

OPUS2

Scottish Covid-19 Inquiry

Day 54

June 27, 2024

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1 Thursday, 27 June 2024
 2 (10.00 am)
 3 THE CHAIR: Now, good morning, everybody. Before we start
 4 formal proceedings in a moment or two, I would just like
 5 to welcome everyone to our new hearing suite. We're
 6 delighted to be here and be able to offer, I hope,
 7 improved facilities for witnesses, legal
 8 representatives, and members of the public. We have
 9 increased the capacity, as those of you in George House
 10 will have appreciated, and we look forward therefore to
 11 offering more people the opportunity to attend our
 12 hearings in person.
 13 In October 2023, we began taking oral evidence from
 14 people who had been impacted by the devolved strategic
 15 response to the pandemic in the Health and Social Care
 16 sector. Mr Gale will say more about that in these
 17 sessions.
 18 Before we hear his closing submissions, I want to
 19 personally thank every witness who attended during
 20 the last several months and shared their experiences.
 21 It's not easy to give evidence in a public forum such as
 22 this, particularly when doing so involves sharing
 23 personal and often emotional experiences. What you have
 24 all told us is shaping and steering our investigations
 25 and our questions for those responsible for making and

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1 implementing decisions. I want to assure you of
 2 the value I personally place on the information you have
 3 shared with us.
 4 I also recognise that during these hearings on
 5 Health and Social Care, not all witnesses felt able to
 6 give oral evidence nor was it possible to invite
 7 everyone to give oral evidence. Therefore, I want to
 8 reassure you all that by written statements to
 9 the Inquiry, they have been read, analysed, and will
 10 form part of the Inquiry's digest of evidence.
 11 Now, I'm coming to invite Mr Gale to present his
 12 submissions, but before I do, I'll play the policeman
 13 for a second and say, as you know, you've all been
 14 allocated time slots and 15-minute slots to give your
 15 submissions. I will keep you to that. I have to do it
 16 to keep the thing running on time and schedule. So
 17 I apologise, and to forewarn you, I'll interrupt you
 18 a minute or so before you get to the end of your
 19 15 minutes and fire a warning shot across your bows.
 20 So with that warning, can I turn please to Mr Gale
 21 and invite him to make his closing submissions.
 22 Closing statement by MR GALE
 23 MR GALE: Thank you, my Lord, and good morning. And good
 24 morning to everybody here in the room and to all those
 25 who are watching us online.

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1 As has been observed by both many in these hearings
 2 and in more general commentary, the SARS COVID 2 virus
 3 confronted this country and indeed the world with
 4 the most pernicious and devastating public health
 5 emergency in living memory. The word "unprecedented"
 6 often accompanies mention of the pandemic. The word is
 7 not a synonym for "unforeseeable", and as we progress in
 8 our investigations in this Inquiry, we will examine
 9 critically the extent to which the authorities in
 10 Scotland were or should have been prepared for this
 11 pandemic.
 12 Four years on from the start of what became known as
 13 the COVID-19 pandemic, we are now largely in
 14 a post-pandemic world. But for many people in Scotland,
 15 the effects of the pandemic and its imposed restrictions
 16 will live long in the memory and will continue to have
 17 an adverse effect through the loss and bereavement
 18 caused, and many will carry with them the distressing
 19 memories of their loved ones' last days and moments, or
 20 in many cases where they were unable to be with their
 21 loved ones at the end of life. That distress is
 22 compounded by having to speculate about those last
 23 minutes.
 24 For others, the immediate impact was the enforced
 25 separation from loved ones in care institutions and

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1 the isolation which came with lockdowns. For those who
 2 worked through the pandemic in the Health and Social
 3 Care sector, and those engaged in the third sector,
 4 the memories of the unremitting pressure have left their
 5 scars, the witnessing of the suffering of others while
 6 trying to protect themselves against infection.
 7 As my Lord has said, we commenced hearing oral
 8 evidence in George House on 27 October last year in
 9 relation to the impacts of the pandemic and
 10 the strategic decisions that were taken in connection
 11 with it, all at this stage in the context of
 12 the Inquiry's Health and Social Care portfolio.
 13 Our first witness was Jane Morrison of the Scottish
 14 Covid Bereaved Group who spoke movingly of
 15 the circumstances which led to the death of her wife
 16 Jacky and her attendant grief and loss. Since then, we
 17 have heard oral evidence on 51 days concluding on 23 May
 18 of this year. In that period, we heard from 154
 19 witnesses. On a number of occasions, and where we
 20 considered it appropriate, we heard from panels of
 21 witnesses. Each witness, whether as an individual or in
 22 the case of panels, spoke to a written statement and in
 23 total we have 154 statements.
 24 At the outset of this concluding statement, on
 25 behalf of the Inquiry Team, I would like to express

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1 thanks to a number of people.
 2 Can I begin by expressing the Inquiry's thanks to
 3 all those witnesses who have engaged with the Inquiry,
 4 both in the process of providing statements and in many
 5 cases associated documents. The Inquiry recognises that
 6 for many witnesses, particularly for those who have
 7 experienced loss and/or have spoken of distressing
 8 circumstances, that process was not an easy one.
 9 Very few of our witnesses were familiar with
 10 the process of providing statements and then
 11 subsequently giving oral evidence, and the Inquiry has
 12 always recognised that the circumstances which the
 13 witnesses related were ones which, if they had
 14 the choice, they would have preferred not to have gone
 15 through.
 16 The Inquiry could not have assembled the evidence it
 17 now holds on health and social care impacts without
 18 the courage and fortitude of those witnesses, and we pay
 19 tribute to them.
 20 We would also like to thank and recognise
 21 the contribution of both solicitors and counsel, who
 22 represented various witnesses either individually or in
 23 groups, or who represented Core Participants and who
 24 contributed to the eventual presentation of
 25 the witnesses' evidence.

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1 We would also like to acknowledge with thanks
 2 the written closing statements which various Core
 3 Participants have filed with the Inquiry. Those have
 4 been, and will continue to be, analysed, as will any
 5 further oral statements which are made in amplification
 6 of those written statements.
 7 In my capacity as co-lead Counsel to the Inquiry and
 8 as the counsel leading the presentation of the evidence
 9 in this session, I am under no illusion as to the amount
 10 of work that has been involved in getting the Inquiry to
 11 this day. I would like to personally record thanks to
 12 my colleagues in the counsel team, to Mr Caskie KC,
 13 Miss Bahrami Advocate, Mr Stephen Advocate, Mr Dunlop
 14 Advocate, Ms Trainor Advocate and Mr Edwards Advocate.
 15 Each member of the counsel team has led a number of
 16 witnesses and has been responsible for leading evidence
 17 relating to particular topics. Members of the counsel
 18 team, in conjunction with members of the legal team,
 19 reviewed witness statements in draft and were
 20 responsible for the selection of those witnesses who
 21 subsequently gave oral evidence.
 22 The Inquiry has, as has been mentioned on a number
 23 of occasions, always endeavoured to carry out its work
 24 having regard to its human rights-based and
 25 trauma-informed approaches. The Inquiry has also set

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1 out in a statement published on its website this week
 2 its approach to considering equalities issues while
 3 undertaking its work, including hearings.
 4 We have strived to proactively provide opportunities
 5 for everyone to participate meaningfully in
 6 the Inquiry's investigations and recognise
 7 the importance of working closely with a range of
 8 diverse participants and organisations in gathering
 9 evidence on impacts.
 10 With all this in mind, I asked when we began this
 11 process that prior to the leading of evidence that each
 12 member of the counsel team should meet with the witness
 13 together with a member of the legal team. As we
 14 progressed this exercise, it was extended to include
 15 a member of the witness support team.
 16 The purpose of this was to establish a connection
 17 between the witness and the counsel who would be leading
 18 the evidence and to, hopefully, reassure the witness
 19 that we would endeavour to minimise the stress involved.
 20 With time slots allocated to each witness, these
 21 meetings were useful to ensure that the significant
 22 issues that the witness wished to convey to the Inquiry
 23 and/or to elaborate on were identified.
 24 As was repeatedly emphasised to witnesses, all
 25 the material that they provided us with in their

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1 statements would be taken into consideration by
 2 the Inquiry in its ongoing analysis, and I would wish to
 3 repeat that point now.
 4 I would also like to record my thanks to my co-lead
 5 counsel, Ms Van der Westhuizen KC and her counsel team
 6 of David Turner Advocate and Mary Ellen Stewart
 7 Advocate, for the assistance and support they have
 8 readily given us as we have progressed through
 9 the preparation for our hearings and the hearings
 10 themselves. And, in particular, the input which they
 11 gave where there was an overlap, as there frequently
 12 was, between the evidence that the witness was to give
 13 to our hearings and the matters which had relevance to
 14 the portfolios which the other team were concerned.
 15 I am pleased to say that we managed to achieve,
 16 I think, a 100% record of counsel meeting with witnesses
 17 in advance of their giving evidence, and on some
 18 occasions there was more than one meeting. I can speak
 19 from my own perspective that I found these meetings
 20 extremely helpful, and I am pleased that those
 21 solicitors who acted for witnesses largely confirmed
 22 that the witnesses found this process of assistance.
 23 I would also like to thank all the members of
 24 the legal team. Initially that team was led by
 25 Joanna Bain, then by Gordon McNichol and more recently

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1 by Pauline Reid. Their overall guidance has always been
2 informed and welcomed. The direct responsibility for
3 assembling the evidence which we have heard lay with
4 teams led by Joanna Mortimer and Samantha Rore, both
5 deputy solicitors to the Inquiry. And I pay tribute to
6 them, together with all the assistant solicitors and
7 paralegals.

8 The task of preparing the statements that have been
9 used in these hearings fell initially to the Inquiry's
10 team of statement-takers and their ability to relate to
11 and engage with witnesses and secure from them
12 comprehensive statements was essential. And, again, for
13 their work which was carried out under a great deal of
14 time pressure, we thank them.

15 As already mentioned, we involved members of
16 the witness support team in pre-evidential hearing
17 meetings with witnesses. We thank all of the members of
18 the witness support team for their involvement in these
19 meetings, but more specifically for the sensitive and
20 supportive work that they carried out during our
21 hearings to ensure the comfort of witnesses and their
22 supporters.

23 I will mention other members of the Inquiry Team in
24 certain specific contexts as I proceed in this closing
25 statement, but at this stage, I would also like to

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1 mention and thank those members of the document and
2 evidence management team, who have been responsible for
3 presenting the various statements and other documents on
4 the screen for the assistance of the witnesses and
5 indeed everyone else who was following proceedings; and
6 (b), the team of technicians who have been responsible
7 for recording and broadcasting our proceedings; and (c),
8 finally, the team of stenographers who have transcribed
9 our proceedings and who have produced our transcripts.

10 With that, which may sound a little like an Oscar
11 acceptance speech, I can turn, I think, perhaps to
12 the more substantial matter, which is the purpose of
13 this opening statement.

14 It will be appreciated that, given the number of
15 witnesses we have heard from, a detailed resumé of all
16 that written and oral evidence is beyond what can be
17 accommodated into a closing statement lasting just
18 a couple of hours. I will provide a brief indication of
19 what will be included in this closing statement in due
20 course, but at this stage, I should emphasise that while
21 the oral evidence that we have heard is of course an
22 extremely significant part of the material that
23 the Inquiry has assembled in its work to
24 examine the impacts in the Health and Social Care
25 sectors, the Inquiry has garnered considerable other

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1 information which will inform our work going forward.

2 In particular, we have written statements from
3 witnesses who did not give oral evidence, as well as
4 other information that has been provided to the Inquiry
5 in terms of Section 21 of the Inquiries (Scotland) Act
6 2005 or has been otherwise volunteered to the Inquiry.
7 All that information will be considered in the terms in
8 which it has been submitted. In addition, and as has
9 been publicised on the Inquiry website, the Inquiry has
10 commissioned and received from academics, considered to
11 be leading authorities in their respective fields,
12 research reports relevant to the issues presently under
13 consideration and discussion.

14 This has included introductory scoping research into
15 the provision of health and social care services from
16 academic institutions, including the universities of
17 Edinburgh Napier, Birmingham, Highlands and Islands,
18 Edinburgh and Glasgow.

19 We have supplemented this with further research from
20 Edinburgh Napier University into additional areas which
21 have been identified as our investigations have
22 progressed.

23 We have found the high quality research, which has
24 been produced to date, extremely instructive and we are
25 very grateful to all the academics involved for their

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1 continued and invaluable input.

2 We also have material which has been received by
3 the Inquiry's Let's Be Heard Team. So far, more than
4 5,500 people have shared their experience with
5 the Inquiry through Let's Be Heard. We heard directly
6 from people from every local authority in Scotland and
7 the team has participated in or looked — and hosted
8 more than 90 events. Many participants shared their
9 experiences online, on paper, and some 800 participated
10 in group discussions led by Let's Be Heard and
11 organisations in their communities.

12 Let's Be Heard published its preliminary findings in
13 November 2023, and many of the experiences analysed
14 involved health and social care. Key impacts that
15 participants have shared centred on communication
16 challenges, including poor coordination between
17 different areas of the healthcare system, and patients
18 and their families facing challenges trying to adapt to
19 new ways of communicating with healthcare staff.
20 Several respondents described the impacts of
21 the suspension of services, which resulted in missed or
22 late diagnoses, many with tragic consequences.

23 Many respondents recounted how they, or loved ones,
24 were forced to travel by ambulance, attend hospital
25 appointments, have major surgery, undergo cancer

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1 treatments, or give birth alone due to the COVID-19
 2 restrictions .
 3 Many experiences shared with Let's Be Heard also
 4 centred on care homes, where respondents shared
 5 the experience of losing family members, the inability
 6 to visit loved ones and the many difficulties navigating
 7 the difficult rules and restrictions . People who worked
 8 in care settings shared with Let's Be Heard the poor
 9 working conditions that were impacted by staff
 10 shortages, poor access to PPE, a lack of information and
 11 rules that they did not feel able to implement.
 12 That material has been and continues to be analysed
 13 by the Let's Be Heard team and we would like to pay
 14 tribute to Dr Anderson and her team for the work that
 15 they have done from the very beginning of this — of
 16 the Inquiry's existence .
 17 We have also heard from organisations representing
 18 those with protected characteristics and other
 19 disadvantaged groups, who have told us that the impact
 20 of the pandemic was not the same for everyone, nor
 21 did it feel equal .
 22 These insights have been instrumental in helping us
 23 consider how impacts have been felt by different
 24 communities across Scotland, and any potential
 25 disparities in that — in these impacts .

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1 It is appropriate at this stage that I give some
 2 indication of how the Inquiry intend to take forward
 3 the evidence and the information that we have heard and
 4 the information that the Inquiry has assembled relevant
 5 to impacts in the health and social care sector .
 6 As was explained both in the preliminary hearing in
 7 advance of this evidential session and in the opening
 8 statement, which I gave on 24 October last year,
 9 the decision to begin the Inquiry's oral hearings with
 10 evidence from those who were and continue to be affected
 11 by the pandemic and the associated strategic decisions
 12 was a quite deliberate one, guided by the desire to
 13 understand the effects that the pandemic and
 14 the associated decisions had on individuals who were
 15 receiving health and social care services , whether they
 16 were immediately and perhaps unexpectedly affected by
 17 contracting the virus , or where contracting the virus
 18 has had long-term implications, or where they were in
 19 receipt of longer-term health and social care service
 20 provision .
 21 We also wanted to understand and appreciate
 22 the effects of the pandemic and its restrictions had on
 23 those who were health and social care providers, whether
 24 they were in the NHS, the social care sector , the third
 25 sector or were part of the legion of unpaid carers . And

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1 in that connection, we were anxious to hear from
 2 individuals and representative organisations .
 3 As the Inquiry has made clear, we intend to progress
 4 from this evidential basis in the health and social care
 5 context to consider — to a consideration of
 6 the implementation of the strategic decisions and
 7 the decision-making processes themselves which
 8 underpinned those decisions .
 9 As has been previously stated, decisions have
 10 consequences and an understanding of those consequences
 11 is, in the view of this Inquiry, an essential element in
 12 assessing the decisions that were taken and the way in
 13 which they were implemented, and will, in our view,
 14 assist in the Inquiry's task of determining whether
 15 lessons can be learned should there be a future
 16 pandemic .
 17 Having assembled the evidence from these hearings as
 18 well as the other information to which I have made
 19 reference, the Inquiry is reinforced in its view that
 20 the sequence in which evidence has been taken has been
 21 conducive to providing a wealth of informed and detailed
 22 evidence, which the Inquiry can take forward to the next
 23 stages of our investigations .
 24 It is the Inquiry's intention to proceed to produce
 25 a detailed written narrative relating the evidence and

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1 other information that it has received in relation to
 2 impacts in the areas of health and social care . This
 3 will be just what I have said, it will be a narrative
 4 record, narrating all the impacts that the Inquiry has
 5 heard about . It will not be a report in the sense of
 6 a document reaching conclusions, and in particular will
 7 not include conclusions on matters of controversy where
 8 witnesses and informants have criticised matters of
 9 decision-making and implementation .
 10 It will also — it will, however, provide a context
 11 in which decision-making and implementation will be
 12 critically examined by the Inquiry . It will also
 13 provide an enduring record of the impacts of the most
 14 significant public health emergency experienced by
 15 the people of Scotland in living memory .
 16 It is our intention to provide a draft of this
 17 narrative by the end of this year and to publish
 18 a narrative on our website in Spring 2025 .
 19 As I have probably already indicated, the purpose of
 20 this closing statement is not an attempt to provide
 21 a comprehensive review of all the evidence that has been
 22 heard . The purpose is to identify certain of
 23 the significant themes which have emerged during
 24 the evidence and which we intend to pursue in our
 25 investigations going forward .

