24 169:5  
 processes (1) 9:10  
 processing (2) 132:8 159:21  
 produce (1) 132:2  
 produced (1) 4:20  
 production (1) 131:25  
 products (1) 4:3  
 profession (2) 15:21 19:9  
 professional (15) 9:14 16:9,14,16,22 18:10 25:8,13 26:10,11 31:10 32:17 44:23,25 149:7  
 professionals (8) 5:25 7:17 17:1 21:9 131:17 145:12,14 149:15  
 profile (1) 69:18  
 progression (1) 134:1  
 prominent (1) 3:10  
 promised (1) 170:5  
 prompted (1) 151:3  
 proof (1) 70:16  
 proper (1) 105:14  
 properly (4) 36:17 104:17 105:10 120:25  
 protect (1) 171:11  
 protecting (1) 74:9  
 protection (3) 34:13 37:21,25

protective (1) 3:11  
 protocol (4) 74:13,15,15 111:22  
 protocols (6) 23:16 45:6,15 88:2,8,18  
 proud (2) 26:24 27:2  
 provide (11) 18:16,24 29:22 30:18 39:9 72:9 73:7 78:3,4 132:14 172:21  
 provided (15) 2:13 16:13 34:17 37:20 41:9,23 89:7,9 106:6 130:11 133:25 140:15 157:18 169:22 170:25  
 provider (1) 47:23  
 providers (3) 42:21 45:18 88:13  
 providing (4) 27:25 30:11 47:8 155:11  
 provision (8) 3:3 18:25 19:5 29:11,17 41:14 55:20 96:10  
 psychologist (1) 40:20  
 psychotic (1) 158:17  
 public (18) 31:21 44:18 45:12 67:12 68:19,23 69:2,7,12 81:13,14 87:20 141:20,25 142:4,19 171:10,10  
 published (5) 21:12 47:11 91:18,21 130:19  
 pun (1) 26:13  
 punished (1) 63:2  
 purchase (1) 53:14  
 purely (1) 12:13  
 purpose (1) 59:8  
 purposes (1) 130:12  
 push (2) 117:8 127:3  
 pushed (2) 96:3 150:14  
 pushing (4) 103:19 117:14 121:13 150:18  
 putting (7) 27:24 36:24 65:22 77:2 110:18 113:18 173:14

106:4,9,16,21 107:11,19,25 108:9,24 109:11,20 110:3,6,9,15 111:7,13,15,20 112:4,7,10,18,20,23 113:1,5,20,24 114:2,9,23 115:7,9,19 116:4,9,17,25 117:5,13,17 118:1,6,22 119:4,13,20,23 120:5,8,14,16 121:2,4,18,22 122:3,6,10,21 123:2,5,9,18 124:12,18,21,24 125:2,18 126:4,6,8,17,21 127:6 128:1,12,17 129:2 130:5,10,23 131:7,9,12,24 132:11,20 133:19 134:11,14,16,18,20 135:3,11,18 136:1,11 138:2 139:1,3,10,12,17 140:5,13,18 141:12,17 142:13,17,24 143:3 144:5,11,25 145:25 146:3,5,8,18 150:2,4,7 151:3,8,18 152:3,5,15,24 153:4,8 154:11 155:9,17,19,24 156:1,5,15 157:3,7,19 158:1,24 159:3,5,9 160:7,24 161:2 162:10 163:9 165:2,4,6,19,25 166:9 167:1,7,15,21,23 168:2,4,11,16 169:14 170:6,11,15,25 171:20,22,24 172:19  
 qualification (1) 65:11  
 qualifications (1) 121:2  
 qualified (4) 30:14 119:23 127:12 140:16  
 qualify (1) 16:12  
 quality (1) 157:15  
 quarter (2) 129:11,12  
 reasonable (2) 8:13 141:1  
 reason (8) 13:14 114:2,19,20 124:5 125:11 139:24 141:1  
 reasons (2) 8:13 141:1  
 reasonably (1) 153:5  
 reasons (2) 37:23 171:2  
 reassure (1) 25:24  
 receive (6) 27:24 31:8,16,17 33:17 41:18  
 received (8) 29:3 32:2,14 35:1,3,13 53:2 71:2  
 receiving (11) 17:14 54:23 70:23,24 71:1,2 94:3 101:19 136:21 137:20 159:19  
 quiet (4) 61:24 144:3,22 154:22  
 quite (68) 3:12,22 4:6,16 5:23 6:3 9:18 13:20 15:5 17:13 18:4,18 22:11 23:22 24:23 25:1 27:11 31:23,25 53:2,8,15,20,24 54:2,5,13 55:19,23 56:8,17,20,24 57:3,13 58:6,10,15,19,22 59:16,19,24 60:5,9 61:1,8,11,15 62:7,11,17 63:14,21,23 64:4,17,21 65:8,15 66:2,6,13,18 67:9,15,25 68:6,9 69:6,13,16,18,22 70:1,18,23 71:2,4,11,14,23 72:5,13,16,20 73:12,15,20 74:13 75:1,9,11,18,21 76:11,20 77:13 78:6,10,21 79:4 80:4,9,12,17 81:12,15,17 82:1,8,13 83:24 85:2,13 86:5,9 87:25 91:3,6,9,12,14,17,20,23 92:9,12,14,17,20,22 93:9,11,24 94:3,10,17,25 95:8,10,21 96:5,8,20 97:6,10,14,17,24 98:8,16,24 99:3,8,14 100:2,8,16 101:8,24 102:4,11,22 103:6,11,16,22,25 104:8,12 105:3

rarely (1) 105:7  
 rash (1) 137:6  
 rate (2) 71:16 72:22  
 rates (2) 29:3 78:19  
 rather (2) 86:25 89:11  
 rationale (1) 103:18  
 reach (1) 25:15  
 reached (1) 156:9  
 react (1) 8:2  
 reaction (2) 153:2 164:1  
 read (12) 5:24 9:15 133:10 143:7 163:13 165:17,25 166:5,10 171:5 172:3,14  
 readily (2) 105:3 145:9  
 reading (3) 7:4 65:23 108:15  
 ready (2) 1:13 7:9  
 real (1) 164:12  
 realise (3) 42:9 57:7 154:9  
 realised (2) 6:2 57:11  
 realising (1) 52:20  
 reality (1) 42:18  
 really (86) 5:14 9:8,15,16 16:21 39:18,21 40:18 41:1 51:15 53:12 55:9 58:3 60:23 62:5,6,13 64:8,16 67:18 73:8,8 74:5 75:15 77:7 82:1 83:7,10,10,13 84:25 85:11,17,21,24 86:20 87:5,5,13,16,17,19 94:22 103:5 108:22,23 126:20,24 132:8 136:9,20,21,23,23 137:3,4 138:16,22 139:9,25 142:12 143:18,18,22 144:15 147:6 149:4 150:16,24 151:15 155:7 156:13 157:11 159:19 160:3,5,22,22 161:21 162:17,19 166:14 168:22 169:6,12 172:15  
 reappeared (1) 17:12  
 reason (8) 13:14 114:2,19,20 124:5 125:11 139:24 141:1  
 reasonable (2) 8:13 141:1  
 reasonably (1) 153:5  
 reasons (2) 37:23 171:2  
 reassure (1) 25:24  
 receive (6) 27:24 31:8,16,17 33:17 41:18  
 received (8) 29:3 32:2,14 35:1,3,13 53:2 71:2  
 receiving (11) 17:14 54:23 70:23,24 71:1,2 94:3 101:19 136:21 137:20 159:19  
 quiet (4) 61:24 144:3,22 154:22  
 quite (68) 3:12,22 4:6,16 5:23 6:3 9:18 13:20 15:5 17:13 18:4,18 22:11 23:22 24:23 25:1 27:11 31:23,25 53:2,8,15,20,24 54:2,5,13 55:19,23 56:8,17,20,24 57:3,13 58:6,10,15,19,22 59:16,19,24 60:5,9 61:1,8,11,15 62:7,11,17 63:14,21,23 64:4,17,21 65:8,15 66:2,6,13,18 67:9,15,25 68:6,9 69:6,13,16,18,22 70:1,18,23 71:2,4,11,14,23 72:5,13,16,20 73:12,15,20 74:13 75:1,9,11,18,21 76:11,20 77:13 78:6,10,21 79:4 80:4,9,12,17 81:12,15,17 82:1,8,13 83:24 85:2,13 86:5,9 87:25 91:3,6,9,12,14,17,20,23 92:9,12,14,17,20,22 93:9,11,24 94:3,10,17,25 95:8,10,21 96:5,8,20 97:6,10,14,17,24 98:8,16,24 99:3,8,14 100:2,8,16 101:8,24 102:4,11,22 103:6,11,16,22,25 104:8,12 105:3