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1 In the Direction issued by the Chair on 30 April of
2 this year regarding closing statements, it was indicated
3 that the Inquiry would find it particularly helpful if
4 Core Participants who wished to make closing statements
5 would identify those impacts that are considered (a)
6 foreseeable, (b) most significant and/or detrimental,
7 and (c) might have been minimised or excluded had
8 reasonable steps been taken to do so.

9 We are extremely grateful to those Core Participants
10 who have expressed views on these matters. We accept
11 that, at this stage, the Inquiry has not heard evidence
12 against which some of these matters can be fully judged,
13 and in particular has not yet heard from
14 decision-makers. Obviously, issues covered in
15 particular by items (a) and (c) referred to in
16 the Direction will be matters on which the Inquiry will
17 wish to consider fully the evidence available to it and
18 reach conclusions and, where appropriate, make
19 recommendations.

20 That said, the Inquiry is interested to know
21 the views of those who have given evidence on
22 the impacts that the pandemic and its restrictions had
23 on these matters. We entirely accept that the evidence
24 of the witnesses we have heard from does not come from
25 the standpoint of independent expertise, or that, at

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1 this stage, is informed by the expertise of others. As
2 has been apparent from the evidence we have heard, many
3 of those who lived through the pandemic and lost loved
4 ones or had been struggling to see their loved ones in
5 care homes, or were care providers, or
6 the representatives of care providers, came to have an
7 informed background which is worthy of respect and
8 consideration. For example, the depth of knowledge
9 shown by Ms Russell, Ms Hall, Ms Leitch and
10 Miss Hamilton, the core representatives of the Care Home
11 Relatives Scotland Group and by Mrs Waterton of Scottish
12 Covid Bereaved was truly impressive.

13 There are two distinct matters raised by Core
14 Participants in written closing submissions that we feel
15 we require to be specifically addressed at this stage.

16 In the closing submission on behalf — in
17 the closing statement, rather, on behalf of
18 the Royal College of Nursing, it is mentioned, at
19 paragraph 25, that at the time of writing, it was
20 the College's intention to write to the First Minister
21 seeking an amendment to the Inquiry's current terms of
22 reference, so as to specifically mention Long Covid,
23 together with an amendment extending the period of
24 the Inquiry's remit specifically to consider matters
25 relating to Long Covid.

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1 The Inquiry is aware that such a letter to
2 the First Minister has now been sent. The question of
3 any amendment to the Inquiry's Terms of Reference is
4 accordingly before the First Minister awaiting his
5 decision. The Inquiry will obviously comply with any
6 decision taken by the First Minister in this regard and
7 any direction to the Inquiry as to its Terms of
8 Reference.

9 The closing statement on behalf of Care Home
10 Relatives Scotland/CHRS Lost Loved Ones contains, in
11 paragraphs 40 and following, a case in favour of
12 Anne's Law, a case with which Miss Hamilton in
13 particular and other members of the CHRS group made
14 powerfully in the course of their evidence.

15 What is sought by Miss Hamilton in terms of
16 legislation differs from what is presently before
17 the Scottish Parliament in terms of clause 40 of
18 the National Care Services Bill. As is explained by
19 CHRS in their closing statement, clause 40 is, they
20 contend, what they describe as an "insipid provision".
21 The reference is paragraph 43.

22 Insofar as that provision is directive only as to
23 the Ministers' powers to make directions concerning
24 visiting, it does not and fails to confer any right and
25 it is maintained falls short of what is required and

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1 does not comply with the human rights-based approach for
2 which the legislation contends.

3 On this hypothesis, and given the present position
4 of the attendant legislative process, Care Home
5 Relatives Scotland invites, through the closing
6 statement, the Chair to play a significant role in
7 the development of the position by making
8 a recommendation at this stage, based on the evidence
9 thus far heard in support of the enactment of Anne's Law
10 as sought by Miss Hamilton and her supporters.

11 In support of that submission, CHRS maintains that:
12 "There would be no need to hear further evidence
13 (eg of policy makers) to make such a recommendation;
14 the clear, consistent and overwhelming evidence during
15 these hearings would be sufficient."

16 Whether my Lord considers that he can or should, at
17 this stage, make a recommendation as sought by CHRS is
18 obviously a matter for him. As co-lead
19 Counsel to the Inquiry and having been involved in
20 the leading of the evidence thus far, which CHRS refers
21 to, I consider that I should express my view on
22 the matter. It is recognised that Anne's Law, as
23 contended for by Miss Hamilton and others, has been at
24 the forefront of their campaign. It has been argued for
25 both in these hearings and in other public fora. That

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1 argument has been informed and has been passionate.
 2 The role of the Chair of a public inquiry does
 3 include, where appropriate, the making of
 4 recommendations as to possible legislative innovation or
 5 improvement. In the circumstances presented by this
 6 application by CHRS, it is, in my opinion, and would be
 7 my advice to your Lordship, that a recommendation should
 8 not be made at this stage.

9 A decision has been taken by Government to proceed
 10 to take forward Clause 40 in its present terms.
 11 The Inquiry has not heard from either policymakers
 12 and/or legislators as to their reasoning for the present
 13 wording and its divergence from what is sought by CHRS.
 14 We are also aware that we have not heard fully from
 15 the viewpoint of those who would have to implement
 16 Anne's Law and who would have to act within its terms.
 17 Dr Macaskill of Scottish Care did indicate in his
 18 evidence his support for Anne's Law, but that support
 19 was for the current legislative proposal.

20 I have made my Lord aware of my advice and I have
 21 also communicated this to the representative of CHRS.

22 Can I turn now to consider some matters of research
 23 and background information and evidence.

24 Before we look at some of the significant and
 25 recurring themes which emerged from these impact

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1 hearings, we would like to refer to some research that
 2 the Inquiry team has carried out and prepared as
 3 background to these hearings, together with a number of
 4 matters which we consider to be significant in informing
 5 and contextualising the evidence which we have heard.

6 On the matter of research, can we thank Millie Lewis
 7 in particular and her team for the work that they have
 8 done.

9 We begin with some data about the effects of
 10 the pandemic and, in particular, data concerning
 11 the deaths which occurred during the period of
 12 January 2020 — obviously more realistically March 2020
 13 to December 2022, all in accordance with our Terms of
 14 Reference.

15 It will probably be recalled that during
 16 the pandemic, the daily number of deaths was disclosed
 17 at press conferences conducted by
 18 the Scottish Government and in particular by the then
 19 First Minister. It was regularly said that each death
 20 was a tragedy for the families and loved ones of those
 21 who had died. Over the past months, the Inquiry has
 22 heard evidence which gives much greater detail of
 23 individual deaths and, informed by that evidence,
 24 the Inquiry would wish to recognise the tragedy that
 25 the pandemic has wrought on families in Scotland.

22

1 The Inquiry research team has investigated
 2 the available data concerning deaths in Scotland in
 3 the relevant period. This data is obtained from
 4 consideration of the monthly mortality analyses
 5 published by the National Records of Scotland. These
 6 analyses identify where COVID-19 was (a) recorded as
 7 the underlying cause of death, and (b) mentioned on
 8 the date — on the death certificate as either
 9 the underlying cause or a contributory factor.

10 Firstly, in relation to deaths, data published by
 11 the — I will just use the acronym NRS — the National
 12 Records of Scotland indicated there were 16,537 deaths
 13 within the period of the Inquiry's Terms of Reference
 14 for which COVID-19 was mentioned on the death
 15 certificate as either the underlying cause or
 16 a contributory factor.

17 NRS data indicated that in that period there were
 18 4,489 deaths in care homes, again in which COVID-19 was
 19 mentioned on the death certificate as either
 20 the underlying cause or a contributory factor.

21 The NRS data also indicated that there were 10,700
 22 deaths in hospitals within the period, again where
 23 the death certificate disclosed COVID-19 as either
 24 the underlying cause or a contributory factor.

25 We also analysed the range of ages of those who died

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1 from COVID-19. People aged over 65 made up 87.9% of
 2 total deaths from COVID-19 during that period, and,
 3 tragically, almost 100% of deaths in care homes.

4 We also obtained data regarding positive cases of
 5 COVID-19 from the start to the end of the period of
 6 the Inquiry's Terms of Reference.
 7 Public Health Scotland's data indicated that there were
 8 approximately 2.1 million recorded positive cases of
 9 COVID-19 in Scotland.

10 It should also be noted that during the period of
 11 our consideration, there were 1,092 all—adult care homes
 12 in Scotland with a total of 41,299 available places. As
 13 will be apparent from these figures, people over the age
 14 of 65 contributed disproportionately to the number of
 15 total deaths from COVID-19 in Scotland.

16 The data discloses that in the first wave of
 17 the pandemic, in March and April 2020, the weekly deaths
 18 where COVID was disclosed as either the underlying cause
 19 or a contributory factor peaked at 663 per week. And in
 20 the second wave, in December 2020 into January 2021,
 21 the weekly deaths peaked at 452.

22 As was observed in our opening statement in relation
 23 to these hearings, COVID continues to claim lives.
 24 The number of deaths where COVID has been either
 25 the underlying cause or a contributory factor now

24

1 stands, as at the 16th of this month, at 18,880.
 2 Can I give now some further data regarding
 3 Long Covid, which of course has been something about
 4 which we have heard a good deal of evidence.
 5 We have heard a great deal of evidence concerning
 6 the impact caused by developing Long Covid and its
 7 varying and debilitating effects on individuals. That
 8 evidence has come from individuals, including a number
 9 of individuals who contracted COVID in the course of
 10 their work in the Health and Social Care sectors and
 11 also from individuals speaking on behalf of their
 12 children.
 13 We have also heard from representatives of
 14 organisations speaking of the impact that Long Covid has
 15 had on workforces, particularly within the Health and
 16 Social Care sectors.
 17 Given that evidence, it seemed to us that we should
 18 seek to obtain some data regarding the prevalence of
 19 Long Covid in Scotland during the period of our remit.
 20 Beyond a simple extrapolation from the number of people
 21 who have self-reported Long Covid across the UK, our
 22 researchers have drawn to our attention certain
 23 research, which I will expand on in a moment, but which,
 24 subject to certain caveats, suggests that in the period
 25 between 1 March 2020 and 26 October 2022, some 90,712

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1 individuals had Long Covid, representing 1.8% of
 2 the population.
 3 This figure has been produced by the Usher Institute
 4 at the University of Edinburgh and is entitled — I'll
 5 give you the full title of the work, "Prevalence and
 6 risk factors for Long Covid among adults in Scotland
 7 using electronic health records: a national
 8 retrospective, observational cohort study".
 9 The study looked at the electronic health records of
 10 all adults, being those aged 18 or over, and who were
 11 registered with a general medical practice in Scotland
 12 between the two dates that I have indicated. That
 13 cohort of individuals represents 4.7 million adults, or
 14 98–99% of the population. Four different methods were
 15 used to identify Long Covid cases. These were as
 16 follows.
 17 Firstly, clinical codes where Long Covid was
 18 specifically entered into a patient's records by their
 19 GP.
 20 Secondly, free text in primary care records, which
 21 would include notes or non-coded information recorded
 22 into a patient's records by their GP, for example, about
 23 the symptoms they are experiencing.
 24 Three, sick notes.
 25 Four, using a novel operational definition. This is

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1 a definition of Long Covid developed by the study team
 2 at the Usher Institute based on patients having
 3 a positive COVID-19 test and two or more features, being
 4 either symptoms, clinical investigations or
 5 prescriptions recorded in the patient's records which
 6 are or were suggestive of Long Covid.
 7 This information does come with a number of caveats
 8 which the Usher Institute themselves issue. It is
 9 thought that the findings are likely to be a substantial
 10 underestimate of the number of people who have been and
 11 continue to be affected by Long Covid. This caveat
 12 reflects some of the challenges in diagnosing
 13 Long Covid, about which we have heard a good deal in
 14 evidence, and inconsistencies in recording information
 15 in the Electronic Health Register — records.
 16 However, it is thought that this study does appear
 17 to represent the most complete data source for
 18 estimating the number of positive diagnoses rather than
 19 an estimate depending upon self-reporting.
 20 The study also discloses that several groups have
 21 been and continue to be disproportionately affected by
 22 Long Covid. These groups include females, those aged in
 23 the general population between 38 and 67, those who are
 24 overweight or obese, those who are living with two or
 25 more underlying health conditions, those who are

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1 immune-suppressed, those who were advised to shield,
 2 those who were hospitalised within 28 days of testing
 3 positive for COVID-19 and those who were tested positive
 4 for COVID-19 before the Omicron variant became
 5 the dominant variant in the UK.
 6 I turn now to another background issue, but one
 7 which has been relevant throughout really all of our
 8 hearings and which is, in our view, very significant,
 9 and that is grief and bereavement.
 10 We would like to say something about the information
 11 that the Inquiry has garnered and heard about concerning
 12 grief. Dealing with grief in the context of
 13 the pandemic and its restrictions has been a recurring
 14 theme throughout this — the evidence we've heard. We
 15 of course recognise that grief was poignantly expressed
 16 by those who lost loved ones to COVID-19, but it also
 17 affected those who were denied proper basic contact with
 18 their loved ones during the pandemic and those who cared
 19 for residents and patients and who observed their
 20 suffering and in many cases death in distressing
 21 circumstances.
 22 The Inquiry has had regard to research carried out
 23 into grief experienced during the pandemic and in
 24 particular to Prolonged Grief Disorder, PGD as it is
 25 referred. In this regard, the Inquiry considered

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1 research carried out jointly by the Universities of
2 Cardiff and Bristol and published in a paper entitled,
3 "Prolonged grief during and beyond the pandemic: Factors
4 associated with levels of grief in a four time–point
5 longitudinal survey of people bereaved in the first year
6 of the COVID–19 pandemic", which was produced by Harrop
7 and others.

8 We are very grateful to Ms Morrison of
9 the Covid Bereaved Group for providing us with
10 a statement specific to this matter in which she
11 explained grief in the context of a pandemic and
12 a reference to her own experience and also to those of
13 others within the Scottish Covid Bereaved Group.

14 The work by Harrop and others focused on the factors
15 which have an influence on PGD. These factors included
16 the relationship to the person who died, the cause,
17 expectedness and place of death, the circumstances of
18 death and the disruption of the grieving process.

19 The authors state as follows:

20 "It is recognised that a significant minority of
21 bereaved individuals will experience more complicated
22 and problematic grieving processes, including
23 development of PGD. Essential characteristics of PGD
24 include persistent and pervasive longing for, or
25 preoccupation with the deceased, associated with intense

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1 emotional pain (eg., sadness, guilt, denial), functional
2 impairment and atypically prolonged symptoms relative to
3 cultural norms (lasting a minimum of 6 months post
4 bereavement)."

5 In her evidence and under reference to some of these
6 factors, Ms Morrison explained that in the unique
7 circumstances of the pandemic, the trauma associated
8 with death started before the death of the loved ones.
9 This was particularly in the early days of the pandemic
10 and it was associated with the anxiety about the safety
11 of a loved one in a care home, which was ratcheted up
12 having regard to the frightening news emanating from
13 Spain and Italy. The tension for family members and
14 loved ones was exacerbated by constantly waiting for
15 updates on the specific condition of a relative or
16 a loved one and the information concerning the presence
17 or otherwise of COVID within the institution.