regardless (2) 87:8 163:7  
 register (1) 15:25  
 registered (3) 6:1 29:3 86:21  
 regrettably (1) 150:15  
 regular (2) 35:1 50:10  
 regularly (3) 38:3 86:2 137:12  
 regulatory (1) 72:1  
 reinfected (3) 132:7 168:24 169:7  
 reinforce (2) 22:5,9  
 related (1) 137:17  
 relating (2) 35:5 156:16  
 relation (18) 50:22 58:19 66:3 73:21 88:22 98:18,24,25 111:22 112:11 147:18 156:6 157:23 167:12,12 171:7 173:5,25  
 relatively (2) 136:2,4  
 relaxed (1) 95:2  
 released (2) 26:17 44:21  
 reliable (1) 3:23  
 relied (1) 16:16  
 relief (1) 154:9  
 relieved (1) 152:21  
 reluctance (1) 167:6  
 reluctantly (2) 167:1,2  
 rely (2) 45:25 169:12  
 remained (2) 154:16,17  
 remains (1) 155:17  
 remember (41) 4:25 25:18 50:3,24 51:16 52:11 53:15,21 57:18 58:15 59:25 70:3 71:11,15,16 77:9 84:19,21 93:5,13,14 95:10,14,22 96:18 97:11,12,13,14 99:9,10 100:21 103:6 108:9 116:17 120:3 127:1 134:11 136:17 137:14 138:7  
 remembering (2) 105:6 142:12  
 remind (3) 130:25 131:9,15  
 reminders (2) 22:6,6  
 remote (2) 9:10 157:22  
 remotely (2) 130:2 146:1  
 removed (1) 37:22  
 rented (1) 162:16  
 rep (13) 51:18 56:13,15,18 64:25 88:10,12 99:14 100:11 101:5 123:23 124:22 128:25  
 repeat (1) 69:13  
 repeated (1) 56:1  
 replace (1) 157:12  
 reports (3) 148:2,6,7  
 reported (2) 7:19 15:9  
 report (2) 124:15 161:3  
 represent (2) 123:23 125:6  
 representative (11) 47:20 49:6,7,9,12 56:10 90:16 91:6 92:18,19 125:19  
 representatives (1) 100:22  
 representing (1) 123:25  
 reps (2) 101:3 102:16  
 request (1) 141:19  
 requested (2) 80:20,24  
 required (2) 32:22 37:3  
 requirements (1) 43:15  
 requiring (1) 17:5  
 research (3) 164:13,17 165:17  
 residency (1) 66:10  
 resident (2) 61:22 73:5  
 residents (20) 59:22 60:2,7,11,25 62:21,22 63:5,11 70:9 71:15,18 72:22 74:9 76:5 77:4,18,19 79:1 80:1  
 resign (1) 81:3  
 resignation (1) 80:15  
 resigning (1) 80:16  
 resistant (3) 148:12,13 166:18  
 resolve (1) 114:25  
 resolved (1) 114:24

respect (2) 20:23 60:7  
 respected (1) 37:24  
 response (4) 79:4 93:12,24  
 99:8  
 responsibilities (1) 111:17  
 responsible (1) 44:4  
 rest (1) 11:16  
 restriction (3) 22:22 46:23  
 47:9  
 restrictions (9) 2:8 3:4,11  
 5:20 7:7,16 13:23 17:3  
 44:15  
 restrictive (1) 36:6  
 result (2) 58:8 126:17  
 resumed (1) 17:4  
 return (9) 12:22 80:18  
 81:3,10 98:24 110:9  
 119:8,11 123:3  
 returned (3) 80:4 119:2  
 124:19  
 returning (4) 57:16 107:2  
 119:4 120:10  
 reusing (1) 55:8  
 revealing (1) 141:21  
 revelation (1) 154:6  
 reviewed (2) 31:18 32:17  
 rheumatoid (2) 31:2 32:8  
 rheumatology (1) 32:18  
 ridiculous (6) 51:25 52:4  
 139:21 145:15,19 164:8  
 riding (1) 135:23  
 rightly (1) 25:14  
 rights (2) 87:11,12  
 rigid (1) 16:11  
 rise (1) 19:8 23:19,22  
 106:23 118:18,25 119:2,4  
 120:21 122:18 145:1  
 rising (1) 29:6  
 risk (40) 3:1 6:7,8 14:10,14  
 15:7,8 16:25 17:18 36:8,24  
 73:16,21,25  
 74:3,5,14,19,23 75:23,24  
 77:3 78:3 96:6 118:23  
 119:13,15,20  
 120:2,11,23,23 121:8,9,24  
 122:1 127:9,20 128:5  
 169:10  
 risks (4) 74:1 75:16 126:14  
 170:18  
 risk (2) 76:4,7  
 role (4) 24:18 65:2,15 123:23  
 roles (1) 125:2  
 rolling (1) 44:5  
 room (17) 12:18 34:9  
 37:5,10 38:22 61:3,5,9,16  
 84:7 94:5,5,7,8 105:23  
 136:18 144:22  
 rooms (6) 13:22 60:17 61:20  
 72:2,6 84:6  
 root (1) 156:13  
 roughly (3) 25:16 52:16  
 99:10  
 round (6) 38:13 50:6 58:14  
 93:17 153:10 168:8  
 rouse (1) 138:19  
 route (2) 2:17 41:19  
 routine (3) 7:25 58:22 108:7  
 routinely (4) 58:12 97:18  
 98:8 99:1  
 royal (10) 1:7,21 26:9 33:2  
 90:15 91:3 92:14 140:15  
 146:15 163:10  
 rub (1) 160:19  
 rugs (1) 9:19  
 rules (3) 16:11 60:5 61:2  
 rumbblings (2) 50:13 137:15  
 run (5) 1:20 26:20 27:22  
 85:6 88:25  
 running (2) 25:4 45:24  
 S

sad (1) 143:25  
 sadly (3) 3:23 19:19 22:13  
 safe (6) 7:23 22:12 36:4 94:1  
 125:12,16  
 safety (2) 33:11 117:15  
 safety (3) 36:11 45:16 74:8  
 sake (1) 150:19  
 salaries (1) 12:7  
 salary (1) 28:23  
 same (26) 3:16 4:16 9:3 13:8  
 14:8 15:1 18:9,10,24,25,25  
 30:8 32:11 40:19 64:7,9,11  
 88:24,24 92:11 109:1,23  
 121:23 122:4 134:23  
 155:20  
 samples (1) 92:6  
 sanitised (1) 106:1  
 sanitiser (3) 58:7,11,17  
 sarscov2 (4) 132:7 140:8  
 171:9,15  
 satisfaction (3) 140:18,20  
 141:10  
 satisfying (1) 141:8  
 saturday (3) 5:23 101:14,19  
 save (2) 138:11 142:9  
 savings (2) 157:9 167:19  
 savvy (1) 10:8  
 saw (4) 5:25 39:24 152:24  
 162:4  
 saying (38) 5:1 10:23  
 20:15,16 52:6 54:6  
 55:19,23 58:10 68:12,17  
 69:4 86:13 88:9 96:21,25  
 97:6,11 98:17 100:22,25  
 101:11 102:19 103:6 104:6  
 107:14 109:1 116:5 119:20  
 134:18 138:23 147:7,8  
 148:2,19,19 169:18,21  
 scales (1) 4:19  
 scan (1) 98:6  
 scanned (1) 165:12  
 scans (2) 82:22 84:20  
 scared (6) 19:22 25:25 50:15  
 77:2,3 137:23  
 scariest (1) 136:15  
 scary (5) 20:13 137:4,4  
 155:3 164:20  
 scenario (1) 28:3  
 scenarios (1) 29:16  
 scene (3) 49:19 53:21 54:6  
 scepticism (1) 52:8  
 schedule (2) 32:5 109:8  
 scheduled (1) 46:16  
 scheme (1) 87:15  
 school (20) 40:21,23,25 41:9  
 133:22 134:7,12 135:9  
 136:1,9 145:4  
 150:13,15,17,21 151:6  
 152:9,12,16 154:5  
 schools (1) 30:15  
 scientific (3) 103:23,25 104:1  
 sciwt0118000001 (1) 91:24  
 sciwt0690000001 (1) 1:9  
 sciwt0921000001 (1) 47:3  
 sciwt1120000001 (1) 130:14  
 scope (1) 18:10  
 scotland (3) 50:5 93:3 170:2  
 scottish (8) 34:22 35:25 36:6  
 41:22 42:13 44:22 45:1  
 169:18  
 screaming (1) 154:24  
 screen (3) 37:19 160:1,2  
 screens (1) 37:16  
 seal (1) 38:14  
 second (13) 56:24 57:17 59:4  
 64:6,7 71:7 76:16 106:5,19  
 118:3 120:8 122:11 160:7  
 secondly (2) 66:19 86:15  
 section (18) 63:14,24 84:18  
 85:2 121:18 129:24  
 133:6,11,20 154:11 156:15  
 163:16 165:25 167:8,15  
 171:1,3 173:6  
 sections (2) 29:12 132:14  
 section (11) 3:14 23:21 27:10  
 29:14 30:13 44:14 45:13  
 47:24 48:3 81:13 156:22  
 sectors (4) 5:17 25:10 42:16  
 45:16  
 security (2) 12:24 13:2