18 The final moments with a relative or loved one,
19 which we have heard about, were obviously distressing.
20 For many witnesses, the final moments were hastily
21 arranged and, in some cases, they were unable to be
22 present at the moment of death. Ms Morrison put it
23 thus:

24 "Some of us were lucky enough to be there at the end
25 but even then, we were wearing gloves and masks. Even

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1 the final holding hands was tainted in our experience
2 because of the gloves. You couldn't even kiss them
3 goodbye; you were there trying your best to comfort them
4 and even then, we couldn't do it properly."

5 The Inquiry heard evidence from witnesses who could
6 not be with their loved ones at the moment of death and
7 witnesses expressed a variety of emotions in relation to
8 that denial, including anger, frustration and guilt.
9 Pamela Thomas expressed it thus:

10 "I feel like we abandoned him. We left him. My
11 heart has been ripped out and I will never be the same
12 again. It makes me question everything ..."

13 Death obviously occurred in a wide variety of places
14 and circumstances. For those who acquired COVID–19
15 while living in the community and who were then moved
16 into hospital, the circumstances were particularly
17 alarming for that person and their relative. There
18 would be the departure from the home and the worry that
19 the relative would never see that person again.

20 We would observe that there was evidence that
21 demonstrated poor communication in the lead up to and
22 immediately following the death. Witnesses observe that
23 while death occurred in that context, in the context of
24 a national emergency, the common decencies were on
25 occasions dispensed with. That said, there was evidence

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1 of communication at and around the time of death, which
2 demonstrated compassion and understanding.

3 A specific issue that emerged in the evidence was
4 the prevalence of DNACPR notices. We will look in more
5 detail at this, given that it is specifically referred
6 to in our Terms of Reference 2(i). However, a number of
7 witnesses complained that DNACPR notices were placed on
8 their relatives' notes without an appropriate level of
9 consultation.

10 We would observe at this stage what was said by
11 Dr Jennifer Burns of the British Geriatric Society, who
12 stated at paragraph 59 of her statement that discussions
13 around DNACPR and end of life care generally can be
14 difficult. Then I quote from her statement:

15 "... but it is so important that concerns are
16 alleviated with good communication and trust in
17 the health professionals providing care. A decision not
18 to undertake CPR should also be part of a plan to
19 describe what treatments are available and what might be
20 useful, and these can ... be documented in records in
21 the form of 'Treatment Escalation Plans' or in
22 Anticipatory Care Planning records."

23 Coping with grief was not helped by the processes
24 that had to be gone through in the immediate period
25 after death. We have heard some highly distressing

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1 evidence as to what seemed to relatives to be
2 the absence of the usual decencies which accompany
3 death. While there were accounts that demonstrated that
4 those engaging with relatives around the time of grief
5 acted with compassion and understanding, and also on
6 occasions witnesses who — carers who went beyond what
7 was at that time the restriction, they acted with
8 compassion and understanding.

9 But there was also evidence of unnecessarily and
10 unfeeling insistence regarding the removal of loved
11 one's possessions. Some witnesses returned to an empty
12 house and due to the presence of lockdown restrictions
13 were unable to engage with other relatives or friends to
14 share memories and attempt to offer comfort in what were
15 obviously trying and distressing circumstances.

16 We also heard evidence from many witnesses regarding
17 the restrictions in place on funerals, including
18 the sealing of coffins and the restriction on the number
19 of mourners in attendance. In certain cases, those
20 restrictions caused family tensions and family members
21 had to take the invidious and difficult decision of who
22 to invite to the funeral.

23 Dealing with grief did not end with the funeral and
24 the committal of the deceased's body. Restrictions on
25 associations denied family members the opportunity of

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1 the normal physical comfort that association with other
2 members of the family and friends could bring. There
3 was also evidence of a lack of appreciation by certain
4 health professionals and institutions in the period
5 following upon death. As Ms Morrison put it,
6 "The expression 'cast adrift' comes to mind".

7 There can be little doubt but that death in
8 the context of a pandemic was for many reasons
9 a traumatic experience, both obviously for the deceased,
10 but also for family members and loved ones left to
11 mourn. Dealing with these experiences was exacerbated
12 by the unthinking behaviour of others — those who were
13 COVID deniers, those who were conspiracy theorists and
14 the events in Downing Street were, as Ms Morrison put
15 it, the ultimate insult.

16 Can I deal now briefly with another background but
17 significant issue, and that is in relation to dementia.

18 In amplification and clarification of the evidence
19 that the Inquiry knew had been obtained concerning
20 the impacts on the elderly, particularly those in
21 care homes, the Inquiry sought and obtained evidence
22 from Henry Simmons, the CEO of Alzheimer Scotland, and
23 Dr Jennifer Burns, consultant geriatrician, who was
24 during the currency of the period contained in
25 the Inquiry's remit, the President of

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1 the British Geriatric Society. From their different
2 perspectives, they provided the Inquiry with considered
3 and detailed information about the various challenges
4 that are presented to those with dementia and frailty,
5 and to their carers.

6 The evidence from these witnesses is required to be
7 considered in its entirety, but at this stage, we would
8 wish to make the following observations.

9 (a) there is a dementia spectrum at the far end of
10 which are persons with advanced dementia and who require
11 24-hour care, whether in their own homes with
12 the support of family members, or engaged carers or in
13 care homes. Further along the spectrum were those who
14 had been more recently diagnosed and where there was
15 a desire to work with such people to assist with
16 building resilience so that they could continue to live
17 well, and, if possible, to continue to engage in
18 everyday community activities. There are, according to
19 Mr Simmons, potentially between 15,000 and 20,000 people
20 developing dementia in Scotland, all of whom are at
21 various stages awaiting a diagnosis.

22 (b) The impact of lockdown and associated measures
23 fell on carers, family members, and the stress that they
24 were under was, in Mr Simmons' assessment, "huge".

25 (c) The information which Alzheimer Scotland

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1 obtained in the early days of the pandemic from those it
2 assisted that the organisation become stronger in saying
3 that the impact on people was so significant that
4 the organisation was seeing people in the early stages
5 of dementia advancing to a more advanced stage rapidly.
6 In this regard, Alzheimer Scotland identified a number
7 of significant factors, including the impact of social
8 isolation and loneliness, the loss of usual support
9 networks, the impact of not being able to spend time
10 with family members in care homes, with — and in our
11 view significantly — "substantial levels of anxiety and
12 emotional trauma for both families and people with
13 dementia".

14 (d) Mr Simmons expressed his personal view in his
15 statement at paragraph 68 that:

16 "The public health concerns and focus remained for
17 too long the driving force for decision-making and that
18 impacted people in the most profound way."

19 (e) That the data provided by Alzheimer Scotland was
20 that there were 29,485 long-stay residents in care homes
21 in Scotland and that, of that number, 18,500 had
22 dementia.

23 (f) That the image of someone living with dementia
24 is as someone who is frail and elderly, but a lot of
25 people were active and wished to remain involved in

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1 social activities .
 2 (g) Being confronted with staff wearing face masks
 3 would likely have had an impact on the wellbeing of
 4 residents . Again, I quote from Mr Simmons:
 5 "Someone living with dementia, even advanced
 6 dementia, struggles to have a sense of time, place and
 7 person. When looking after someone with dementia you
 8 need to help them with a sense of self and wellbeing
 9 using reminiscence techniques, social stimulation,
 10 cognitive stimulation. That is all mainly done in
 11 a care home environment in a group basis."

12 That statement is from paragraph 74 of his
 13 statement.

14 (h) That the news emanating from Spain and Italy in
 15 the early days of the pandemic gave rise to
 16 a realisation that the virus could have a devastating
 17 effect on people in care homes, and that it was likely
 18 that in Scotland older people would be very vulnerable,
 19 particularly those who were living with frailty .

20 Frailty is a distinctive health state relating to
 21 the aging process in which multiple body systems
 22 gradually lose their inbuilt reserves. Around 10% of
 23 people over 65 have frailty , rising to between a quarter
 24 and a half of those over 85. Older people living with
 25 frailty are at a risk of adverse outcomes even after

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1 apparently minor challenges to health, such as
 2 infection . People living in care homes are likely to
 3 have more advanced levels of frailty .

4 (i) That the lack of universal testing and delay in
 5 recognising the variation of symptoms in older people
 6 left older people exposed to underdiagnosis in the early
 7 stages of the illness , the illness being COVID.
 8 The mortality rate from COVID infection is very
 9 age—dependent and higher if the person is frailer and
 10 has complex co—morbidity, as was the case with many
 11 hospitalised older people and care home residents.

12 (j) Patients/residents with dementia are more likely
 13 to suffer from delirium if acutely unwell with illnesses
 14 such as COVID, leading to a more confused and agitated
 15 state, thus making it harder to keep them safe in an
 16 environment. Conversely, delirium can cause people to
 17 become very sleepy and to stop eating and drinking.

18 (k) Dr Burns observed that the term "vulnerable" was
 19 a blanket term used to apply to older people and as such
 20 was a shock to many people who were happily living their
 21 lives . A report by Age UK on the impact of COVID—19 on
 22 older people's mental and physical health commented on
 23 anxiety related to the risks from the virus resulting in
 24 many older people being afraid to go out and resume
 25 previous activities , even when restrictions had ended.

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1 Lockdown affected many older people's ability to
 2 undertake activities , such as regular exercise , social
 3 interaction and a sense of purpose and the longer—term
 4 impact is likely to be negative for their physical and
 5 mental health.

6 (l) We would wish to quote from full what Dr Burns
 7 said at paragraph 70 of her statement:

8 "Care homes are an individual's own home and as
 9 the pandemic eased, restrictions eased in many settings
 10 but were slower to relax for those living in care homes.
 11 Social isolation is harmful to care home residents and
 12 can result in low mood or cognitive or functional
 13 decline. We were restrictive for a lot of the pandemic
 14 for reasons that at the time I [that being Dr Burns]
 15 supported, but on reflection and feedback from members,
 16 I consider that these restrictions were too prolonged.
 17 Visiting policies should take account of the benefits
 18 and risks to the individual resident , the potential
 19 risks to the wider care home population and the current
 20 prevalence of COVID in the surrounding community. As
 21 testing capacity increased, a rollout of testing for
 22 visitors to care homes should be added to the strategy
 23 to provide some reassurance."

24 Another factual matter that I would like to discuss
 25 is the evidence that we've heard relating to

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1 the transmission of the virus by airborne means.

2 In the course of the evidence in these hearings, we
 3 have heard reference made to this significance, and it
 4 has an oblique bearing on the impacts incurred in
 5 the health and social care sector, particularly in
 6 relation to the suitability and availability of PPE.

7 This issue concerned the mode of transmission of
 8 the SARS COVID 2 virus. A number of witnesses referred
 9 to that issue, and I make particular reference to
 10 the evidence of Dr Macaskill of Scottish Care,
 11 Dr Ian Kennedy of the BMA Scotland and Colin Poolman,
 12 Norman Provan and Eileen McKenna of RCN Scotland, and
 13 also various witnesses from the STUC.

14 From these witnesses there has been a considerable
 15 body of evidence to the effect that in the early stages
 16 of the pandemic, there was an intransigence on the part
 17 of the Scottish Government to accept the emerging — and
 18 it is said compelling — scientific evidence that
 19 COVID—19 was transmitted in an airborne or aerosol
 20 manner rather than by droplets.

21 The RCN was sufficiently confident by March 2021 to
 22 present to the Scottish Government a case that the virus
 23 was transmitted in an airborne manner, a case backed up
 24 by international scientific research. The apparent
 25 failure of the Scottish Government to accept

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1 this submission was referred to in the evidence of
2 Dr Kennedy of the BMA as adherence to what he described
3 as "droplet dogma".

4 This is clearly a matter which the Inquiry will wish
5 to investigate further in its implementation and
6 decision-making hearings.

7 The Inquiry is aware that
8 the World Health Organisation, on 23 December 2021, on
9 its website, under the heading, "Coronavirus ...
10 (COVID-19): How is it transmitted?", stated that:

11 "Current evidence suggests that the virus spreads
12 mainly between people who are in close contact with each
13 other for example at a conversational distance.

14 The virus can spread from an infected person's mouth or
15 nose in small liquid particles when they cough sneeze
16 speak sing or breathe. Another person can then contract
17 the virus when infectious particles that pass through
18 the air are inhaled at short range (this is often called
19 short range aerosol or short range airborne
20 transmission) or if infectious particles come into
21 contact with the eyes nose or mouth (droplet
22 transmission). The virus can also spread in poorly
23 ventilated and/or crowded indoor settings where people
24 tend to spend longer periods of time. This is because
25 aerosols can remain suspended in the air or travel

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1 farther than conversational distance (this is often
2 called long range aerosol or long-range airborne
3 transmission). People may also become infected when
4 touching their eyes, nose or mouth after touching
5 surfaces or objects that have been contaminated by
6 the virus."

7 The Inquiry is aware that this alteration to
8 the World Health Organisation guidance has been
9 criticised for its lateness and the manner in which it
10 was disseminated, which was described as being "quietly
11 edited".

12 I now turn, if I may, to the position of those in
13 care homes.

14 At the outset of our investigations, and in planning
15 those areas in which we wished to consider the impacts
16 of the pandemic and associated restrictions,
17 the Inquiry Team made a positive decision that we would
18 endeavour to consider the impacts on those who were
19 the most vulnerable in our society. In identifying such
20 groups, we were guided by our trauma-informed and human
21 rights-based approach and also by Terms of Reference
22 7(c), which provides that the Inquiry will, as the Chair
23 deems appropriate and necessary, consider any
24 disparities in the strategic elements of handling of
25 the pandemic, including unequal impacts on people.

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1 A vulnerable group specifically identified for our
2 consideration was and is, of course, those who were
3 residents in care homes and nursing homes, and in that
4 connection, the Inquiry was directed through the wording
5 of Term of Reference 7(g) to consideration of issues
6 relating to the transfer of residents to or from homes,
7 the treatment and care of residents, and infection
8 prevention and control.

9 Other vulnerable groups included those who were
10 disabled, both in care institutions and in
11 the community, those who were socially and/or
12 economically disadvantaged, those who were required to
13 shield, those who were homeless, those who were drug
14 and/or alcohol addicted and those who were in custody.

15 The Inquiry is also grateful for the participation
16 in these hearings by the Scottish women's rights
17 organisations and the evidence provided by the panel
18 from those organisations in support of their statement
19 has been extremely helpful and again will inform work
20 going forward.

21 Of particular concern to the Inquiry is to learn of
22 the impact on both women and children where, because of
23 lockdown, they were confined — as it was put "trapped"
24 — into a home with an abusive partner.

25 It will be appreciated that residents in care homes

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1 largely comprise those who will be described as elderly,
2 and as will have been apparent from the evidence we have
3 heard, the evidence conveying the impacts on that group
4 came principally from their relatives. We should note
5 that not all care home residents about whom we've heard
6 were elderly, and we heard moving accounts of
7 the effects of the pandemic that restrictions had on
8 the children of witnesses within the Care Home Relatives
9 group.

10 We should also observe that while the focus was
11 properly on the impacts on the residents, the evidence
12 also disclosed the impacts on the relatives, who, for
13 substantial periods during the period of our
14 consideration, were forced to wonder and speculate about
15 the condition of their loved ones at times when visiting
16 was prohibited, and, on other occasions, had to view
17 their loved ones either remotely or from a distance
18 without the ability to physically interact with them.
19 While many spoke stoically of their experiences,
20 the impact of these events on these relatives cannot be
21 underestimated.

22 As has already been mentioned under reference to
23 the evidence of Mr Simmons and Dr Burns, and as has been
24 pointedly emphasised by many relatives, the care home is
25 not a clinical setting. It provides a home for the

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1 resident , and many witnesses spoke of the steps that had
2 been taken to personalise the resident 's accommodation.
3 Prior to a resident moving into care, their family
4 members had frequently been the care providers, and
5 aftercare in a care home setting became essential. And
6 prior to the pandemic, relatives had frequently been
7 involved in assisting with care in the care home
8 setting .

9 The immediate closure of care homes in March 2020
10 was, as many witnesses testified , a devastating
11 disruption of normality for both the residents and
12 the relatives . On occasions, the circumstances in which
13 homes closed did not allow for any period of adjustment
14 or where it might have been possible to give some
15 explanation of the reasons for closure .