see (43) 2:25 4:24 5:11 9:13  
 11:4,5 15:23 16:23 19:16  
 23:22 25:14 27:2 28:20  
 34:9 40:21 45:15 47:15  
 50:1 51:15 84:22 85:20  
 87:24 93:2 100:4 103:1  
 104:15,16 117:3  
 126:15,22,24 127:4 138:15  
 150:24 155:7 159:17  
 161:6,15,21,22,24 169:12  
 172:7  
 seeing (9) 11:17 12:10,15  
 14:2 20:2,13 63:2 159:25  
 161:10  
 seek (5) 18:12 41:3 138:2,4  
 147:6  
 seeking (1) 147:11  
 seem (5) 110:17,19 115:11  
 131:13 138:5  
 seems (1) 171:14  
 seen (19) 3:2 4:8 8:23 15:4  
 19:21,24 21:19 24:7 33:11  
 36:15 85:17 86:2,3,3 124:7  
 142:20 151:19 158:7  
 169:20  
 selfemployed (4) 2:3 12:9  
 28:11 45:23  
 selfemployment (1) 28:5  
 send (1) 120:24  
 sending (1) 118:6  
 senior (2) 48:23 101:2  
 sense (1) 162:6  
 sensitive (1) 144:9  
 sensory (3) 40:5 144:6,23  
 sent (11) 6:12 10:16 35:6  
 45:21 69:1,1 79:6  
 117:18,20,23 146:15  
 sentence (2) 143:11 147:13  
 sentences (1) 132:9  
 sentiment (1) 34:23  
 separate (1) 61:17  
 separated (2) 60:17 159:1  
 serious (5) 23:19 52:17,21  
 57:9 93:18  
 seriously (3) 57:11 74:24  
 110:13  
 service (13) 18:18 19:4  
 41:14 42:12 82:17  
 83:14,15,18,19 86:21  
 87:15 152:18,22  
 services (21) 2:13 17:3 18:24  
 23:14 30:11 45:18  
 82:3,15,24 83:3,9 85:15,16  
 86:8,16 88:22 89:4,6  
 169:23 170:1,4  
 session (1) 90:13  
 sessions (2) 126:7,18  
 set (17) 1:19 16:11 22:21,25  
 27:12,13,16 28:25 41:13  
 45:11 48:6 49:3 54:6  
 67:1,12,17 174:1  
 sets (1) 49:19  
 setting (1) 30:3  
 settings (1) 39:20  
 settle (2) 123:2,8  
 settled (1) 101:5  
 seven (4) 25:6 80:16 131:5  
 173:9  
 several (2) 3:9 26:20  
 severe (8) 17:5 33:23 41:17  
 76:12 83:11 138:6 146:7  
 159:11  
 severely (3) 31:12 78:2  
 164:25  
 severity (1) 57:7  
 section (18) 63:14,24 84:18  
 shade (1) 143:24  
 shall (2) 129:10 149:19  
 shame (2) 150:24,24  
 share (3) 35:23 66:11 87:2  
 sharing (1) 58:17  
 sheet (1) 112:2  
 sheets (1) 112:2  
 shes (10) 1:5 131:7 147:6  
 150:25,25 151:1,16 152:11  
 163:7 170:21  
 shield (4) 31:6,8,15 68:10

shielded (6) 22:4 31:4,21  
 32:3,12 168:12  
 shielders (1) 120:1  
 shielding (31) 15:18 28:15  
 31:7,9,14,19 32:1,7 34:22  
 35:5,14,19 36:1,4,9,10  
 107:4 118:23  
 119:1,2,4,8,10 120:9,20,21  
 125:8,11,12 168:13,18  
 shift (15) 49:2 54:20  
 55:9,10,11,12 64:19 65:3  
 77:25 79:24 81:24,24  
 108:1,1,25  
 shifts (3) 54:20 81:21,23  
 shipped (1) 4:20  
 shivering (1) 137:3  
 shock (1) 18:18  
 shop (1) 169:10  
 short (5) 46:19 85:6 115:7,8  
 129:20  
 shortage (2) 75:11,12  
 shortages (3) 62:8 66:15  
 79:11  
 shortlived (1) 170:23  
 shortly (1) 113:2  
 shot (2) 10:21 169:5  
 should (28) 16:6,6 21:21  
 24:7 32:1,3 33:5 35:17,17  
 41:23 48:21,24 56:3 58:3  
 60:25 63:18 68:24 69:3  
 74:14,19 75:6,24 83:19  
 141:4 157:17 158:21,21  
 171:17  
 shouldnae (1) 116:15  
 shoutdnt (5) 116:11 121:11  
 128:4 137:16 170:15  
 show (3) 5:10 107:11 133:7  
 showing (1) 68:1  
 sick (23) 62:9 66:14,16,19,22  
 67:7,10,11,22,23 77:20  
 95:12,12 124:2,13 139:22  
 141:7 142:16 147:4,5  
 163:7 165:14 168:23  
 sicker (1) 168:20  
 sickly (2) 135:14,17  
 sickness (1) 124:15  
 side (3) 94:5,5 139:16  
 sign (1) 20:15  
 significance (1) 141:18  
 significant (21) 13:4,21  
 17:6,12 19:1 21:20 27:11  
 28:1,24 41:4 80:9  
 107:14,15,17 109:2 115:11  
 122:12 123:21 124:25  
 153:16 167:25  
 significantly (3) 24:23 40:4  
 120:11  
 signs (1) 11:8  
 similar (6) 58:19 70:14  
 124:20,20,21 154:4  
 similarly (1) 173:19  
 sit (3) 2:19 43:18 143:22  
 since (4) 1:19 2:2 36:13  
 135:23  
 single (6) 36:24 56:12 157:13  
 165:17 166:21 168:20  
 singleuse (6) 34:7 55:2,25,25  
 56:4,6  
 sister (1) 86:1  
 sit (3) 30:4 73:3 143:24  
 sitting (5) 20:18 38:23  
 136:17 163:1,1  
 situation (15) 13:1 21:17  
 29:25 30:12,23 32:13 57:7  
 60:23 108:4 130:15 149:18  
 150:11 159:4 168:9,17  
 situations (2) 19:19 20:25  
 six (4) 6:19 24:13 84:7  
 162:17  
 skills (1) 40:9  
 skin (1) 6:9  
 skint (2) 157:9 167:19  
 skullcap (1) 38:5  
 slammed (1) 159:16  
 sleep (2) 138:20,25  
 slightly (5) 11:7 12:11 27:15