16 Many witnesses spoke of the immediate cessation of
17 contact with their loved ones, and while in some cases,
18 some form of continued contact was possible through
19 the use of communication devices, in many cases,
20 the isolation of the resident was complete, with
21 the exception, obviously, of contact with people within
22 the care home.

23 That inevitable degree of uncertainty as to
24 the effect that isolation was having on the resident
25 compounded the concern that relatives had about their

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1 loved ones. A number of witnesses spoke of the adverse
2 effect that the period of complete isolation had on
3 the resident in terms of both their physical and mental
4 well being.

5 Subsequent alleviation of isolation did occur
6 through window and garden visits. While those did
7 afford welcome opportunities for relatives to see their
8 loved ones, there were many criticisms of such visits .
9 Windows were frequently in locations and at elevations
10 which made sightlines between visitors and residents
11 difficult . There were obvious problems with relatives
12 in particular making themselves heard. For those
13 residents with dementia, their loved ones often felt
14 that the strangeness of the arrangement caused
15 the resident distress . Weather conditions inevitably
16 and often presented problems. The privacy of
17 conversations was often compromised. Garden visits were
18 frequently a euphemism for meeting outside.

19 Evidence of visits of these types revealed an
20 understandable cause of frustration for relatives .
21 Residents were regularly accompanied by carers during
22 such visits . Indeed, the impression was occasionally
23 given that such visits were being policed by carers.
24 Indeed, on other occasions, the word "imprisonment" was
25 used.

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1 For relatives , the fact that carers could be next to
2 their loved ones, touch them, offer them comfort while
3 they, the relatives , were denied that basic interaction
4 seemed understandably both inconsistent and unfair.

5 Underlying the sense of grievance felt by relatives
6 was the knowledge that their presence as part of
7 the care team for their loved one could help reduce
8 the pressure on the care home staff, provide a familiar
9 face for the resident and the assistance of somebody who
10 was intimately familiar with the resident 's routine and
11 likes and dislikes , and who would take whatever
12 precautions were necessary, or deemed necessary and
13 appropriate to protect their loved one from infection.

14 As has already been alluded to, many witnesses spoke
15 of noticing a marked deterioration in the physical and
16 mental wellbeing of their loved one following upon
17 extended periods of isolation . This deterioration was
18 understandably attributed to the isolation . It should
19 be appreciated that compliance with restricted access to
20 a loved one had an adverse effect on their wellbeing.

21 THE CHAIR: Mr Gale, I appreciate it's a little early, but
22 you're well ahead of schedule.

23 MR GALE: Well ahead of schedule, and there's not very much
24 to go, my Lord, but I would welcome a break at least.

25 THE CHAIR: And we could be indulgent and have a little

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1 longer.

2 MR GALE: Yes.

3 THE CHAIR: So instead of 15 minutes, we'll take about 25 or
4 something and we'll come back at 11.45.

5 MR GALE: Thank you, my Lord.

6 THE CHAIR: Thank you, all.

7 (11.22 am)

(A short break)

9 (11.45 am)

10 THE CHAIR: Good, right. Now, Mr Gale, when you're ready.

11 MR GALE: My Lord, yes.

12 My Lord, I'm about to move on to the subject ---
13 again, it's seen as a background subject --- of
14 communication and guidance.

15 Throughout the hearings, an issue that has been
16 presented on a number of occasions and in a number of
17 different contexts is that of communication. And at
18 this stage, I would like to refer to a number of
19 contexts.

20 Firstly , guidance provided by authorities has
21 frequently been referred to and criticised . In
22 particular , there has been considerable evidence from
23 those who are required to understand guidance issued by
24 authorities which regulated the circumstances in which
25 those in care could be visited . That evidence came from

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1 those who wanted to visit and from those who required to
 2 act in accordance with this guidance in providing care
 3 facilities .
 4 A recurring criticism was that the guidance was
 5 subject to constant change, such that all who required
 6 to understand the guidance had difficulty in knowing
 7 what, at any particular time, was the current guidance,
 8 and this was frequently compounded by guidance being
 9 issued at the end of the week.
 10 Also of concern was the criticism made by many
 11 witnesses that the framing of the guidance was designed
 12 for — or more for application to the circumstances of
 13 acute clinical settings and did not properly take
 14 account of the care settings in which mainly elderly
 15 residents , many of whom suffered some level of dementia,
 16 could not be expected to observe the restrictions more
 17 appropriate for clinical settings .
 18 This is an area of communication between authorities
 19 and the public which is, in the Inquiry’s view,
 20 a significant one having regard to our Terms of
 21 Reference. The Inquiry is, going forward to its
 22 investigations around implementation and
 23 decision-making, conscious of the informed criticisms
 24 made by parties and witnesses in the impact hearings.
 25 The Inquiry does not think that it can be disputed that

1 there exists and existed an obligation on governments
 2 and authorities to express guidance with clarity and
 3 certainty .
 4 The Inquiry has recently considered the report
 5 issued in May of this year by the Independent Commission
 6 on UK Public Health Emergency Powers published by
 7 the Bingham Institute for the Rule of Law. While
 8 relating principally to the use by governments of
 9 primary and secondary legislation in the context of
 10 dealing with the pandemic, the Commission makes
 11 the following comment in its Executive Summary:
 12 "Legal certainty is a key aspect of the rule of law.
 13 In order for people to understand what the rule of law
 14 requires them to do legal rules must be sufficiently
 15 clear, stable and accessible, and should enable people
 16 to foresee with reasonable confidence when they might be
 17 sanctioned for not following the law."
 18 The main areas of legal uncertainty that arose
 19 during the COVID-19 pandemic include, one, uncertainty
 20 caused by the manner of making and frequently amending
 21 large numbers of public health regulations; and, two,
 22 uncertainty caused by the way legal requirements and
 23 public health advice were communicated by
 24 the government, often without clearly distinguishing
 25 between the two.

1 The Inquiry will , as I have said, investigate
 2 the way in which guidance was presented and communicated
 3 to the public, and, in particular , we will
 4 examine the status, whether actual or apparent, given to
 5 that guidance.
 6 On a more micro, but no less important level,
 7 the Inquiry has in these hearings heard considerable
 8 evidence concerning the way in which care institutions
 9 communicated with relatives of loved ones who were in
 10 care, and who, understandably in circumstances where
 11 they were unable to see their loved ones wanted to know
 12 about their conditions .
 13 The evidence that we have heard has disclosed
 14 varying levels of communications. There have been
 15 instances where communication and the information
 16 conveyed were both helpful and compassionate. There
 17 were, however, concerning instances where calls went
 18 unanswered or were responded to only after numerous
 19 repeated calls . On other occasions, responses were
 20 non-specific and formulaic, with the words such as,
 21 "Yes, he/she is fine", deemed to be sufficient to
 22 satisfy a concerned relative. Even allowing for
 23 the exigencies under which staff were working, such
 24 responses of that nature could be — we pose
 25 the question: could those responses be considered either

1 adequate or appropriate?
 2 A specific issue regarding communication arose in
 3 connection with the presence on the records of
 4 a patient/resident of a DNACPR notice. It will be
 5 appreciated that the Inquiry’s Terms of Reference direct
 6 that we should investigate the strategic elements of
 7 the handling of the pandemic relating to the delivery of
 8 end-of-life care and the use of DNACPR.
 9 For a number of witnesses, it was accepted that such
 10 a notice had been discussed either with them or with
 11 the patient/resident and had been included in
 12 the records on an informed basis. A number of
 13 witnesses, however, expressed both shock and distress to
 14 discover that a DNACPR notice existed in respect of
 15 their loved ones. That such should have been the case
 16 without apparent consultation with the patient and/or
 17 family members is a matter of concern, and the Inquiry
 18 will take forward the detailed evidence of these
 19 witnesses to our future consideration of Term of
 20 Reference 2(i). We will also, in consideration of
 21 implementation and decision-making, consider
 22 the protocols and guidance that were in place concerning
 23 the use of DNACPR notices.
 24 The pandemic led us all to communicate through
 25 different methods and using, with varying degrees of

1 success, I have to say, different types of technology.
 2 This Inquiry could not have conducted its business
 3 without resort to remote means of communication. We
 4 have heard throughout our hearings that telephones and
 5 tablets provided means of communication between
 6 relatives who could not access their loved ones in
 7 hospitals or care institutions .

8 As would be anticipated, the success of such means
 9 of communication varied depending largely on the patient
 10 or resident’s ability to use the device and also to have
 11 the cognitive ability to understand why it was their
 12 loved one who was on a screen and not physically present
 13 with them.

14 We have heard evidence that on occasions use of
 15 devices caused patients or residents confusion and
 16 distress , which was reciprocated for the relative on
 17 the other end, albeit that they had an opportunity to
 18 see their loved one.

19 We also heard of the impact on those calling in when
 20 they could see a carer in the institution in close
 21 proximity to the resident when aiding them to use
 22 the device, a fact which brought home to them what
 23 appeared to be the inequity of the situation without
 24 being in any way critical of the carer .

25 There were people who, for various reasons, did not

1 have access to technology or the ability to use it .
 2 This led , particularly within the community, to an
 3 increased level of isolation and loneliness, exacerbated
 4 if the person was disabled and restricted in their
 5 ability to leave where they lived .

6 Obtaining deliveries of essential supplies was
 7 possible through the use of digital ordering, but again,
 8 this was dependent upon the availability of a digital
 9 connection and a device for communicating. It was also
 10 made clear that certain suppliers had a minimum cost of
 11 supply which certain people could not afford or did not
 12 require .

13 We heard of the efforts of organisations,
 14 particularly within the third sector, who not only kept
 15 in touch with the most vulnerable in society of whom
 16 they were aware, but also filled the gap where
 17 provisions were needed.

18 I will deal briefly , my Lord, with the availability
 19 of PPE.

20 As will be appreciated, Term of Reference 2(e)
 21 directs the Inquiry to consider the strategic elements
 22 of the handling of the pandemic insofar as they relate
 23 to the supply, distribution and use of personal
 24 protective equipment. The Inquiry will conduct specific
 25 investigations and hearings into this issue, and indeed

1 this is ongoing. There has been in these impact
 2 hearings a considerable body of evidence relating to PPE
 3 and, in particular , evidence from both individuals and
 4 organisations relating to the availability of suitable
 5 PPE for workers in the health and social care sectors .

6 That evidence will inform our investigations going
 7 forward. In particular , we have heard evidence from
 8 the representatives of various organisations complaining
 9 of the absence of sufficient quantities of appropriate
 10 PPE, the use of PPE which was out of date and the lack
 11 of suitable PPE for a diverse workforce.

12 I move on to consider the impact on members of staff
 13 in the health services .

14 In the hearings which have taken place during
 15 the present calendar year, the Inquiry has heard from
 16 individuals who provided services in health and
 17 social care sectors and those who represented those
 18 working in those sectors. We have also heard from those
 19 who were unpaid carers, who all represented such carers .

20 We also heard from the STUC and its affiliate
 21 unions, from organisations within the third sector, from
 22 representatives within the NHS and from the private
 23 sector, and we have heard from professional
 24 organisations on behalf of their membership.

25 It has been important to secure from these witnesses

1 the perspectives of those who were engaged in the health
 2 and social care sectors during the pandemic. Of
 3 particular interest was to understand the different
 4 approaches in the public and private sectors .

5 The Inquiry has been particularly concerned to note
 6 the effect that working through the pandemic and its
 7 attendant pressures had upon the physical and mental
 8 wellbeing of the health and social care workforce who
 9 worked through the pandemic and its attendant stress and
 10 pressures. The Inquiry is very grateful for those
 11 representing various organisations and individuals who
 12 have provided us with their thoughts in the form of
 13 their closing statements.

14 In addition, I am grateful to colleagues in
 15 the counsel team, who have each provided us with
 16 detailed assessments of the various witnesses they led.
 17 In addition to the assessment of the evidence provided
 18 by witnesses who worked within the health and
 19 social care sector , we have also been provided with
 20 detailed assessments of the evidence concerning
 21 the impacts on the asylum and refugee community,
 22 including within that community women who were pregnant,
 23 those who were in custody, those who were homeless
 24 and/or alcohol and drug dependent, those who were in
 25 receipt of end-of-life care, including those who were

1 residents in hospices, those who were shielding,
2 children who were in need of protection and looked after
3 and accommodated children, those who were in receipt of
4 assistance from organisations within the third sector,
5 and those who were in receipt of care within
6 the community, and in particular those who were cared
7 for by unpaid carers.

8 With this evidential basis, the Inquiry is satisfied
9 that its efforts to secure a comprehensive foundation of
10 knowledge regarding impacts to proceed with confidence
11 to the next stage of our investigations. I repeat again
12 our thanks and gratitude to all witnesses who have
13 assisted us in this task.

14 My Lord, finally, after that, there is one further
15 thanks I should make, and that is to my Lord, for
16 the direction that he has given throughout these
17 hearings, and we, as the Inquiry Team, are very
18 grateful. Thank you.

19 THE CHAIR: Thank you very much indeed for that
20 presentation, Mr Gale.

21 We are, of course, ahead of schedule, but that gives
22 us the benefit of, I think, a slightly extended lunch
23 break. We're back at 2 o'clock with presentation,
24 firstly, from the Scottish Ministers when we'll hear
25 Mr Mitchell KC. Thank you very much indeed. 2 o'clock.

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1 (12.00 pm)

2 (The short adjournment)

3 (2.00 pm)

4 THE CHAIR: Good afternoon, everybody. Good afternoon,
5 Mr Mitchell, please. Thank you.

6 Closing statement by MR MITCHELL

7 MR MITCHELL: My Lord, ladies and gentlemen, this is
8 the closing statement on behalf of
9 the Scottish Government.

10 In October last year, at the outset of these impact
11 hearings, we gave a commitment, on behalf of
12 the Scottish Government, to the Inquiry process, to
13 the Chair and to the people of Scotland. That
14 commitment was to assist, to cooperate fully and openly,
15 to listen and to learn. That commitment has not wavered
16 and we renew that commitment today.

17 In acknowledgement of the likely difficult
18 experience for those who were due to give evidence, we
19 also undertook to listen to that evidence with respect
20 and with consideration. We have done so. We therefore
21 begin by paying tribute to those who have given evidence
22 to the Inquiry and to the courage, humility and candour
23 that they have displayed. It has not gone unnoticed by
24 the Scottish Government.

25 On behalf of the Scottish Government, we also pass

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1 our deep sympathies and condolences to the others,
2 the many thousands, who have lost loved ones, who have
3 suffered and who continue to suffer because of COVID-19.

4 In due course, during this implementation and
5 decision-making phases, the Inquiry will no doubt
6 examine the situation faced by the Scottish Government,
7 the options open to it and the decisions that were
8 taken. Evidence may be led from policy makers,
9 decision-makers and experts. Until then, it would be
10 premature to reach a concluded view on matters such as
11 foreseeability and minimisation of impacts, as I suspect
12 Mr Gale recognises.

13 What I can do today is to address some of
14 the evidence and to draw the Inquiry's attention to
15 points it may wish to consider as it prepares for future
16 hearings.

17 Firstly, to speak for a few moments in general terms
18 about foreseeability of harm. When the pandemic hit our
19 shores, the first and most immediate priority was to
20 avoid direct COVID-19 health harm. Very early on, it
21 was foreseen by the Scottish Government that the virus
22 had the potential to cause harm in many ways. It must
23 be understood that the complexity of the challenge posed
24 by the rapid spread and evolution of COVID-19 meant that
25 there was no single correct response; there were few, if

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1 any, harm-free decisions open to governments, including
2 the Scottish Government.

3 The Four Harms, that is the pandemic and
4 the measures and the response to it, could cause harm in
5 four areas, were interlinked. This was well understood
6 by the Scottish Government at the time. Measures
7 designed to curtail the spread of the virus reduced
8 the direct health harm, but on the downside, risk
9 causing isolation and loneliness, economic upheaval and
10 disruption to education. These devastating effects of
11 the pandemic were foreseeable, but a consequence of
12 avoiding the harm caused by the virus.

13 In these circumstances, the challenge was for
14 the Scottish Government to assess risks and benefits and
15 take decisions to reduce overall harm as much as
16 possible.

17 Turning now to aspects of the evidence led during
18 the impact hearings and looking firstly at care home
19 evidence.