36:5 159:12  
 slogans (1) 138:12  
 slowly (2) 3:19 6:21  
 small (5) 13:16 38:8 100:18  
 136:4 153:11  
 smiling (2) 20:14,16  
 sneeze (2) 37:6,7  
 sneezes (1) 37:21  
 social (17) 39:22 40:8 41:18  
 42:17,21 44:19 45:18  
 59:25 60:5 61:2,13 65:24  
 66:25 67:12,17 89:21  
 173:5  
 socialise (1) 61:23  
 socialising (2) 61:24 62:5  
 socially (1) 62:4  
 society (4) 122:1  
 125:12,14,16  
 sold (1) 5:3  
 sole (4) 2:4,9 27:13 28:3  
 solely (1) 56:16  
 solicitor (2) 172:4,6  
 solicitors (1) 173:11  
 somebody (18) 2:21 6:17  
 11:3,12 15:1,9 20:13  
 23:10,11 25:19 37:5 59:20  
 98:11 111:5 121:1 128:15  
 144:14 158:22  
 somebodys (3) 11:6,9 23:6  
 somehow (2) 159:15  
 someone (21) 10:20 12:3  
 17:9 26:7 47:19 53:18  
 60:12 61:25 64:22 65:10  
 70:23,25 71:2 73:3 87:8,9  
 89:10 97:7 98:8 112:23  
 121:5  
 something (28) 4:24 9:2,5,15  
 13:5 15:10 17:8,19 18:13  
 23:2 24:4,12 25:20 35:9  
 43:2 62:19 64:11 65:12  
 71:25 82:2 112:20 137:8  
 142:20 153:20 154:23  
 162:8 167:18 172:13  
 sometime (3) 52:23 99:12  
 110:3  
 sometimes (16) 3:22 4:22,24  
 14:24 22:13,15 37:13  
 45:12 55:5 59:22 62:2 73:4  
 94:9 111:3 140:2 155:2  
 somewhat (3) 7:3 130:23  
 159:15  
 son (2) 39:15,17  
 sons (1) 39:12  
 soon (3) 6:3 26:23 74:19  
 sooner (3) 6:10 14:18 24:7  
 sort (20) 3:18 4:12 11:24  
 24:22 46:9 50:23 71:25  
 79:16 82:8 93:1,12,24  
 94:8,11 95:3 99:21 114:10  
 123:3 138:7 159:10  
 sorta (1) 94:19  
 sort (2) 25:3 123:12  
 sorts (1) 102:9  
 sought (1) 19:11  
 sound (2) 17:9 40:7  
 source (4) 45:25 46:1  
 53:13,17  
 space (6) 42:8 70:18,22,24  
 105:25 114:9  
 spaces (3) 24:15 29:17 30:15  
 spanned (1) 173:8  
 spark (2) 143:13 144:2  
 speak (5) 25:10 51:19 61:25  
 68:23 170:3  
 speaking (3) 27:23 114:11  
 117:11  
 special (5) 38:7 45:2  
 65:8,11,11  
 specialist (1) 32:16  
 specifically (7) 24:2 30:10  
 72:20 76:12 78:23 88:20  
 125:23  
 speculation (1) 158:9  
 speed (1) 2:17  
 spend (3) 12:3 93:4 157:4  
 spent (4) 13:17,18 101:16

157:13  
 spitting (1) 155:6  
 split (1) 48:17  
 spike (2) 7:8 150:4  
 spotted (1) 37:13  
 spread (2) 3:20 68:21  
 spreading (1) 50:8  
 square (1) 160:5  
 staff (124) 2:12 6:12 7:23  
 8:15 12:7 13:24 25:7 26:24  
 29:20 33:13 34:10  
 38:20,22,25 39:3 43:8,12  
 51:16,21 52:1,2 54:9,19  
 55:2,16,17,19,20  
 56:3,6,10,11,16 57:8  
 58:5,17 59:3,10 61:21 62:8  
 63:5 64:14 65:5,10,13,23  
 66:11,15  
 67:6,7,19,20,20,23 70:9  
 72:3,18 73:2 74:12  
 75:11,12 76:1,6,10 77:20  
 78:4,11,13,17,18 79:11  
 80:1,10,14,14 83:21  
 84:15,19 85:5 86:24 87:10  
 88:23 94:7 95:15  
 96:11,19,23 97:1,2  
 98:11 111:5 99:18 102:1,24  
 104:9,22,23 105:4 106:23  
 107:5,8 115:23  
 116:2,21,23  
 118:7,10,15,20 119:9  
 120:19  
 123:14,16,16,19,21,23  
 124:12,16,18,23 128:13  
 163:17 173:13  
 staffed (2) 85:6 109:25  
 staffs (2) 51:20 101:5  
 stage (3) 5:21 6:4 133:8  
 stages (2) 24:20 40:15  
 stagger (1) 13:25  
 staggered (1) 38:19  
 stand (1) 128:21  
 standard (4) 50:23,25 51:6  
 66:22  
 standards (2) 26:11,12  
 standing (1) 43:6  
 stark (1) 4:10  
 start (24) 1:12,17 6:21 10:2  
 14:2,3 58:4 71:8 76:25  
 82:17 86:24 98:20 107:9  
 159:15  
 129:10,12 131:1 159:17  
 160:17,21 168:23,25  
 started (28) 12:10 17:4  
 39:17 40:23,24  
 50:7,9,12,13,15 51:16  
 52:17,20 54:24 55:12  
 57:6,22,25 58:2,4 71:19  
 81:1 120:24 123:8 134:24  
 135:1 153:23 158:12  
 starting (6) 51:23 76:22  
 107:6 120:21 144:11,14  
 stated (1) 56:3  
 statement (63) 1:8 41:21  
 46:5,24 47:2,10,14 48:7,13  
 50:20 54:14 58:6 73:15  
 76:11 80:5 81:18 85:13  
 89:16,23 91:10,17,23  
 92:3,22 93:11 96:22  
 107:25 111:21 121:19  
 128:18,20 129:4  
 130:13,17,18 131:16,25,25  
 132:5,13,23  
 133:1,5,9,16,20 134:5,20  
 140:5 146:9 150:8 154:11  
 156:16,19,20,25 167:8  
 168:11 169:4,17 171:1,3,7  
 stations (1) 58:2  
 statistics (2) 21:12 107:11  
 stats (1) 140:1  
 stature (1) 38:10  
 status (3) 28:9 66:22  
 67:10  
 stay (16) 21:22 30:9 36:2,3,3  
 40:13 61:5 67:8 68:9 75:3  
 112:4 117:6,10 144:22

151:6 162:4  
 stayed (4) 61:9 109:1  
 137:1,2  
 staying (1) 75:21  
 step (3) 7:4 152:20 156:7  
 stepped (1) 152:16  
 steps (1) 7:22  
 still (40) 4:20 8:8,23  
 15:14,18 21:3,4 22:4,19  
 23:16 28:13 36:23 41:1  
 45:8,14,15 72:7 73:10  
 97:19,21,23 98:3 101:22  
 106:13 109:20 110:8,10  
 113:13 117:8,16 121:6  
 125:15,17 135:9 144:19  
 156:11 163:6 165:16  
 168:13 169:8  
 stock (1) 5:2  
 stocking (1) 58:4  
 stomachaches (1) 161:17  
 stop (2) 3:13 33:18  
 stopped (5) 22:8 45:5  
 61:12,13 62:13  
 straight (2) 74:17 142:7  
 straightforward (1) 31:22  
 stranger (1) 161:25  
 strap (1) 38:12  
 strapping (1) 38:7  
 strategic (1) 24:22  
 stream (1) 36:21  
 struck (1) 8:19  
 structure (4) 2:7 6:23 17:15  
 48:14  
 struggled (3) 40:3 41:1 83:7  
 struggling (2) 21:5 83:13  
 stuck (2) 84:7 114:6  
 stuff (1) 102:8  
 stumbled (1) 153:11  
 stupid (1) 142:5  
 stuttering (1) 155:6  
 subject (4) 46:23 47:9 72:21  
 111:20  
 subjected (1) 8:12  
 submitted (2) 10:12 141:19  
 subsequent (1) 146:14  
 subsequently (2) 10:2 159:3  
 substantive (1) 122:17  
 subtle (1) 11:11  
 successful (4) 161:9,12,13  
 162:6  
 succession (1) 135:2  
 sudden (7) 6:22 18:17 36:13  
 125:13 136:13,18 155:3  
 suffer (1) 131:22  
 suffered (4) 77:15 79:2  
 140:22 155:13  
 suffering (9) 104:10 140:11  
 142:6 145:4 151:25 152:7  
 155:14 158:7 160:11  
 suggest (1) 160:9  
 suggested (2) 164:2 170:19  
 suggesting (3) 145:21  
 147:24 163:11  
 suggestions (1) 164:1  
 suited (1) 76:8  
 suits (1) 93:18  
 summarise (3) 48:16 52:6  
 57:17  
 summarising (1) 71:25  
 summer (2) 143:6,25  
 sunak (2) 25:20,22  
 sunday (1) 33:7  
 sunlight (1) 144:9  
 sunshine (1) 163:2  
 super (1) 129:18  
 supervision (1) 122:24  
 supervisors (1) 123:1  
 supplement (1) 28:16  
 supplier (2) 4:23 5:1  
 suppliers (3) 3:13,23 5:15  
 supplies (6) 3:6,10,21  
 4:1,4,11  
 supply (3) 3:17

45:19 72:24 76:3 82:22  
83:1,9,14,23 89:2  
100:10,12 101:4,6,10  
**supported (1)** 32:20  
**supporting (1)** 101:16  
**supportive (1)** 163:5  
**supports (1)** 164:14  
**suppose (2)** 86:11 138:8  
**supposition (1)** 142:21  
**suppressed (1)** 31:12  
**sure (34)** 4:17 25:11  
26:14,19,22 27:3 32:20  
36:17 37:10 46:3 61:9 62:4  
65:22 66:10 68:14 74:7,8  
80:1 88:16,18 93:20  
108:22 113:12 129:8  
142:22,25 146:23 148:4,17  
153:22 155:23 158:21  
172:9,19  
**surfaces (1)** 12:19  
**surgeons (1)** 96:14  
**surgeries (4)** 4:7,9 109:8  
110:11  
**surgery (6)** 2:23 24:1,5  
123:15 124:4 138:10  
**surgical (4)** 53:25 54:3 94:8  
106:6  
**susceptible (1)** 31:20  
**suspect (1)** 137:16  
**suspected (4)** 41:6 98:9,18  
140:16  
**suspended (1)** 37:17  
**suspicion (4)** 134:10  
165:4,5,7  
**sweating (1)** 137:3  
**swimming (3)** 135:20,20,21  
**swine (3)** 7:1,6,11  
**switch (1)** 155:3  
**symptomatic (3)** 68:13,22  
69:10  
**symptoms (35)** 33:9,23  
63:19 65:19 68:1,6,17  
69:16 70:14 95:6,6 115:17  
116:10 134:21 135:4  
138:14 139:25 143:6,15  
144:15 145:6,11 146:7,12  
148:25 149:1,19 151:20  
153:1 154:4 157:14  
159:11,12 164:7,18  
**syndrome (4)** 140:7 154:19  
155:21 156:2  
**system (5)** 27:15 31:3,12  
126:11 170:20  
**systemic (1)** 110:19

---

**T**

**tables (1)** 61:18  
**taken (17)** 14:4 30:7 33:1  
34:16 37:14 51:12,18,19  
75:6 95:1 133:15  
142:7,11,15 159:18 170:11  
172:21  
**takers (1)** 173:12  
**takes (1)** 132:22  
**taking (14)** 16:22 38:6 39:5  
62:7 69:19 79:18 90:4,5  
92:4 94:2 113:24 133:15  
153:14 168:16  
**talk (10)** 7:9 54:13 73:10  
131:1 146:8 152:9 156:21  
163:20 169:17 170:3  
**talking (10)** 82:25 87:19  
88:11 99:16 100:3 118:2  
120:5 157:7 159:6 167:23  
**tandem (1)** 28:5  
**tank (1)** 143:12  
**task (1)** 113:19  
**tasks (1)** 123:13  
**tax (1)** 28:7  
**taxable (1)** 29:4  
**taxing (1)** 170:20  
**teacher (2)** 150:9,23  
**team (9)** 2:11 12:21 26:10  
42:8 43:8 104:3 172:23  
173:7,10  
**teamed (1)** 7:18

**tearing (1)** 154:24  
**tears (1)** 165:23  
**technological (1)** 10:8  
**technology (2)** 9:20 10:4  
**teem (1)** 24:25  
**telephone (1)** 10:19  
**television (1)** 35:7  
**telling (9)** 1:17 44:24 55:11  
60:15 69:9 79:10 100:13  
118:15 137:22  
**temperature (3)** 136:22  
137:10 138:1  
**temporarily (1)** 140:8  
**temporary (1)** 162:17  
**ten (11)** 4:9 39:8,9,18,23  
65:6 70:13 84:2,4,5 108:6  
**ten (1)** 160:9  
**tended (2)** 2:14,25  
**tending (1)** 78:18  
**tennis (1)** 135:21  
**tens (1)** 157:6  
**tens (3)** 9:10 24:24  
163:19  
**terminated (1)** 124:8  
**terminations (2)** 123:21  
124:8  
**terminologies (1)** 9:24  
**terms (9)** 2:6 57:20 82:24  
88:1,25 89:4 114:9 132:21  
164:6  
**terrified (1)** 163:16  
**terrifying (3)** 149:2  
158:17,20  
**test (13)** 45:10 67:8 115:14  
137:9 140:3 146:20,24  
147:1,20,23,23 148:3,18  
**tested (13)** 33:3 66:23 67:2  
68:1,4,13 69:14 70:7 72:6  
104:14,16 111:6 116:10  
**testing (9)** 67:25 70:8,11  
71:6,9 95:8,9 98:4 140:4  
**text (1)** 35:6  
**texts (1)** 35:1  
**thank (53)** 1:10,14 2:3 3:4  
5:20 6:24 7:24 8:24 12:1  
13:11 17:3 19:6 20:23  
23:18 24:18 27:8 29:8 31:1  
32:21 34:20 39:12  
46:5,13,14,15,16 58:6  
59:24 67:25 82:1 86:9  
89:13,22,24  
90:2,3,7,8,18,24 91:13  
129:6,18 130:23 139:16  
172:23,25 173:2,7,19,23  
174:4  
**thanks (1)** 173:17  
**thats (60)** 17:17 35:22 37:6  
49:7 52:17 57:14 61:7 71:8  
73:6 78:7 82:6 91:5,6,8,9  
95:24 97:11,19 98:20  
99:16,19 100:3,4 101:3  
102:6 103:2 104:5 109:11  
114:19,20 117:13  
118:18,19 120:19  
121:16,16 129:1,13,18  
130:22 131:6 132:21  
134:19 139:15 140:22,25  
141:5,7 144:13 146:17  
147:17 148:11,20,23 157:9  
162:16 168:16 173:3,23  
174:3  
**theatre (1)** 109:13  
**theatres (3)** 92:5 109:8  
110:14  
**theme (2)** 71:23 92:25  
**themes (3)** 92:23,25 96:21  
**themselves (1)** 171:11  
**themselves (5)** 23:11 24:3  
55:21 104:23 165:1  
**therapists (1)** 127:10  
**therapy (2)** 163:4,4  
**thereafter (1)** 162:10  
**therefore (9)** 7:15 12:23  
14:23 19:12 31:21 40:16  
43:22 45:5 146:21  
**theres (17)** 6:2 11:2,7 21:11

86:12 88:7,15 93:17 95:25  
98:3 105:12 120:19  
122:4,25 149:14 163:14  
167:5  
**theyre (22)** 11:5 18:17  
21:7,9 38:9 50:13 65:22  
86:22 88:25 101:2,6,7  
107:4,6 113:12 145:23,24  
147:7 164:22 165:21  
166:13 169:21  
**theyve (1)** 125:10  
**thing (21)** 4:16 10:15  
16:8,24 20:14 24:17 26:24  
38:3 51:15,23 66:1 82:19  
93:19 104:5 110:21 127:22  
135:22 137:25 139:21  
148:20 149:9  
**thinking (4)** 18:5 35:8  
77:8,10  
**third (6)** 42:16 76:17 82:8  
86:5 123:10,11  
**thomson (1)** 91:2  
**thorough (1)** 158:10  
**though (7)** 19:10 23:9 25:21  
104:24 125:16 127:2 140:4  
**thought (25)** 9:9 25:19,25  
44:1 62:20 77:2 95:16  
96:5,6 108:19 114:24  
118:16 135:7 137:10,1  
139:13 141:11 145:16,23  
154:6 155:4 161:20  
162:2,18 172:13  
**thousands (2)** 157:4,6  
**threat (1)** 8:5  
**threatening (1)** 6:18  
**three (16)** 4:17 12:12 13:22  
28:7 29:12 48:17,22 49:2  
71:21 86:4 99:15 129:12  
136:12 137:19 139:4  
149:24  
**threeyear (2)** 28:7,13  
**through (27)** 2:20 5:4 10:16  
14:4,11 20:7 32:4 40:20  
42:20,24 44:9 48:8 93:21  
94:6 110:1,22 117:2  
126:10 131:20 139:15  
140:21 145:8,25 155:13  
164:15 166:4 172:4  
**throughout (14)** 3:17 16:7  
23:16 64:5,9 67:15 71:4,6  
92:15 128:17 156:25  
168:12 173:7,21  
**thursday (1)** 1:1  
**ticks (1)** 166:21  
**tidbit (1)** 26:5  
**tiger (5)** 161:4,6,10,15,24  
**tigers (2)** 160:25 161:1  
**tightly (1)** 38:13  
**time (154)** 4:18 5:16  
8:6,16,21 12:1,5  
13:6,16,18 14:8 15:15,19  
16:2,8,24 17:2,19 19:25  
21:13,16 22:18 24:4 25:20  
26:25 28:4,8,14 30:25  
31:11 32:14 34:5,7,18  
35:7,14 36:22,24 37:12  
38:1,18,20 39:11  
40:2,6,9,21 41:15 43:7  
44:2,25 46:13 48:7 52:1  
55:11,25 56:2,18 59:14,19  
61:22 62:8,20 69:24 71:12  
74:2,3 80:21 84:11 89:20  
93:4 94:1 95:8,15,20  
96:13,13,16,19  
97:17,19,22 98:3,5,7,20  
99:14,19 101:1,2,11 102:6  
103:15,24 104:21 105:24  
106:5,11,14,24 107:3  
109:24 111:16 112:9 113:7  
115:8,16 116:3,4,7,16,19  
117:8 118:22 119:14  
122:10 124:16 125:8  
126:11 131:21 132:16  
134:8,23 135:20 136:7,16  
137:15 142:9,13 143:19  
145:15,19,23 146:6