20 On behalf of the Scottish Government, we acknowledge
21 the severe impact of the pandemic on the social care
22 sector. The evidence and this chapter of the hearings
23 was at times extremely distressing for those who gave
24 evidence and for those who suffered loss. It reflected
25 the concerns of witnesses on topics such as the changing

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1 nature of guidance, the isolation experienced by
 2 residents and the continuation of restrictions as
 3 the rest of the nation emerged from the pandemic.
 4 Evidence was also heard of the experiences of those
 5 suffering from different forms of dementia. Anger and
 6 guilt were frequently mentioned emotions, the grief of
 7 witnesses who were not able to say goodbye to their
 8 loved ones was palpable and moving.
 9 It has to be remembered that decision-making in this
 10 area was detailed and complex, taking place amid
 11 a dynamic and rapidly changing situation. In the early
 12 stages of the pandemic, due to the concern of the risk
 13 of rapid infection within care homes, measures were
 14 focused on trying to prevent ingress of an infection and
 15 on minimising transmission. It must be remembered that
 16 at this time, there was no vaccine and limited
 17 availability of testing, therefore it was recommended
 18 that routine visiting should be paused, but that
 19 essential visits for end-of-life or distress should be
 20 supported.
 21 The complexities surrounding decisions and visiting
 22 was discussed in a report prepared in late 2022 by
 23 the chief medical officers of the United Kingdom.
 24 The CMOs commented that:
 25 "Reducing risk of transmission in care homes

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1 involved some of the most complex trade-offs of risk to
 2 individuals of any part of the pandemic. These included
 3 considering the needs and rights of individuals as well
 4 as those of the wider resident population. This in turn
 5 meant balancing the risk of COVID-19 outbreaks in a very
 6 vulnerable group with maintaining staffing, access to
 7 healthcare, close contact needs of residents, visiting
 8 by relatives and friends in what are often the last
 9 months of life and dignity and quality of life among
 10 a group with high prevalence of dementia."
 11 Bearing all that in mind, I turn to some of
 12 the points made in evidence and in the written
 13 submissions. The point has been made that guidance for
 14 care homes changes frequently. In the absence of
 15 specific clinical COVID-19 guidance for care homes and
 16 in response to a request from the adult social care
 17 sector for specific guidance, the Scottish Government
 18 issued such guidance.
 19 Understanding of the virus and its effects developed
 20 rapidly. There was a clear need to update the guidance
 21 as new data and evidence emerged, whilst recognising
 22 that it was challenging for care homes to respond to
 23 changing guidance, it was essential for the guidance to
 24 be updated to reflect new developments and our
 25 understanding of it.

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1 More broadly, it is important to have regard to
 2 the actual guidance that was produced by
 3 the Scottish Government in contrast to the measures that
 4 individual care homes chose to put in place. For
 5 example, Scottish Government guidance to care homes did
 6 not restrict end-of-life visiting. From the outset of
 7 the pandemic, the Scottish Government was clear that
 8 end-of-life visits should be supported.
 9 A focal point of the evidence was that residents
 10 should have the right to receive in-person visits. In
 11 April 2022, two new health and social care standards
 12 were introduced that set out the expectation that people
 13 living in care homes should be able to see someone who
 14 was important to them, even during a pandemic, and be
 15 able to name a person who can directly participate in
 16 meeting their needs. But that approach has to be
 17 embedded in legislation.
 18 The Inquiry will be aware that the National Care
 19 Service Bill is currently at stage 2 of its
 20 Parliamentary process. During stage 1, the Parliament
 21 took extensive evidence from a range of stakeholders at
 22 which time the Anne's Law provisions received in depth
 23 scrutiny.
 24 The Scottish Government values the support of
 25 Care Homes Relative Scotland in helping develop and

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1 deliver Anne's Law. It is currently considering
 2 the feedback from that organisation, amongst other
 3 organisations. This process includes consideration of
 4 ways to strengthen Anne's Law, as well as assessing
 5 the potential for alternative legislative mechanisms to
 6 deliver Anne's Law more quickly.
 7 Evidence was given regarding a lack of consultation
 8 between the Scottish Government and care sector
 9 representatives prior to the taking of decisions or
 10 issuing guidance. In fact, there was widespread
 11 consultation at senior official ministerial level with
 12 care sector groups, relatives and unpaid carers in
 13 addition to stakeholder participation and a range of
 14 Scottish Government-led social care advisory groups.
 15 Of course, where urgent decisions or guidance was
 16 needed, consultation might not have been as detailed or
 17 lengthy as would otherwise be the case and as with any
 18 consultation a range of views would often be provided,
 19 not all of which could be accommodated.
 20 Turning to Long Covid.
 21 The Inquiry has heard evidence of the pernicious
 22 impact of Long Covid on the lives and health of both
 23 adults and children suffering from the illness who have
 24 struggled to have their voices heard, have faced
 25 difficulties in obtaining a diagnosis, and suffer

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1 feelings of isolation and abandonment by the medical
2 profession.

3 We wish to reassure the Inquiry and Long Covid
4 sufferers that the Scottish Government has taken steps
5 to improve their lives. It has committed to ensuring
6 that every person with Long Covid is supported with
7 access to the care they need in a setting that is as
8 close to their home as possible. We mention here an
9 initiative of the Scottish Government called,
10 "Scotland's Long Covid Service". It has four key
11 elements: supported self-management, primary care and
12 community-based support, rehabilitation support and
13 secondary care investigation and support.

14 These elements are supported by the establishment of
15 a £10 million Long Covid support fund. NHS health
16 boards are responsible for delivering services to meet
17 the needs of people suffering from Long Covid in their
18 areas. The fund will ensure the right support is
19 available within primary care, providing a response
20 focused on each patient's needs with referrals to
21 secondary care where necessary. A total of £6 million
22 has been made available from the fund over '22 to '23,
23 and '23 to '24, and a further £3 million has been made
24 available in the current financial year.

25 Turning to the impact on care providers, charities

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1 and the third sector.

2 The Scottish Government recognises the dedication
3 demonstrated by all care workers during the pandemic.
4 Care workers in the private and public sectors and in
5 charities, as well as healthcare workers, made
6 sacrifices and continued to perform important services
7 during the pandemic.

8 The Inquiry heard evidence on behalf of a charity
9 Promoting a More Inclusive Society, or PAMIS, which
10 provides help and support for people with profound and
11 multiple learning disabilities, PMLD, and their
12 families.

13 The Inquiry heard evidence that the former
14 Cabinet Secretary for Health and Sport, Ms Freeman, sent
15 a letter in November 2020 to a number of health and
16 social care providers in Scotland emphasising that for
17 hospital visiting purposes, carers should not be
18 regarded as visitors and that persons with complex care
19 needs should receive the same level of social care in
20 a hospital setting as they received in the community.

21 The intention of the Scottish Government and of
22 the letter was clear. The level of person-centred
23 social care to an individual should remain consistent
24 regardless of whether they are in the community or in
25 hospital. The evidence given on behalf of PAMIS was

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1 that this problem existed prior to the pandemic and
2 indeed continued during it.

3 The Scottish Government will examine whether it
4 should have taken stronger measures to assist people
5 with PMLD to achieve a consistent level of social care
6 during the pandemic when they were admitted to hospital
7 and, if so, what form those measures could have taken.

8 We heard evidence that families and unpaid carers
9 described as "the forgotten army" are an essential part
10 of caring for those with profound and multiple
11 disabilities, and that they considered that
12 decision-makers did not understand the impact of their
13 decisions on the people for whom they cared.

14 The Scottish Government recognises the contribution
15 that unpaid carers and the third sector have made to
16 the pandemic response and societal recovery. It has
17 listened to the evidence that charities should be
18 treated as partners of government and of the NHS when
19 dealing with any future crisis. Working to design
20 services with the third sector, with those who have
21 lived experience and with stakeholders is a vital part
22 of the Scottish Government's ongoing programme of work
23 to establish a national care service in Scotland.

24 In our written statement, we have addressed
25 the evidence led on children's rights and lack of

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1 personal protective equipment. Both are significant
2 areas and were significant areas of evidence. But in
3 view of the time remaining to me, the Inquiry will
4 forgive me if I direct interested parties to our written
5 statement on those topics. In so doing, I do not mean
6 to reduce the importance of the evidence given nor
7 the significance of the issues to those affected.

8 Turning to our final thoughts. The pandemic was, of
9 course, unprecedented, but what was also unprecedented
10 was the loss suffered by the Scottish people and
11 the contribution made by them to
12 the Scottish Government's response to the pandemic.

13 We have heard evidence of the trauma experienced by
14 members of the public, by healthcare and social care
15 workers, key workers and their representatives, and by
16 members of the third sector. But there was also an
17 unprecedented contribution by the people for the greater
18 good of society from those working in social care and
19 the NHS, from key workers and from the voluntary and
20 charity sector. Much of the evidence in the health and
21 social care impact hearings has been given by those who
22 said they were neither heard nor listened to.

23 Over the course of the last few months, we have
24 heard evidence from unpaid carers and those living in
25 supported accommodation. We have heard moving evidence

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1 from those who were denied visiting rights to visit
2 their loved ones and the emotional devastation that this
3 caused. The Scottish Government understands that
4 the most important way to recognise the loss and
5 suffering of the people of Scotland is to learn from
6 the evidence, to identify what could have been done
7 better and to improve government decision-making.

8 With that in mind, these witnesses should therefore
9 know that the Scottish Government has listened to their
10 evidence. On behalf of the Scottish Government, we pay
11 tribute to those witnesses who exhibited such bravery in
12 making the decision to come forward and to give evidence
13 to this Inquiry.

14 Thank you.

15 THE CHAIR: Thank you very much indeed, Mr Mitchell.

16 Now, we'll next hear from Ms Toner on behalf of
17 the Care Inspectorate. Ms Toner.

18 Closing statement by MS TONER

19 MS TONER: My Lord, good afternoon.

20 THE CHAIR: Good afternoon.

21 MS TONER: My Lord, on behalf of the Care Inspectorate,
22 the submission is made with reference to the evidence as
23 it has been heard from October of last year concluding
24 last month at the impact hearings on health and
25 social care. And the scope of that evidence, my Lord,

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1 led at the hearing was in terms of the Inquiry's
2 direction and opening statements from September of last
3 year, the impacts of the strategic decision-making in
4 relation to the theme of health and social care
5 insofar as are matters related to the Inquiry's Terms of
6 Reference.

7 And the Care Inspectorate, my Lord, offers its
8 closing submission on the basis of that evidence as it
9 has been heard and at this stage, my Lord, and in its
10 continuing efforts to assist the Inquiry.

11 My Lord, during the impact hearings, evidence was
12 led from a number of witnesses who spoke of their
13 experiences with relatives and loved ones who resided in
14 care settings during the time of the pandemic, and
15 the evidence spanned impacts within the health and
16 social care sector on both a personal level and also at
17 an organisational level.

18 My Lord, insofar as the witness evidence made
19 reference to any involvement or interaction with
20 the Inspectorate, the principal issues, in my
21 submission, which emerged from that evidence, were,
22 first, the nature of the role of the Inspectorate; and,
23 secondly, my Lord, the process of inspection and advice
24 from the Inspectorate during the pandemic.

25 My Lord, it will be important for the Inquiry to

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1 have a full understanding of both matters in fulfilling
2 its Terms of Reference, particularly in the context of
3 the impacts of the strategic elements of the handling of
4 the pandemic in terms of the Inquiry's Terms of
5 Reference. And, in particular, my Lord, it will be
6 vital, in my submission, for the Inquiry to fully
7 understand not only the procedures of the Inspectorates,
8 but also, my Lord, the limitations upon its powers, both
9 generally and in the wider context of the pandemic.

10 Evidence was led from a number of witnesses to
11 the effect that care home inspections during
12 the pandemic developed a focus on infection prevention
13 and control and that that had a negative impact upon
14 both residents and staff. And further, my Lord,
15 evidence was led of discrepancies in advice between
16 the Inspectorate and Public Health Scotland.

17 And, my Lord, it will be important for the Inquiry
18 to understand the changes imposed upon the Inspectorate
19 to its inspection framework during the pandemic,
20 particularly in the early part of 2020, and
21 the significant efforts, my Lord, made by its staff to
22 comply with those changes during what was, on any view,
23 a very challenging time.

24 The Inspectorate will provide the Inquiry with full
25 information to allow these matters and any other matters

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1 with which it can assist to be examined carefully at
2 future hearings in order that the role of
3 the Inspectorate and the constraints under which it
4 worked during the pandemic can be placed in their proper
5 context.

6 Lastly, my Lord, the Inspectorate reiterates that it
7 will continue to assist the Inquiry in whatever way it
8 can, so that the Inquiry can fulfil its Terms of
9 Reference thoroughly and expeditiously.

10 My Lord.

11 THE CHAIR: Thank you, I'm very grateful. Thank you,
12 Ms Toner.

13 Now, we'll next hear from Scottish Care, Ms Burke?

14 Closing statement by MS BURKE

15 MS BURKE: Good afternoon, my Lord.

16 THE CHAIR: Good afternoon.

17 MS BURKE: Scottish Care has lodged detailed written
18 submissions on the evidence heard by the Inquiry in this
19 phase of its work and I adopt those submissions in full.
20 Time does not allow me to cover all of the matters
21 contained in those submissions. Instead, I will focus
22 on those matters which Scottish Care considers should be
23 highlighted and these are broadly grouped into five
24 themes relating to the impacts of: guidance in
25 the social care sector; visiting restrictions;

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1 the withdrawal of healthcare services from care homes;
 2 the experience of social care staff; and the social care
 3 sector being under-resourced and undervalued at
 4 the outset of the pandemic.

5 Before turning to each of those, I would like to
 6 take this opportunity on behalf of Scottish Care to
 7 thank all of the witnesses who have given evidence to
 8 date and also to acknowledge the losses many experienced
 9 during the pandemic, and also the challenges faced by
 10 those receiving social care, their families, and
 11 social care staff, who worked with dedication throughout
 12 the pandemic.

13 It is recognised that the Inquiry is in its first of
 14 three stages relating to health and social care and much
 15 more evidence will be heard. It's also recognised that
 16 not all evidence will be heard orally. Nevertheless,
 17 Scottish Care wishes to highlight that limited evidence
 18 has been heard to date in relation to social care
 19 services delivered in the community by those who deliver
 20 and receive them.

21 As a majority of social care in Scotland is
 22 delivered at home, it is essential that sufficient
 23 evidence is heard to allow lessons to be learned from
 24 the impact the pandemic had on service users, providers
 25 and staff in the care-at-home sector.

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1 Turning to the first of the themes I have mentioned.
 2 The Inquiry has heard evidence about the impact on
 3 the social care sector of the volume of guidance
 4 produced and the frequency with which it changed, not
 5 least in placing significant pressure on staff.

6 It was inevitable that guidance would be required to
 7 be updated as the pandemic progressed. However,
 8 the initial failure to summarise the changes in each
 9 iteration meant that care home managers had to
 10 scrutinise updated guidance to identify the changes
 11 which then had to be communicated to staff. This
 12 process added to the burden of care home managers and
 13 staff and diverted them from providing care to
 14 residents.

15 Witnesses also spoke of occasions when guidance had
 16 to be updated shortly after it had been distributed,
 17 because those in the sector identified problems with
 18 the guidance or its implementation. This caused
 19 confusion and at times frustration, which could have
 20 been avoided had the care sector been consulted prior to
 21 the guidance being issued.

22 Guidance often indicated a lack of understanding of
 23 the care sector by those responsible for producing it.
 24 Elizabeth Martin, a registered nurse and
 25 GMB representative described the frustration she felt in

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1 reading guidance which seemed to be written by people
 2 who did not know or understand how a care home works.

3 It is submitted that seeking input from those with
 4 expertise in the provision of social care would have
 5 helped to ensure that guidance issued was fit for
 6 purpose.

7 The guidance often did not take account of
 8 the variety of settings in which social care services
 9 can be delivered, nor was it framed in a way which
 10 allowed staff flexibility to make assessments about what
 11 was in the best interests of those they cared for.

12 Viv-Dickenson, CEO of CrossReach, described feeling like
 13 the guidance was coming down in an NHS directive model
 14 rather than in a way which took into account the nuances
 15 of different settings.

16 In Scottish Care's submission, the care sector's
 17 professional expertise and capacity to make decisions
 18 taking account of such nuances were not recognised, and
 19 this lack of recognition was also visible in
 20 the visiting restrictions and the increased scrutiny of
 21 the care home that occurred during the pandemic.