149:21,25 150:20 152:3  
153:10 155:20 158:25  
159:2 163:12 164:17 166:9  
168:17 169:2,3,6,7,14  
170:20 172:21 173:12  
**timeframe (2)** 132:20 156:17  
**timeline (3)** 4:14 26:16 52:12  
**timely (1)** 27:5  
**times (19)** 4:2,19 5:6,9 15:24  
38:24 46:2 48:25 56:5 65:6  
70:13 86:4 101:18 138:19  
143:23 155:4 158:20  
161:18 164:21  
**tired (2)** 161:18 172:14  
**today (20)** 14:1 33:1 46:7,7  
47:8 48:2 63:10 79:24  
89:16,23 91:20 125:18  
128:21 129:23 130:12,18  
131:1 133:19 155:15 172:2  
**today (1)** 130:19  
**toe (1)** 11:18  
**toenail (2)** 17:15 18:5  
**toenails (6)** 17:10,14,16,23  
18:3 24:2  
**together (8)** 7:21 24:25  
38:20,21 122:7 128:21  
130:17 173:14  
**tokenistic (1)** 169:24  
**told (47)** 6:13 15:11 41:15  
42:23 43:4,11 45:8 51:25  
53:15 54:18,23 55:6 58:25  
61:17 63:9 67:7,20  
74:2,10,12,21 79:11,15  
81:6,9,10 84:12 98:8  
99:20,23 101:7,13,25  
102:14,20 103:24,25 104:1  
111:12 121:13 138:10  
139:5 141:2 153:12  
165:10,12 172:3  
**tolerance (1)** 40:1  
**too (14)** 15:20 17:25 21:1  
23:21 24:6 54:23,23 73:13  
122:25 137:23 138:5 154:8  
163:7 172:18  
**took (21)** 6:4,20 7:22 12:9  
33:16 68:18 74:23 98:10  
105:22,23 121:7 134:16,18  
136:12,19 146:13  
148:10,11 158:10 166:17  
170:11  
**touch (5)** 23:5 31:16,17  
133:14 172:5  
**touched (1)** 172:11  
**towards (6)** 8:15 71:7,7 78:8  
82:5 85:2  
**towers (1)** 142:3  
**trade (2)** 49:4 87:5  
**trader (3)** 2:4,9 28:3  
**traders (1)** 27:13  
**trained (1)** 106:2  
**training (17)** 9:16 18:9 49:14  
63:15,16,20 64:8,12,13  
65:8,12,14 89:3,5 105:5,6  
**trajectory (1)** 168:21  
**transferred (1)** 93:15  
**transition (2)** 36:10 40:25  
**transmission (2)** 171:8,13  
**transmitted (2)** 7:14 171:15  
**transparent (1)** 87:20  
**transpired (1)** 32:6  
**traumatic (1)** 142:12  
**travel (3)** 21:24 22:3,12  
**travelling (2)** 22:1,9  
**treat (7)** 6:15,22 8:12 9:5  
15:17 23:5 36:23  
**treatable (2)** 155:8,10  
**treated (16)** 2:7 4:9 6:8,20  
32:25 87:12 89:12 95:5,19  
124:7,11 147:6 155:12  
158:7,23 169:21  
**treating (4)** 14:6 15:9 20:17  
170:13  
**treatment (24)** 13:22  
15:4,14 16:18,19 17:6  
19:14 20:22 24:12 31:2  
32:22 33:14,17 96:22

131:18 142:11,16 155:11  
156:22 157:14,23  
158:12,13 159:5  
**treatments (5)** 3:22 16:5,6  
24:13 157:16  
**tree (2)** 16:15,15  
**triage (3)** 14:17 29:18 33:9  
**triaged (2)** 9:12 14:6  
**triaging (3)** 14:3 16:13 33:6  
**tribunal (1)** 79:18  
**trickier (3)** 3:17 8:7 21:7  
**tricky (1)** 27:15  
**tried (6)** 10:13 24:3 54:22  
84:8 138:21 160:19  
**trigger (1)** 155:2  
**triggered (3)** 136:7 154:1  
164:10  
**trip (1)** 161:16  
**trivial (2)** 17:9 21:18  
**true (3)** 71:5 157:17 162:25  
**truth (1)** 118:15  
**try (19)** 4:17 15:12 19:18  
20:6 25:11 26:14 27:3  
40:22 55:17 61:19 62:24  
131:11,14 138:22,22  
164:22 165:15 168:4  
169:10  
**trying (25)** 14:20 15:24 25:7  
32:20 38:10 42:18,21 43:2  
55:6 60:19,23,24 62:1  
64:25 65:9 83:2,9 137:17  
138:6 150:15,17 154:24  
157:13 165:20 169:3  
**tshirt (2)** 59:10,11  
**tunnel (1)** 159:18  
**turn (18)** 19:14 49:20 59:24  
63:23 67:25 75:1 82:2 86:9  
107:19 111:20 115:9,19  
118:24 123:18 127:6  
136:13,14 141:4  
**turned (5)** 39:17 136:5  
137:24 161:19 166:18  
**turning (4)** 98:12,15  
115:17,21  
**turnover (1)** 80:10  
**turns (5)** 73:15 107:25  
108:23 168:9 169:13  
**tv (2)** 35:9 136:18  
**twice (2)** 4:24 86:4  
**twoweek (1)** 121:23  
**type (4)** 5:1 18:25 97:19  
127:17  
**types (1)** 3:9  
**typical (1)** 26:16  
**typically (4)** 4:7 48:21 49:2  
54:20

---

**U**

**uk (5)** 42:13 50:7,12  
141:21,23  
**ulceration (1)** 6:9  
**ulcerative (1)** 17:16  
**ulcers (2)** 17:22 18:3  
**umhum (1)** 61:8  
**unable (1)** 168:14  
**unacceptable (1)** 79:15  
**unaware (1)** 171:10  
**unawares (1)** 35:8  
**unbelievable (2)** 154:21  
158:3  
**unbelievably (1)** 147:5  
**uncertainty (1)** 26:6  
**uncharacteristic (1)** 150:10  
**unconfirmed (1)** 148:7  
**underlying (1)** 120:19  
**undermining (1)** 147:3  
**underneath (2)** 17:16 18:6  
**underreacted (1)** 151:17  
**understand (22)** 3:5  
8:4,5,11,22 14:25 22:2  
30:7 76:15 101:15 130:15  
133:17 134:6 135:5 144:16  
147:17 149:7 150:11  
151:22 159:25 164:8,11  
**understanding (7)** 7:13 8:2  
22:11 39:5 42:11 43:18

133:15  
**understood (7)** 8:20 13:7  
26:20 37:24 85:8 107:23  
149:17  
**undertake (1)** 66:2  
**undiagnosed (1)** 148:6  
**unequal (1)** 96:22  
**unexplained (2)** 164:7,10  
**unfocused (1)** 9:19  
**unhappy (1)** 102:12  
**uniform (9)** 50:23,25  
58:23,25 59:1,3,4,14,16  
**uniforms (1)** 59:23  
**union (26)** 47:20 49:4,4,17  
51:18 56:10,13,15,18  
64:25 66:25 67:5 87:8  
88:10,12 90:16 91:6 99:14  
100:11 101:5 102:16  
116:13 123:23 124:22  
125:19 128:25  
**unions (5)** 45:1 87:4 99:8  
116:9,12  
**unit (6)** 33:13  
48:18,19,19,20 59:12  
**unite (4)** 90:17 91:7 92:17,19  
**units (1)** 48:18  
169:10  
**unless (3)** 113:16 114:8,21  
**unofficial (2)** 51:18 56:15  
**unpaid (1)** 63:22  
**unpredictable (1)** 76:5  
**unsure (1)** 97:23  
**until (15)** 6:20 26:18 40:22  
66:25 111:13,14 115:17  
117:9,14 126:24 134:25  
159:23 161:25 170:21  
174:3  
**unusual (4)** 5:11 19:20 28:19  
32:10  
**unwell (7)** 134:25 135:1,7  
136:24 141:13 147:7  
158:16  
**unwilling (1)** 151:9  
**update (2)** 45:6 65:7  
**updated (1)** 64:2  
**updates (3)** 35:1 45:2,5  
**uphill (2)** 43:16 44:3  
**upon (2)** 51:19 68:19  
**upper (1)** 137:6  
**upset (2)** 96:4 166:6  
**upsetting (2)** 159:17 160:3  
**upstairs (8)** 48:18,22  
75:24,25 76:2,9 78:1  
136:20  
**uptodate (2)** 65:23,24  
**urged (1)** 14:15  
**urgency (1)** 14:7  
**urgent (6)** 6:16 13:12  
14:2,19 16:3 23:23  
**used (8)** 3:21 18:13 34:5  
36:19 55:10 56:1 109:16  
147:13  
**using (4)** 10:3 54:23 105:10  
163:8  
**usual (1)** 12:19  
**usually (3)** 3:2 76:1 94:13  
**utilised (1)** 172:8

---

**V**

**vaccinated (1)** 170:8  
**vaccination (4)** 7:10 42:5  
170:22,24  
**vaccinations (1)** 170:7  
**vaccinator (1)** 19:3  
**vaccine (6)** 33:22 41:24 42:8  
43:3,9 44:9  
**vaccines (2)** 33:21 46:11  
**validation (1)** 156:12  
**valley (1)** 33:2  
**variable (1)** 5:14  
**variant (2)** 159:7,16  
**varied (2)** 18:2 44:3  
**various (3)** 62:11 131:18  
132:14  
**vary (1)** 4:22  
**variables (1)** 104:20

**verbal (2)** 8:13 160:15  
**verbally (1)** 8:3  
**video (6)** 9:11  
10:3,9,14,17,20  
**videos (1)** 20:9  
**views (1)** 171:13  
**violence (1)** 160:15  
**violent (1)** 149:5  
**virus (6)** 5:24 7:5,14,20  
50:14 171:9  
**vision (1)** 11:10  
**visit (4)** 62:24 63:8,12 65:25  
**visiting (5)** 62:12,12 73:13  
85:15,16  
**visitor (3)** 85:18,19 86:2  
**visitors (1)** 84:10  
**visits (4)** 22:17,19 82:17,18  
**visor (3)** 20:13 37:9 38:6  
**visors (1)** 34:5  
**visual (1)** 20:19  
**voice (1)** 87:7  
**volunteer (2)** 2:2 83:14  
**volunteered (1)** 49:9  
**volunteers (1)** 83:16  
**vulnerable (5)** 7:25 31:3  
84:24 89:11 107:5

---

**W**

**wae (2)** 98:21 104:21  
**wage (3)** 28:20,23 80:23  
**wait (5)** 5:12 14:13 31:15  
41:16 170:21  
**waiting (2)** 124:2,3  
**waking (1)** 77:10  
**walk (1)** 11:11  
**walking (1)** 79:12  
**walked (2)** 60:13 84:9  
**wanting (2)** 52:2 137:5  
**ward (19)** 76:4 93:21 94:4  
95:11,17 96:26 96:1,4 105:20  
110:23,23,24  
111:1,2,4,5,11 114:21  
115:4  
**wards (6)** 95:25 109:16,18  
110:16,20 111:2  
**warm (1)** 143:24  
**warned (1)** 8:18  
**wash (1)** 59:22  
**washed (5)** 36:18  
59:2,14,17,19  
**wasnae (9)** 99:6 102:10  
109:23 111:4,9 113:23  
122:24 126:15 127:23  
**wasnt (7)** 5:11 9:13,15  
10:9,10 13:22 15:1,17  
16:10 28:15 40:18,22  
41:13 49:13 50:7,9 51:14  
53:11 55:7,7,12,13 56:4  
58:12,13,13,25 59:6,14  
64:13 66:24 68:12,14  
70:7,20 74:12 78:12 79:22  
81:22 83:3,15,21  
85:10,21,22 87:11 107:9  
112:23,25 113:21 134:25  
136:3 137:5 139:22  
140:23,25 141:1 144:4  
147:20 148:9 150:17  
153:20 158:8,20 159:23  
161:25 162:12 164:9,17  
171:23  
**waste (2)** 51:7 92:6  
**watch (2)** 30:4 35:6  
**watching (1)** 136:18  
**water (1)** 144:8  
**wave (1)** 131:4  
**waves (1)** 31:9  
**way (27)** 2:20 8:15 9:3  
11:7,10 14:11 29:1,2 34:9  
40:

wear (29) 34:10 36:14 38:7  
52:2,5 59:11 94:14,19,24  
97:22 98:21 99:19,20,23  
100:13 101:17  
102:1,15,17,20 103:4,4,19  
104:25 123:13,13 127:19  
169:8,10  
wearing (7) 20:8 34:10  
38:2,5 63:18 101:22  
106:12  
weather (1) 135:8  
website (3) 26:21 44:22,23  
wed (3) 59:4 93:8 113:9  
wee (3) 30:21 102:7 170:21  
week (22) 3:12 4:8,9 25:6,17  
26:2 41:1 71:21,21 79:13  
80:2,3,15,16 81:23 94:6  
108:6 115:2,6 121:23  
122:5 134:13  
weekly (1) 24:23  
weeks (14) 4:8 6:8,19 12:22  
13:19 24:11 32:15 79:14  
112:10,13 136:12 137:20  
139:4,23  
weighed (1) 85:22  
weighing (1) 170:18  
weird (1) 136:20  
wellbeing (1) 28:24  
wellknown (1) 67:18  
went (35) 4:25 8:6,21 32:14  
38:1 55:14 62:2 63:9 66:14  
67:6,21 74:17 76:8,23  
77:25 78:1 81:9,12 84:21  
87:22,24 99:16,22  
101:9,14 105:20,21,22  
111:13,14 115:2 134:13  
135:20 152:11 161:19  
werenae (8) 95:20 99:24  
103:3 108:23 113:9  
120:23,25 121:1  
werent (38) 6:8 8:23 9:20  
12:21 13:15 16:1 18:8  
21:23 30:19 56:17 58:20  
59:2,8 62:25 63:3 68:1,6  
69:10 70:7 72:11 73:2,4  
75:15,21 77:21,23  
84:4,6,8,10 85:22  
108:22,24 114:3 116:4  
122:22 142:3 164:18  
weve (9) 42:3 45:8 46:9  
132:5 133:10 164:14  
168:6,6,6  
whatever (3) 109:18 123:16  
138:6  
whats (4) 22:22 76:16 128:9  
150:10  
whatsoever (1) 83:23  
wheel (1) 162:5  
wheelchair (6)  
162:1,10,13,14,20 163:5  
whenever (1) 45:11  
whereas (2) 76:3 117:20  
wherever (1) 114:16  
whilst (5) 41:7 67:24 84:7  
102:14 120:23  
whole (8) 11:14,21 37:12  
38:18 41:13 64:5 128:20  
137:4  
whos (2) 9:22 166:20  
whose (3) 8:1 154:3 164:24  
wide (2) 2:13 18:2  
widely (1) 105:8  
wider (1) 21:11  
wideranging (1) 153:1  
wild (4) 136:22 155:1,1  
165:3  
wildlife (1) 161:4  
wildly (1) 153:1  
willing (1) 21:23  
wind (1) 108:2  
window (1) 63:10  
windows (1) 62:14  
wipe (1) 5:2  
wish (1) 77:10  
withdrawn (1) 144:3  
witness (23) 1:4 46:23,24