22 Guidance also failed to take into account
 23 the realities of living with or caring for someone with
 24 dementia. For example, it did not take account of
 25 the propensity of those who live with dementia to wander

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1 with purpose, or the fact that residents with dementia
 2 may not understand why they are being asked to socially
 3 distance. Implementation of guidance in such
 4 circumstances had a potential to cause real distress.

5 Witnesses, including Dr Donald Macaskill, CEO of
 6 Scottish Care, gave evidence about the impact that
 7 isolation and social distancing had on residents,
 8 particularly those with dementia, for whom routine and
 9 physical touch is so important. Alzheimer Scotland and
 10 others also spoke of cognitive decline that those with
 11 dementia experienced during the pandemic.

12 The evidence that the Inquiry has heard in this
 13 phase of its work indicates that the impacts of dementia
 14 were not sufficiently understood by those responsible
 15 for producing guidance for the care sector.

16 Scottish Care considers that such impacts could have
 17 been reduced had input from dementia care experts been
 18 sought and respectfully submits that the Inquiry should
 19 seek input from such experts to support its
 20 investigations.

21 On the theme of visiting restrictions, the Inquiry
 22 has heard evidence of the significant distress
 23 restrictions caused to residents of care homes and their
 24 relatives, and of the trauma experienced by those who
 25 were unable to be with their loved ones when they died.

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1 At the outset of the pandemic, Scottish Care
2 supported visitor restrictions and advised its members
3 to lock down in advance of the national lockdown as
4 a precautionary measure. However, by April 2020, it was
5 making representations that restrictions should be
6 relaxed. Scottish Care continued to advocate for
7 the easing of restrictions and called for a human rights
8 impact assessment to be undertaken in relation to
9 the restrictions.

10 The Inquiry has heard evidence of some care homes
11 taking a more restrictive approach or being slower than
12 others to reintroduce visiting in a meaningful way.
13 Evidence has also been heard about why some care homes
14 considered it necessary to take a more cautious
15 approach, including the risk of prosecution resulting
16 from Operation Koper.

17 Witnesses described the pressure on providers to
18 make the right decisions in face of conflicting
19 guidance, combined with pressure from residents and
20 family members to see their loved ones.

21 Jennifer Ewen, a director for Voluntary Services
22 Aberdeen, referred to considering, when making
23 decisions, whether she could stand up in court and
24 justify the decisions that she made. Staff did not want
25 to keep families apart and at times found enforcing

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1 restrictions distressing. They were often under
2 significant pressure to admit visitors and were
3 criticised in the media for enforcing restrictions that
4 they did not create.

5 The lack of clarity of the status of guidance caused
6 confusion, and in Scottish Care's view, put care home
7 managers in an invidious position. The Inquiry has
8 heard evidence from family members of residents who
9 expressed a view that as it was just guidance,
10 care homes could choose to depart from it, whereas
11 insurers made conditional cover in compliance with
12 guidance, and trade unions, focused understandably on
13 protecting their members, sought to challenge providers
14 who had departed from it.

15 Due to its inflexible nature, Scottish Care
16 considers that acting in accordance with guidance
17 prevented providers from being able to make a human
18 rights-based assessment in relation to visiting.

19 Care homes also had to consider the wishes of
20 relatives who did not want visitors to be allowed access
21 as they considered that this would expose loved ones to
22 a greater level of risk.

23 The Inquiry has heard evidence that on occasion
24 changes to visiting guidance were publicly announced at
25 lunchtime briefings prior to such changes being

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1 communicated to the social care sector. This led to
2 care homes receiving queries about guidance which they
3 had not yet seen and put additional pressure on staff to
4 implement changes quickly due to the expectations that
5 such announcements creates for relatives who are
6 understandably desperate for changes for visiting to
7 take effect.

8 Care homes could not always respond immediately to
9 changes in guidance. In some areas, they required their
10 plans to be signed off by local public health teams.
11 Independent Care Homes Scotland gave evidence about
12 the delay that this could cause.

13 It is submitted that the harms caused by visiting
14 restrictions could have been mitigated had
15 the Scottish Government undertaken a human rights-based
16 assessment at an early stage of the pandemic. Adopting
17 guidance which provided for a designated visitor for
18 each resident, as first called for by Natasha Hamilton
19 of Care Homes Relatives Scotland, with visitors also
20 being required to comply with PPE and testing
21 requirements, would have been a proportionate approach.
22 This would also have provided clear and balanced
23 guidance for care homes to implement.

24 Turning to consider the impacts of withdrawal of
25 healthcare services for care homes.

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1 Scottish Care has provided evidence of the sense of
2 clinical abandonment experienced by staff when GPs and
3 other health professionals ceased to visit care homes.
4 Social care providers have also given evidence about
5 the impact that the lack of physical assessment had on
6 residents as a result of primary healthcare services
7 transferring to telephone appointments. Guidance issued
8 by the Scottish Government also created an impression
9 that there was a blanket ban on residents who were
10 COVID-positive being transferred to hospital, which
11 persisted even after the guidance was clarified.
12 Witnesses have spoken of ambulances refusing to take
13 care home residents to hospital.

14 Care homes, unlike nursing homes, are not designed
15 to provide clinical care. It is submitted that it was
16 foreseeable that a withdrawal of healthcare services for
17 residents would increase pressure on staff and would
18 lead to deterioration in the health of residents.

19 Moving to consider the impact of the pandemic on
20 social care staff.

21 The level of fear experienced by the public at
22 the outset of the pandemic when the nature of the virus
23 was unknown must not be forgotten. Social care staff
24 continued to care for others despite being frightened,
25 or, as some witnesses have said, terrified that they

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1 would take the virus home to their families, or transmit
2 it to those for whom they were providing care. In
3 community settings, this was compounded by seeing NHS
4 visiting service users wearing full PPE when guidance
5 did not yet provide for PPE for social care staff.

6 Social care staff also witnessed unprecedented
7 levels of death in the initial months of the pandemic.
8 Staff often develop close relationships with those for
9 whom they provide care, which was particularly important
10 during the pandemic when residents and service users
11 could not see their relatives. Social care staff also
12 lost colleagues to the virus. The Inquiry has heard
13 evidence of the significant trauma experienced by those
14 in the sector.

15 Staff and managers worked long hours, taking
16 additional staff — taking additional shifts to provide
17 cover when colleagues were required to isolate. They
18 had to take on additional responsibilities, including
19 comply with increased infection prevention and control
20 requirements and new reporting requirements, and staff
21 also missed the valuable assistance that visitors
22 provided when caring for their loved ones.
23 The pressures encountered by staff has led to burn-out
24 and staff leaving the sector, creating further staff
25 shortages. The Inquiry has heard evidence that those in

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1 the care sector felt second class when compared with NHS
2 staff. Furthermore, care at home staff felt invisible
3 throughout the pandemic; they did not feature in
4 conversations taking place on a national stage in
5 the way that NHS and care home staff did.

6 Family members also provided evidence about
7 the treatment of care workers. Dr Wightman agreed, when
8 asked by Mr Gale KC, that those who worked in care homes
9 were unfairly treated or castigated, noting that
10 care homes were treated as isolation hospitals.
11 The impact that the pandemic had on staff, health and
12 wellbeing is significant and continues to have
13 a detrimental impact on the provision of social care in
14 Scotland.

15 This brings me to the final theme that I wish to
16 address in my oral submissions: the impact of
17 the social care sector being under-resourced and
18 undervalued at the outset of the pandemic.

19 The Inquiry has heard from a number of sources that
20 there were significant staff shortages in the care
21 sector prior to the pandemic. Scottish Care agrees with
22 the evidence from Royal College of Nursing that
23 the pandemic brought into sharp focus major problems
24 that pre-date the beginning of this crisis, and also
25 that the problems care homes have faced during

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1 the crisis have in many respects been symptoms of how
2 the sector, and the people that live and work in it,
3 have been undervalued by society for far too long. It
4 is submitted that it was foreseeable that a sector which
5 was undervalued and under-resourced prior to
6 the pandemic would be severely impacted during it,
7 particularly in light of the increased responsibilities,
8 increased scrutiny and reduced support from external
9 agencies.

10 Unless I can assist your Lordship further, that
11 concludes my submissions.

12 THE CHAIR: Thank you very much indeed, Ms Burke.
13 Thank you.

14 Right, I think we've reached the first scheduled
15 break, so we'll take 15 minutes now, and then, when we
16 come back, we'll hear from the College of Paramedics.
17 So 15 minutes.

18 (2.33 pm)

19 (A short break)

20 (2.50 pm)

21 THE CHAIR: Right, now, as I said, the College of
22 Paramedics, Laura Donald. Thank you.

23 Closing statement by MS DONALD

24 MS DONALD: Good afternoon, my Lord.

25 THE CHAIR: Good afternoon.

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1 MS DONALD: My Lord, my client, the College of Paramedics,
2 was grateful to be invited to make a closing statement,
3 which was duly submitted to the Inquiry. I adopt
4 the contents of that closing submission and ask that it
5 be read alongside the — closing statement and ask that
6 it be read alongside the opening statement, previously
7 submitted.

8 The opportunity to supplement the closing statement
9 orally is also welcomed, particularly as we are able to
10 do so in light of the other Core Participants' written
11 statements, which I, my instructing solicitors and my
12 clients have had regard to. I don't intend to do this
13 at length, but simply to highlight some points where
14 there appears to be a similar approach amongst some of
15 the parties.

16 Firstly, my Lord, my clients have instructed me to
17 be very clear that the College and its members consider
18 it to have been a privilege, a great privilege, to have
19 supported the public during the pandemic. They took
20 their supporting role very seriously. In my written
21 statement, on page 2, I refer to the first report on
22 the Let's Be Heard project where a paramedic had
23 reported how difficult it was taking a patient away from
24 their family in an ambulance as an example of impact on
25 our pre-hospital care team, and that came from

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1 the Inquiry's own report.
 2 I've previously submitted on behalf of the college
 3 that the guidance coming out from
 4 the Scottish Government and their advisers to have
 5 been "one size fits all", and I'm quoting from somebody
 6 else's submission there, with no account apparently
 7 being taken of the different working environments across
 8 the wider healthcare sector, and this is a submission
 9 which has found a community of thinking with other Core
 10 Participants.

11 For paramedics, there was no specific guidance for
 12 those working in the constricted space of the ambulance
 13 described as "a box". For care homes, or care at home,
 14 we've referred to them variously, it's been submitted
 15 that they, too, felt the guidance was directed at
 16 the clinical setting and did not take account of
 17 the fact that the care home was actually their
 18 resident's home. That was referenced earlier today by
 19 Mr Gale.

20 There appears to have been a lack of consideration
 21 or understanding of specific workplace challenges, and
 22 that is clearly the position of my clients, the College
 23 of Paramedics.

24 The guidance — others have referred to this,
 25 the guidance was also constantly being updated,

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1 understandably updated, as matters moved on and changed,
 2 but constantly being updated with the consequent
 3 difficulties of understanding and communicating changes.
 4 A subject many Core Participants have referenced and
 5 mention is made of the Friday afternoon dissemination
 6 being a particular problem.

7 I have been asked — instructed to emphasise
 8 the importance to the College, on behalf of members, of
 9 the need to ensure that never again should paramedics,
 10 in common with other frontline medical staff,
 11 particularly paramedics responsible for frontline
 12 pre-hospital care, often of very seriously unwell
 13 patients of unknown etiology, never again should they
 14 have to fight for respiratory equipment or suitable
 15 protective equipment.

16 The uncertainty over the provision of such equipment
 17 in the face of changing guidance or advice added to
 18 the extreme anxiety paramedics were subject to, when at
 19 the same time dealing with very anxious, understandably
 20 anxious, and worried patients and families.

21 The shortage of PPE at the beginning of the pandemic
 22 and the concern that caused is again a common theme
 23 amongst a number of Core Participants. My Lord will
 24 recall mention in my written submission at page 5 that
 25 the College carried out a survey of Scottish members and

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1 that did show that the majority of the responding
 2 paramedics, the Scottish paramedics, did not feel
 3 confident that they were well protected.

4 My Lord, I have referenced a couple of times other
 5 parties, or other Core Participants, and largely those
 6 who make similar submissions to those I make on behalf
 7 of my clients, are Scottish Care, Scottish Healthcare
 8 Workers' Coalition, Scottish Hazards, CrossReach, STUC,
 9 and Scottish Hazards again — they get a double mention.

10 The importance of recognising the clamor from
 11 a number of parties as to the route of transmission
 12 where the government — well, both governments were
 13 focused on transmission by droplet and not the airborne
 14 route is something my clients again would like to see
 15 recognised and later explored in evidence.

16 Again, that's been referenced by Mr Gale rather
 17 helpfully this morning.

18 That lack of earlier recognition of the airborne
 19 route of transmission caused difficulties with
 20 the provision of PPE, or appropriate PPE, to paramedics
 21 and others, and it caused the focus to remain on
 22 the hierarchy of controls, which I set out on page 3 of
 23 my written statement. The RCN and Scottish Hazards also
 24 comment on difficulties caused by the failure to
 25 recognise airborne transmission and the College aligns

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1 itself with their comments.

2 In future sessions, it's my submission, it will be
 3 helpful to hear from those responsible for not
 4 apparently acting on the growing body of evidence of
 5 the airborne transmission route, to understand why
 6 the response to that was so slow and what their
 7 competing evidence, if any, was.

8 My Lord, I would like to draw attention to one last
 9 element of the written statement at page 6. Reference
 10 is made to the written reference of one witness. That
 11 witness didn't give evidence orally, but that statement,
 12 and supporting papers, has been provided by the widow of
 13 a paramedic who had caught the virus early in
 14 the pandemic, in March 2020, and subsequently died.

15 That paramedic was sent into a house without knowing
 16 that the prospective patient had recently returned from
 17 Italy, and it's my submission that that evidence and
 18 the supporting papers shows the human impact on
 19 the paramedic profession, as part of the wider health
 20 profession. And in my submission, it's important that
 21 this is reflected at every turn of the Inquiry's work as
 22 it appears is the intention of the Inquiry from this
 23 morning's oral submissions.

24 In concluding these remarks, my Lord, I think it
 25 relevant for me and of interest to the Inquiry to inform

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1 his Lordship that I am advised by my clients that
 2 the Inquiry is being closely followed by their members
 3 across the UK, not only here in Scotland. Ms Nicholls,
 4 the College CEO, who gave evidence to the Inquiry, has
 5 received very many messages of support and thanks from
 6 paramedics who are grateful to have their voice and
 7 their concerns heard here in Scotland, not yet heard in
 8 England, although it's anticipated Ms Nicholls will give
 9 evidence to the UK Inquiry later this year. We felt it
 10 important that the Inquiry appreciate that the work thus
 11 being done by the Inquiry here is being seen to have
 12 a much wider influence and impact elsewhere.

13 My Lord, those are my submissions.

14 THE CHAIR: I'm very grateful. Thank you very much indeed.
 15 Now, the Royal College of Nursing, Ms Shand.

16 Closing statement by MS SHAND

17 MS SHAND: My Lord, the Royal College of Nursing in Scotland
 18 extends its thanks for the opportunity to have
 19 participated in and contributed to the Inquiry in
 20 respect of the health and social care impact hearings.
 21 It is grateful also for the opportunity to have this
 22 oral closing statement made on its behalf.

23 As the Inquiry is aware,
 24 the Royal College of Nursing in Scotland is
 25 the representative voice of nursing across the four

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1 nations of the United Kingdom and is the largest
 2 professional union of nursing staff in Scotland —
 3 sorry, nursing in the world. Sorry, the Royal College
 4 of Nursing, my Lord. It is a registered trade union.
 5 The Royal College of Nursing in Scotland is a distinct
 6 directorate operating within the UK-wide
 7 Royal College of Nursing rather than as a separate legal
 8 entity.

9 Over 48,500 of Royal College of Nursing members are
 10 based in Scotland from a UK-wide and international
 11 membership of over half a million registered nurses,
 12 student nurses, midwives and nursing support workers.
 13 Members of the Royal College of Nursing in Scotland work
 14 across NHS hospitals and specialist health facilities ,
 15 in care nursing homes, the community and private
 16 healthcare sector, amongst others.

17 On 24 October, an opening statement relating to
 18 the Inquiry's impact hearings was delivered on behalf of
 19 the Royal College of Nursing in Scotland. It had
 20 earlier submitted a written submission, which set out in
 21 detail what it hoped to achieve from this phase of
 22 the Inquiry and the varying impacts on its members
 23 bearing on Terms of Reference 2(a) to 2(i).

24 The Royal College of Nursing in Scotland thereafter
 25 submitted witness statements on behalf of

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1 the organisation from three senior office holders:
 2 Colin Poolman, Norman Provan and Eileen McKenna. On
 3 20 March 2024, these three witnesses attended
 4 the Inquiry and delivered oral evidence expanding on the
 5 points raised in these statements.

6 On 17 June, the Royal College of Nursing in Scotland
 7 submitted a written closing statement in which it
 8 addressed the impacts that it considers were (a)
 9 foreseeable, (b) most significant and/or detrimental,
 10 and (c) might have been minimised or excluded had
 11 reasonable steps been taken to do so.

12 That written statement also identified what future
 13 investigations and further evidence
 14 the Royal College of Nursing in Scotland considers would
 15 be necessary for the Inquiry to complete its
 16 consideration of the pandemic decisions and
 17 implementation measures which resulted in or failed to
 18 minimise the impacts identified.

19 In accordance with the direction of the Chair, this
 20 oral submission seeks to draw to the Chair's attention
 21 matters of concern addressed in the organisation of
 22 witness statements, oral evidence and written closing
 23 statement, which the Royal College of Nursing in
 24 Scotland believe require to be highlighted in order for
 25 the Inquiry to complete its consideration of the matters

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1 referred to in its Terms of Reference. These matters
 2 are as follows.

3 First, the understaffing of the nursing workforce.
 4 Prior to the pandemic, there had for a number of years,
 5 to the knowledge of the Scottish Government, been high
 6 numbers of unfilled nursing vacancies within the NHS
 7 Scotland and social care sector. The whole time
 8 staffing required to provide a good level of service was
 9 in deficit at the start of the pandemic. This was
 10 significantly exacerbated as a result of the pandemic.

11 Because of staffing issues, nursing staff were
 12 required to be redeployed during the pandemic with no
 13 additional training into unfamiliar clinical
 14 environments, including intensive care. Student nurses,
 15 amongst others, were mobilised to address the shortfall.
 16 These initiatives led to staff being made to shoulder
 17 more responsibility than they were equipped for.
 18 Factors such as these caused mental health problems
 19 amongst the staff concerned. So too did the general
 20 burden placed by the pandemic on nursing staff having to
 21 work harder and longer in difficult circumstances in an
 22 already understaffed workforce. As a result, to RCN's
 23 knowledge, many health and social care staff are
 24 experiencing significant and complex mental health
 25 issues as a result of the pandemic.

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1 Further, across the UK, the prevalence of Long Covid
2 among staff working in health and social care is
3 significantly higher than in the wider population.
4 There are nursing staff who contracted Long Covid, who
5 have been unable to return to work, or have had their
6 working hours reduced.
7 The impact of Long Covid on the workforce, along
8 with continuing psychological symptoms being experienced
9 by many RCN Scotland members, means that there is
10 a cohort of the registered nurses and nursing support
11 workers now unable to practice, or who have had to
12 reduce the hours they work. Not only has this impacted
13 on their earnings, but RCN Scotland's position is that
14 this reduction in staff has had a consequential adverse
15 effect on the quality of care capable of being delivered
16 to patients and care home residents.
17 RCN Scotland's position is that without an adequate
18 number of nursing staff with the right mixture of
19 skills, who are able to deliver the appropriate standard
20 of patient care to meet the demand of the country at the
21 present time in the absence of a pandemic, then there is
22 no prospect of the demand created by any future pandemic
23 coming close to being met.
24 On the matter of Long Covid, which I mentioned,
25 the RCN has this month written — RCN Scotland has this

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1 month written to the First Minister seeking an amendment
2 to the current Terms of Reference to the Inquiry to
3 explicitly include Long Covid. This is with a view to
4 ensuring that evidence about the foreseeability of
5 long-term, post-viral symptoms, such as those arising
6 from Long Covid, the impact of Long Covid on individuals
7 and its impact on the already depleted nursing
8 workforce, are fully part of the Inquiry's
9 investigations and report.
10 The second area I wish to highlight, my Lord, is the
11 adequacy and hierarchy of the provision of PPE. From
12 the beginning of and throughout the pandemic, RCN
13 Scotland regularly expressed its concerns in
14 correspondence to the First Minister of Scotland
15 regarding the difficulties its members had in accessing
16 adequate supplies of PPE.
17 Care homes were particularly affected by lack of PPE
18 due to not being able to access their usual supplies and
19 suppliers. RCN Scotland consider that the evidence has
20 highlighted that there appeared to be a hierarchy in
21 terms of the supply of PPE. RCN Scotland members were
22 reporting that they consider there was a prioritisation
23 of PPE, in particular of the more so-called heavy duty
24 PPE, such as FFP3 masks, in the intensive care units and
25 some parts of the acute sector.

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1 PPE in the care home and community care sector, both
2 in relation to the procurement and provision thereof,
3 was considered by RCN Scotland to be inadequate. This
4 inadequacy resulted in RCN Scotland members having to
5 reuse PPE, which was intended for single use only, or in
6 some cases procure their own PPE.
7 Further, the "one size fits all" approach in
8 the design of protective equipment had been a problem
9 for frontline health workers who had to wear this life
10 saving equipment for up to 12 hours at a time. Face
11 fitting was an issue, as many people had not been
12 properly trained to carry out this. And this was
13 exacerbated by the fact that a number of brands were not
14 producing masks which fitted female faces, nor took into
15 consideration workers who may have religious headwear.
16 As a result of issues of this type, the masks were often
17 ill-fitting for those individuals and, as a consequence,
18 the masks did not form a seal and allowed air to get in
19 at the side of the mask.
20 RCN Scotland contend that it was a foreseeable
21 consequence of insufficient and/or ill-fitting PPE that
22 it would increase the likelihood of contracting
23 the virus.
24 RCN Scotland observes that a further recurring
25 concern expressed by its members was in relation to

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1 the confusion regarding the guidance on use of PPE.
2 The evidence led supports the position that the guidance
3 on PPE changed frequently, leading to confusion on how
4 to apply it. Many RCN Scotland members reported that
5 this caused them a dilemma over whether they could or
6 could not treat patients without wearing PPE.
7 The frequency at which PPE guidance was updated caused
8 inconsistency in its application, which in RCN
9 Scotland's view, will undoubtedly have contributed to
10 the transmission of the virus.
11 Third, my Lord, mode of transmission of COVID
12 infection.
13 Intrinsically linked to the issues of adequacy in
14 the type and provision of PPE were the consequences of
15 the Scottish Government strictly following the advice of
16 anti-microbial resistance and healthcare associated
17 infection are high, an advisory group which continually
18 reported that COVID was a droplet spread infection
19 rather than an airborne infection. Health boards
20 therefore only routinely offered higher levels of
21 protection, such as FFP3 masks, in the areas where
22 Aerosol Generating Procedures were routinely performed.
23 From early in the pandemic, the RCN raised this
24 issue throughout the workforce senior leadership group
25 — that's CRCN Scotland — and other pandemic strategic

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1 management groups established by the Scottish Government
2 in the early stages of the pandemic and on which RCN was
3 represented, amongst others.

4 RCN Scotland carried out an independent review of
5 the literature that was emerging in this regard and
6 considered that the evidence was clear that
7 the transmission of the virus was airborne. RCN
8 Scotland wrote directly to the Scottish Government
9 citing international evidence to support its position,
10 but the Scottish Government continued to favour the view
11 that the virus was transmitted by droplet. Ultimately,
12 the World Health Organisation acknowledges that COVID is
13 an airborne infection.

14 RCN Scotland considers that had the government
15 approached this issue on a more cautious basis, it is
16 likely that it would have had an impact on
17 the recommendations of what protective equipment staff
18 should have been using and when.

19 The final issue to be highlighted at this stage,
20 my Lord, is the approach to the application of reporting
21 of injuries, diseases and dangerous occurrences
22 regulation 2013, colloquially known as RIDDOR.

23 In terms of the effect of the pandemic on nurses,
24 the RCN in Scotland and across the UK is concerned by
25 the failings that led to a lack of RIDDOR reporting.

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1 RCN Scotland repeatedly experienced resistance from
2 health boards to the suggestion that they should be
3 reporting to the HSE, the Health and Safety Executive,
4 incidences of COVID which appeared to have been acquired
5 at work. Some of these health boards dismissed the
6 suggestion that this could happen stating that it would
7 be impossible for staff to contract COVID at work as
8 they had been provided with PPE.

9 After the issue was raised with
10 the Scottish Government, the Scottish Government did
11 provide guidance to NHS boards on reporting to the HSE,
12 via the RIDDOR process, where staff may have
13 occupationally derived COVID. However, that guidance
14 suggested that a PCR test, that is to say a polymerase
15 chain reaction test, should be completed by staff.
16 PCR tests could only be analysed in a laboratory.
17 However, by this time, by the time the guidance was
18 issued, PCR testing was not the methodology that was
19 being used by health boards for staff to test as it had
20 been replaced by the self-testing process.

21 This anomaly likely meant that there will be many of
22 the workforce who contracted COVID at work, whose
23 infection was never reported, because a PCR test had not
24 been undertaken. Thus the potential for the Health and
25 Safety Executive to be more involved with

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1 Scottish Government and employers was lost.

2 RCN Scotland contend that had there been more
3 stringent reporting mechanisms, there would more likely
4 have been more stringent control mechanisms, which would
5 have decreased the number of people contracting COVID-19
6 in the workplace and decreased also the number who went
7 on to develop Long Covid.

8 In conclusion, my Lord, RCN Scotland looks forward
9 to receiving the findings of this phase of hearings,
10 which both serves as a reminder that the impact on our
11 professionals in the health and social care sector was
12 considerable and must not be forgotten, and provides
13 the opportunity for important lessons to be learned.

14 Thank you, my Lord.

15 THE CHAIR: Thank you, Ms Shand. Now, the Scottish
16 Healthcare Workers' Coalition. Mr Webster, please.

17 Closing statement by MR WEBSTER

18 MR WEBSTER: My Lord, Mr Gale, good afternoon.

19 My Lord, in your recent direction, you asked Core
20 Participants in their closing written submissions to
21 focus on impacts that were foreseeable, significant and
22 which might have been minimised or elided had reasonable
23 steps been taken so to do. And in these oral
24 submissions, to highlight the matters, Core Participants
25 believe the Inquiry needs to be addressed.

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1 The Inquiry, having heard evidence over 53 days of
2 this tranche of hearings, can be in no doubt as to
3 the burden borne by the people of Scotland, and in
4 particular those health and social care workers who
5 looked after us during the most intense days of
6 the pandemic and thereafter.

7 Witnesses spoke to the loss of relatives and
8 loved ones, others of the emotional trauma of being
9 close to the passing of so many. I mean no discourtesy
10 to those who have suffered bereavement as a consequence
11 of COVID, in raising, as I do today, the issues for
12 Scotland's health and social care workers. There is no
13 moral equation of suffering. For all who suffer, in
14 whatever way, there is a personal emotional and physical
15 consequence and burden, one which can also impact on
16 those nearest to us.

17 My task, however, as others in the room will do
18 today and tomorrow in respect of their own clients, is
19 to advocate for those who I have the honour to
20 represent, those who have worked and continue to work in
21 our healthcare sectors, including those who, having
22 placed their own health on the line to protect others,
23 find themselves the victim of a disease they sought to
24 defeat.

25 The Inquiry has endeavoured to allow many voices to

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1 be heard in this Inquiry and that is to the Inquiry's
2 credit. There are no doubt many others who would have
3 wished to have a voice, but it is recognised that there
4 is a balance to be had between listening and acting,
5 between considering and recommending. And as many of
6 those that I represent continue to suffer in real and
7 disabling terms from the effect of Long Covid, the need
8 for balance and for timely reporting is all too evident.

9 So if these hearings have been about informing
10 the Inquiry about the reality of the nation's experience
11 of COVID-19, I venture to suggest it paints a somewhat
12 disheartening picture of a government not prepared for
13 a pandemic, of institutions not resourced to meet
14 the challenge that fell upon the nation, of panic and
15 ineptitude at best in the implementation of protective
16 and preventative measures, of confusion induced by poor
17 communications and of questionable — again, at best —
18 compliance with health and safety and equality laws.
19 And, finally, of an inconsistency in treatment of
20 the health and social care workforce.

21 And perhaps the most demoralising thing of all, when
22 we consider the risks our health and social care workers
23 took as regards their own lives and health, a pervading
24 professional employer and potentially state scepticism
25 that there are long-term disabling consequences from

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1 infection from a significant number of health and
2 social care workers. That is made manifest in not only
3 personal economic suffering, but also the loss from
4 the health and care workforce of those who remain
5 capable of making some form of contribution.

6 There are many areas where further investigation is
7 necessary, but my task today is to highlight those
8 worthy of attention from the point of view of the health
9 and social care workforce. So let me be direct and
10 identify four broad issues.

11 Firstly, the immediate response. The Inquiry has
12 heard from witnesses as to the inadequate provision of
13 PPE in the early stages of the pandemic, including
14 shortcomings in the assessment of the need for PPE masks
15 generally, shortcomings in the provision of PPE,
16 shortcomings in the assessment of individual need for
17 PPE, shortcomings in the arranging of fitting of
18 appropriate PPE, shortcomings in the need to identify
19 the need for PPE based upon individual protected
20 characteristics.

21 These shortcomings were, I venture to suggest,
22 entirely foreseeable in the absence of a plan, to use an
23 expression which is currently in vogue. So was there
24 a plan? The Inquiry is charged to consider
25 the Scottish Government's pandemic planning and to do so

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1 without restriction as to time. It must, therefore,
2 look at the extent to which the Scottish Government
3 considered, assessed and acted upon these foreseeable
4 consequences as the evidence suggests there was no plan.

5 The Inquiry is also charged with considering
6 the supply, distribution and use of PPE. Now, that is
7 constrained by the Terms of Reference to the period
8 1 January 2020 to 31 December 2022. However, I submit
9 to the Inquiry that a proper consideration of
10 the reasonableness of the supply, distribution and use
11 of PPE during that period can only be made having regard
12 to the arrangements, if any, that were in place and were
13 capable of deployment on day one of that period.

14 That, I submit, does justify the Inquiry looking at
15 the extent to which the NHS in Scotland, by which I mean
16 the NHS Scotland centrally and individual health boards,
17 were in a position to plan for, did plan for and prepare
18 to provide appropriate PPE to protect the health and
19 social care workers from an airborne virus. And also to
20 ensure that it was fairly and appropriately provided,
21 based on individual professional need, individual
22 personal and, where appropriate, protected
23 characteristics, and individual susceptibility to
24 the virus.

25 Beyond planning, the Inquiry must also look at how

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1 the provision of PPE was handled in the light of
2 developing knowledge as to airborne transmission. Was
3 the supply, distribution and use of PPE lawfully and
4 fairly achieved at Health Board and Health and Social
5 Care employer level? The pandemic did not justify
6 employers ignoring existing legislation on health and
7 safety, discrimination or equality issues. So was there
8 compliance or was there panic? Were those charged with
9 ensuring compliance properly discharging their
10 responsibilities? We implore the Inquiry to look at
11 those issues.

12 I turn then to safe working environments. I've
13 referred to PPE, but the health and wellbeing and
14 resilience of our health and social care workforce and
15 thus the resilience of the country itself to manage
16 the pandemic and the health and economic challenges it
17 presented turned on more than just the appropriate
18 provision of PPE.

19 Safe working environments were essential for
20 the provision of proper care for those in receipt of
21 health and social care services and for the safety and
22 resilience of those who provided it.