47:2,6,10,14 90:1,3,4,5,20  
91:23 92:22 128:20  
129:8,9,10,10,12,23,24  
173:12  
witnessed (3) 121:7,7,9  
witnesses (2) 50:17 124:24  
women (4) 38:10 74:1,11  
75:17  
wonder (1) 130:24  
wonderful (1) 41:10  
wont (1) 152:8  
work (2) 101:23 106:13  
work (95) 2:10 7:25 12:5  
13:12,12 25:23 26:2,12  
27:2,6 28:14 29:24 30:8,13  
35:2 36:11 38:14,18 42:1  
45:7 48:3,13 50:13 54:17  
55:10 59:1,2,20 61:16  
68:2,10,15,18,25 73:16  
76:10,22,23,24 77:5,8,11  
80:4,23 81:12,16 85:25  
86:22 87:15,16 101:14  
107:5,6  
108:1,5,14,14,16,24  
109:2,20 110:1,1 114:9  
115:17,22,23 116:15,16,19  
117:1,4,16  
119:3,4,9,11,12,19  
120:2,10 121:6,12,15  
122:19 124:5,17  
125:9,10,15 130:7 135:9  
151:1 166:17 172:8  
worked (22) 6:25 7:6 14:11  
26:12 36:12 47:19 48:9,14  
51:13 54:20 70:19 71:12  
81:8 87:23 90:14 91:3  
92:14 115:24,25,25 116:1  
125:2  
worker (7) 29:10,13,15,19  
46:10 75:4 127:2  
workers (13) 29:10,11 30:13  
39:2 41:23 42:15 43:17  
44:16,17 45:14 73:17,21  
108:13  
working (21) 13:1,14,15  
15:19 23:16 25:6  
26:13,18,25 30:1 54:10  
59:11 66:12 80:7,20,21,24  
99:25 108:17 115:12  
133:12  
workload (5) 108:20  
109:9,23 110:6,7  
workplace (2) 39:6 45:15  
world (3) 7:19 20:4 21:10  
worries (1) 75:15  
worse (10) 33:18 87:13  
136:13 137:24 151:16  
159:10,20 160:6 165:21  
168:25  
worsened (3) 18:22 146:14  
153:9  
worst (5) 8:10 84:3  
106:17,21,22  
worth (2) 81:2 158:5  
wouldnae (6) 94:16 111:10  
113:15 114:7 115:3,4  
wouldnt (24) 9:7 13:1 19:20  
28:19 51:9 53:16 54:10  
64:24 84:12 98:8 110:10  
135:17 137:6,11,13 140:20  
141:7,14 142:7,16 149:10  
150:19 156:14 158:19  
wound (8) 2:25 4:3 6:17  
21:2,3 22:20 24:9,11  
wounds (2) 17:23 18:6  
wow (2) 154:21 158:11  
wrapped (1) 112:2  
write (4) 43:12 80:15 132:4  
169:4  
writing (4) 35:10 68:25  
142:20,25  
written (2) 33:4 172:13  
wrong (4) 11:7 148:1,16  
153:19  
wrongly (1) 25:14

X  
xray (2) 95:11,17  
xrays (1) 92:5  
Y  
yeah (3) 5:17 63:9 161:22  
year (11) 43:6 45:4 56:24  
123:7,9 130:6 132:7,22  
146:10 167:10  
years (18) 1:21,24 14:1 28:7  
33:1 39:1 47:25 73:1 83:18  
90:15 91:4 132:6 135:24  
140:18,21 147:1 151:16  
164:15  
yet (8) 14:16 50:7 53:2  
91:11,11 129:9 164:11  
166:23  
youll (4) 15:4 37:6 149:12  
172:9  
young (2) 133:13 170:1  
younger (3) 10:6 48:19,24  
yours (47) 1:13 11:16 23:10  
24:15 29:25 30:19 37:14  
38:2 42:23,23 45:23,24  
46:3 47:18 52:6 54:6  
55:19,23 65:4 76:15 88:9  
90:4,4 91:6 96:21,25 97:6  
100:22 103:6 107:11,13  
108:15,16 109:1 116:5  
117:3 119:19,20 121:11  
132:16 139:19 147:8  
148:19 155:23 164:20  
167:19 168:8  
yours (1) 135:5  
yourself (15) 27:17,24  
28:2,19,21 36:24 55:20  
66:2 68:3 73:18 88:6  
100:23 131:22 157:8  
167:16  
youve (26) 7:24 23:18 30:16  
76:16,17 78:24  
86:11,13,15 110:11,11,12  
120:1 132:17,20  
133:1,5,10 139:5 147:12  
149:15 156:21,24 157:3  
167:15 172:21  
Z  
zerohour (1) 81:21  
I  
1 (5) 29:12,12,13,19 175:2  
10 (4) 26:18,22 95:10 124:16  
10000 (2) 25:24 29:3  
103 (1) 166:14  
1049 (1) 46:18  
11 (3) 52:22,24 131:7  
1115 (1) 46:16  
1116 (1) 46:20  
115 (1) 166:12  
12 (5) 26:17 53:25 81:23  
96:10,25  
1216 (1) 90:9  
123 (1) 167:17  
1230 (1) 90:3  
124 (1) 167:17  
129 (1) 168:11  
13 (2) 54:14 97:24  
130 (1) 90:4  
130examinationinchief (1)  
175:4  
131 (2) 90:11 169:17  
132 (1) 170:7  
133 (1) 170:8  
134 (1) 133:8  
14 (4) 54:14 99:8 134:20  
136:11  
15 (3) 12:22 56:8 124:16  
1520 (1) 117:24  
155 (1) 133:9  
165 (1) 171:6  
17 (2) 58:6 101:24  
18 (4) 19:22 103:17,18 140:5  
19 (2) 1:20 140:14  
1999 (1) 36:13  
Ievidence (1) 175:2

2  
2 (5) 29:12,15 40:24 130:6  
136:5  
20 (4) 12:13 102:11 141:18  
142:17  
200 (1) 29:18  
2004 (1) 1:19  
2005 (1) 1:20  
2019 (1) 125:25  
2020 (45) 5:25 13:11 31:4  
32:21 39:17 40:3 49:22  
51:12 52:13,24 56:22  
58:11 71:14 78:8 82:16  
92:19 93:11 94:18 95:3  
98:16 99:11,13 106:7,9,17  
107:12 110:3 112:21  
115:22 116:5 118:4,25  
121:22 123:9 131:4 134:4  
143:6 146:10,11,12,21  
147:21 152:18 153:8  
171:19  
2021 (10) 1:21 86:6 123:9  
154:13,13 156:17,18 158:2  
159:10 170:5  
2022 (5) 40:24 132:18,24  
134:2 166:16  
2024 (2) 1:1 174:6  
21 (2) 62:11 141:12  
22 (1) 143:5  
227 (1) 129:19  
23 (7) 1:1 14:1 64:1 104:8  
135:12 143:9,10  
24 (6) 104:12 135:12 138:3  
143:10,12 144:5  
25 (2) 91:4 105:5  
259 (1) 129:21  
26 (1) 144:25  
27 (6) 68:3 106:4 174:1,2,3,6  
28 (3) 108:4 146:9 147:13  
29 (1) 69:22  
3  
3 (6) 29:12 39:17 48:6,12  
92:3 173:6  
30 (8) 6:24 12:3,4,14 48:18  
70:2 77:18 109:11  
30minute (1) 37:4  
31 (1) 109:20  
32 (2) 71:23 72:13  
33 (2) 8:24 72:16  
35 (3) 74:13 150:8 151:5  
36 (3) 12:1 75:5 79:14  
37 (4) 13:11 151:18,23  
152:15  
4  
40 (3) 76:11,12 153:9  
41 (1) 115:20  
42 (3) 76:11,12 116:9  
425 (1) 174:5  
43 (1) 154:12  
45 (2) 77:14 117:17  
46 (2) 78:21 118:6  
47 (3) 80:5 118:24 154:14  
47evidence (1) 175:3  
47examinationinchief (1)  
175:3  
48 (1) 108:5  
49 (1) 121:5  
5  
5 (1) 49:3  
50 (3) 29:17 120:16 156:8  
500 (1) 13:20  
500odd (1) 14:5  
51 (1) 120:16  
5130evidence (1) 175:4  
52 (1) 155:9  
55 (1) 81:17  
56 (1) 82:6  
57 (1) 82:9  
58 (2) 156:18 157:19  
59 (1) 160:8

6  
6 (1) 93:11  
60 (3) 41:21 48:9,17  
62 (1) 42:8  
63 (1) 161:2  
66 (1) 123:20  
67 (3) 87:25 123:20 162:11  
7  
7 (2) 32:5 94:3  
70 (4) 31:1 125:20 163:9  
166:1  
70kg (1) 38:9  
71 (1) 125:20  
75 (2) 8:20 128:19  
78 (1) 34:20  
8  
8 (5) 26:18,22 50:20 94:11  
134:5  
80 (3) 28:6,12,23  
800 (1) 6:13  
8000 (1) 29:4  
86 (1) 39:12  
86yearold (1) 9:22  
9  
9 (2) 94:25 95:3  
90 (2) 140:2 175:4  
90evidence (1) 175:4  
91 (1) 140:1  
911 (1) 138:13  
92 (2) 140:1 163:21  
95 (2) 166:1,2  
950 (1) 1:2  
99 (4) 121:6,10,11 166:11