23 In considering the Inquiry's responsibility to
24 investigate the provision of healthcare services and
25 social care support, including the support of staff,

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1 the Inquiry is encouraged to consider the extent to
 2 which health boards and other public sector health and
 3 social care providers undertook timely, rigorously and
 4 properly informed risk assessments with particular
 5 regard to staff health and protected characteristics .
 6 Were those assessments reviewed, as knowledge improved,
 7 as to the effect of the pandemic was having on those
 8 with identifiable protected characteristics ?
 9 And what of the workplaces themselves? The Inquiry
 10 is encouraged, when considering the provision of
 11 healthcare services generally and care and nursing
 12 homes' handling of the pandemic, to consider whether
 13 there was any prior or timely consideration given and
 14 whether future consideration ought to be given to
 15 ensuring that in health and social care settings,
 16 adequate provision exists to provide any state that can
 17 properly provide a safe working environment in
 18 workplaces that pose risks from airborne infection
 19 during a pandemic.
 20 I turn then to occupational health. In my opening
 21 submissions to the Inquiry, I referred to the debt owed
 22 by the nation to our health and social care workers,
 23 those who put their lives at risk in order to help those
 24 in peril, but find that they have succumbed to the very
 25 disease that they sought to protect us from, and who are

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1 therefore worthy of our utmost care and support.
 2 It is not the least disheartening aspect of
 3 the evidence that we have heard from health and social
 4 care staff, who did not falter in their employment
 5 duties in the face of the virus, but who became infected and
 6 ill, to find employers who were ignorant,
 7 indifferent or unsympathetic to their plight. And in
 8 that regard, I have particular regard to those who have
 9 or are suffering from Long Covid.
 10 This Inquiry has heard evidence of workers'
 11 frustration upon being told that because of
 12 insignificant — insufficient testing at the start of
 13 the pandemic and the absence of an early positive test,
 14 Long Covid could not be diagnosed despite symptoms
 15 otherwise consistent with Long Covid. And further
 16 frustration at being told that, whilst they may have
 17 worked in a COVID—19 rich environment, it can't be said
 18 that their symptoms were indeed as a result of
 19 occupational exposure as opposed to exposure outside
 20 the workplace, on the bus on the way to work.
 21 So my third broad issue, which I say is worthy of
 22 further investigation by the Inquiry, is the extent to
 23 which, in the provision of healthcare services and
 24 social care support, there was proper respect for health
 25 and social care workers to retain employment and

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1 continue to provide for the care and welfare of
 2 the nation as a whole.
 3 Were health boards and other healthcare and
 4 social care providers properly appraised of Long Covid?
 5 For too many, the reality of a COVID infection has been
 6 the blight of Long Covid. The research referred to by
 7 my learned friend Mr Gale this morning would seem to
 8 confirm what has been the reality for many in respect of
 9 this illness .
 10 So in its planning, was the Scottish Government
 11 aware of that risk? Did it factor it into its planning?
 12 Similarly, did the NHS in Scotland do the same? Did
 13 the Scottish Government and NHS Scotland centrally
 14 inform health and social care providers of the risk?
 15 Did they take steps during the acute phase of
 16 the pandemic to in—gather information, assess it and
 17 provide information to inform decision—making at
 18 the employer level? Were occupational health measures
 19 fairly and proportionately deployed in the face of
 20 someone suffering from Long Covid? Were fair and
 21 reasonable adjustments offered to the workforce
 22 returning to work?
 23 Did health boards, the NHS in Scotland more
 24 generally and the Scottish Government reasonably and
 25 responsibly in—gather, coordinate and disseminate

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1 learning as to Long Covid to inform workplace risk
 2 assessments, work requirements, and return to work
 3 arrangements? And was such work done and were steps put
 4 in place during the period of the Terms of Reference to
 5 ensure that such collaborative effort was effectively
 6 delivered?
 7 Significantly, I ask the Inquiry when considering
 8 the strategic handling of the pandemic to consider
 9 whether there were deficiencies in the state's response
 10 that now justifies the recognition of Long Covid as an
 11 occupational illness and the provision of welfare
 12 assistance to those who now suffer from Long Covid.
 13 That, therefore, takes me to my fourth broad area of
 14 concern: the extent to which Long Covid is recognised
 15 outwith the workplace, although the issues that I raise
 16 are perhaps of broader import.
 17 For those who have lost their employment as
 18 a consequence of Long Covid and for those who fear that
 19 possibility, there is a distinct issue as to the support
 20 provided to them by the state. For health and
 21 social care workers, the issue is particularly sensitive
 22 for it may well be that their illness was caused by
 23 having to work in a health and social care environment
 24 in which COVID was present.
 25 For those there may be difficulties in identifying

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1 that their illness is indeed caused by such exposure.
 2 The Inquiry, in considering the strategic response to
 3 the pandemic, including welfare assistance programmes,
 4 should consider whether there is a case for the burden
 5 of proving an employment connection to lie not on health
 6 and social care workers, but on those who might
 7 otherwise deny such support.

8 The Inquiry heard much of its evidence in George
 9 House, the home of the Pensions Appeal Tribunal for
 10 Scotland, which hears appeals in respect of what we
 11 still, or perhaps with renewed relevance, call "war
 12 pensions". We, as a nation, recognise the risk to those
 13 who placed themselves at risk of injury to protect
 14 others. In providing pensions for our armed service
 15 personnel, the state has already inverted the onus of
 16 proving a service-related cause of injury to justify
 17 a financial award.

18 It is not for our armed forces personnel to prove
 19 that an injury sustained during service was caused by
 20 service, but for the state to prove beyond reasonable
 21 doubt that it was not. That's part of the covenant
 22 between us and our armed forces.

23 So I encourage the Inquiry to consider whether there
 24 is justification for there being a similar covenant
 25 between us and our health and social care workforce,

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1 when it comes to pandemic-induced illness, to reflect
 2 the peculiar risks borne by our health and social care
 3 workers.

4 Is there a case for a Long Covid pension provision?
 5 And if so, in relation to health and social care
 6 workers, should the onus of proof of causation truly lie
 7 with a worker or the onus of proof of disproving
 8 the connection lie with the employer?

9 Finally, the ability of the country to look after
 10 and improve the lives of those with Long Covid can only
 11 be enhanced by a proper understanding of the cause and
 12 effect of that illness, and that turns on the sharing of
 13 information nationally and internationally. The
 14 Scottish Healthcare Workers' Coalition encourages
 15 the Inquiry, when considering the strategic response to
 16 the pandemic and the extent to which there was and is
 17 adequate provision for all healthcare services, to
 18 consider the extent to which the Scottish Government has
 19 actively engaged in in-gathering and assessing
 20 information relating to Long Covid.

21 So those are the primary issues we submit
 22 the Inquiry may find as areas of foreseeable of harm
 23 that are worthy, indeed cry out for further
 24 investigation and we ask the Inquiry to approach these
 25 issues having regard to three core issues: awareness,

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1 assessment and action. The Inquiry should ascertain
 2 the extent to which the Scottish Government and the NHS
 3 in Scotland were aware of the issues that I have
 4 highlighted, what assessment was then made of those
 5 risks, and what action was taken in response, for in
 6 considering those three As, one further can be
 7 involved: accountability.

8 I fear the Inquiry will have to be robust in its
 9 investigations, despite the platitudes of willingness to
 10 assist the Inquiry made in opening statements by public
 11 bodies such as NHS NSS. With perhaps one, I think,
 12 notable exception, there is little assistance afforded
 13 to the Inquiry in their closing submissions as to
 14 the specific issues that ought to be investigated. Two
 15 or three lines, after 53 days of hearings, does not
 16 suggest a meaningful desire to assist.

17 The Scottish Government itself can't be criticised
 18 for brevity in its written submission, but the Inquiry
 19 will not have missed that its position appears to be
 20 that its objective was to contain and suppress the
 21 virus, and that the consequential devastating effects
 22 were "but a consequence" of avoiding the harm caused by
 23 the virus. Did they not see that those consequences
 24 were harm in themselves? The Inquiry will want to
 25 consider whether there was a too narrow and blinkered

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1 approach by the Scottish Government. It's regrettable,
 2 standing the direction that your Lordship issued, that
 3 the Scottish Government has not directed the Inquiry to
 4 lines of investigation that might demonstrate proactive
 5 and engaged government. The reference to —
 6 THE CHAIR: You're straying over time, Mr Webster, I have to
 7 tell you.

8 MR WEBSTER: I'll bring it to the end, my Lord, then.

9 The reference to a recognition of Four Harms and
 10 a need to built equality in decision-making doesn't
 11 assist us in identifying where and how the Inquiry will
 12 see how those issues are addressed, so healthcare
 13 workers might also note the rather shallowness of
 14 the simple assertion that the Scottish Government will
 15 fully reflect on the evidence. Simply to refer to one
 16 letter of an apology from the Cabinet Secretary to
 17 ambulance workers does not assist the Inquiry in
 18 understanding where it might go and understand
 19 a sympathetic approach — of where it might go, sorry,
 20 in looking to find a sympathetic approach of government
 21 to the many challenges it faced.

22 So at the start of the Inquiry I referred to how
 23 Scotland's healthcare workers had served the people of
 24 Scotland with courage and conviction, I referred to
 25 the risks they took, the physical and emotional trauma

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1 that they bore, and that for many, frankly too many,
 2 COVID—19 continues to be an ongoing and real impediment
 3 to their lives. I call then on the Inquiry to repay
 4 the nation's indebtedness to those individuals by
 5 robustly investigating and holding to account those who
 6 were responsible for strategic decision—making, and
 7 I call upon the Inquiry to look to our decision—makers
 8 and to ascertain what decisions were taken, and why they
 9 were taken, in the face of the pandemic. My Lord, with
 10 your indulgence, that remains the case and I make no
 11 apology for reaffirming that expectation.

12 THE CHAIR: Very good. Thank you very much, Mr Webster.

13 Now, lastly this afternoon, we hear from Scottish
 14 Women's Rights Organisations. Ms Smeaton.

15 Closing statement by MS SMEATON

16 MS SMEATON: Thank you, my Lord.

17 The Scottish Women's Rights Organisations are made
 18 up of Close the Gap, Engender, JustRight Scotland,
 19 Rape Crisis Scotland and Scottish Women's Aid. As
 20 the Inquiry is aware, these five organisations have
 21 grouped together for the conduct of this Inquiry due to
 22 their common interest in gender equality and
 23 the protection of women, children and young people.
 24 The SWRO have lodged written submissions with
 25 the Inquiry in respect of the health and social care

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1 hearings, and fully detailed in those submissions their
 2 concerns about the impact of the pandemic on women and
 3 children across Scotland. I adopt those submissions,
 4 my Lord.

5 This statement focuses on four key areas of concern
 6 in respect of decision—making and impact, namely
 7 the lack of gender competence and failures to comply
 8 with equality law resulting in foreseeable negative
 9 impacts on women's security, health, employment and
 10 their financial position.

11 The first key area of concern is a lack of gender
 12 competence in decision—making and widespread failure to
 13 comply with the requirements of the Public Sector
 14 Equality Duty.

15 The SWRO submits that pre—existing structural
 16 gendered inequalities in Scotland, which already
 17 disadvantaged women, led to unequal negative impact and
 18 avoidable harm for women and children during
 19 the pandemic. These inequalities were worsened by
 20 a lack of intersectional gender competence in
 21 decision—making across Government and public
 22 institutions throughout the COVID—19 response.

23 Decisions that do not take account of
 24 the differences in the lives and experiences of women
 25 and men exacerbate these inequalities. If it is to be

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1 effective, gender competence must be fully integrated
 2 into all public sector decisions. Considerations of
 3 gender and its intersections cannot simply be added on
 4 after decisions have been made, nor can gender analysis
 5 or an Equality Impact Assessment be carried out as an
 6 extra step only when time or resources allow. Moreover,
 7 to be intersectional, decisions must take account of
 8 the intersecting drivers of inequality or disadvantage
 9 that contribute to women's overall experiences, and
 10 these include race, ethnicity, disability, age,
 11 socio—economic group and migrant status.

12 Dr Scott of Scottish Women's Aid told the Inquiry
 13 gender incompetence operates with a male default, but
 14 a failure to understand that the male default gaze is
 15 built into decision—making means that you make decisions
 16 that are deeply incompetent and harmful. For example,
 17 decisions around the procurement of PPE designed as
 18 standard to fit men failed to ensure that PPE was sized
 19 correctly to fit women's bodies and faces and that it
 20 properly protected the majority of health and
 21 social care workers who are women. This meant that
 22 frontline workers were at increased risk of contracting
 23 COVID—19 in their workplace. Had structural
 24 inequalities been addressed before the pandemic, or, if
 25 decision—making during COVID had been gender competent,

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1 the impact on women would have been very different.

2 The SWRO encourage the Inquiry to consider all
 3 the evidence heard in the health and social care
 4 hearings through an intersectional gendered perspective
 5 taking into account the different shape of women's
 6 lives, the sectors in which women make up the majority
 7 of workers, the role of women as primary carers for
 8 children and adults, and the foreseeable consequences of
 9 lockdown measures, all of which resulted in an unequal
 10 impact on women throughout the pandemic.

11 The SWRO also encourage the Inquiry to investigate
 12 the compliance of Scotland's public bodies with
 13 the Public Sector Equality Duty. Amongst other
 14 requirement, the Public Sector Equality Duty, as it
 15 applies to Scotland, requires public bodies to
 16 mainstream equality and to undertake Equality Impact
 17 Assessments in decision—making. This requires
 18 consideration of the differences between women's and
 19 men's lives. Decisions that may appear neutral can
 20 nevertheless result in a detrimental effect on women.
 21 Despite being a legal requirement, there was
 22 a widespread failure to adhere to these duties during
 23 the pandemic. The SWRO believes that public bodies in
 24 Scotland ought to be held accountable for their
 25 shortcomings in meeting the Public Sector Equality Duty.

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1 The Inquiry provides a key opportunity for public bodies
 2 to properly understand and to learn from the gendered
 3 impacts which resulted from public sector
 4 decision-making, impacts which, in many cases, could
 5 have been avoided.

6 Pre-existing structural inequalities harmed and
 7 continued to harm women, most commonly in terms of
 8 poverty and economic security, employment, access to
 9 justice and personal safety. These pre-existing
 10 inequalities could have and should have formed a basis
 11 for public sector decision-making throughout
 12 the pandemic. The SWRO encourage the Inquiry to
 13 examine the exacerbation of pre-existing inequalities
 14 through the lack of intersectional gender competence
 15 exhibited by the government and bodies, and the failure
 16 to apply principles of equality law.

17 The second key area of concern relates to domestic
 18 abuse and gender-based violence.

19 The SWRO invite the Inquiry to consider the impact
 20 of measures taken in response to the pandemic on
 21 instances of domestic abuse, as well as the effects of
 22 domestic abuse on women and children. Domestic abuse is
 23 a systemic problem, and the vast majority of victims are
 24 women and children, with between one-quarter and
 25 one-third of women in Scotland being affected by it. It

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1 is submitted that the number of victims alone ought to
 2 have meant greater care was taken to consider
 3 the consequences of decisions being made by public
 4 authorities throughout the pandemic, and instead, the
 5 opposite seems to have occurred.

6 For example, the "stay at home" message overlooked
 7 that home was not a safe space for many, including for
 8 women who were experiencing domestic abuse. There was
 9 an increase in both the frequency and the severity of
 10 domestic abuse during the pandemic, and measures that
 11 kept those suffering from domestic abuse at home
 12 increased the opportunity for domestic abuse to be
 13 carried out, whilst at the same time limiting the ways
 14 in which victims could flee or seek support. Poverty,
 15 the lack of available refuge spaces and limited choices
 16 forced women and children to stay in unsafe homes, while
 17 lockdown restrictions ensured that they remained
 18 isolated and without access to services that might
 19 otherwise have recognised the signs of domestic abuse
 20 and provided help. For children, the places that they
 21 felt safest — school, nursery, or the homes of family
 22 or close friends — were no longer available to them.
 23 As the Inquiry heard, for women experiencing domestic
 24 abuse, it was a perfect storm.

25 The SWRO's third key area of concern relates to

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1 the impact on women's health.

2 The full impact of the pandemic on the mental and
 3 physical health of the population is not yet known.
 4 Significant health problems continue to affect many, and
 5 only long term research will show the effects. But what
 6 is known is that women are twice as likely to report
 7 that their mental health worsened during the pandemic.
 8 This was in no small part due to the increased unpaid
 9 responsibilities which came to be expected of them, in
 10 terms of childcare, home-schooling and caring for
 11 vulnerable relatives, which were added to the strains of
 12 lockdown and homeworking, or to the pressures of
 13 continuing to work in public-facing roles in essential
 14 jobs.

15 Women's higher levels of poverty and gender-based
 16 violence are also connected to adverse mental health
 17 impacts. For victims and survivors of domestic abuse,
 18 sexual violence and gender-based violence, the closure
 19 of the courts and resultant backlog of cases has meant
 20 significant delays in cases proceeding to trial.
 21 The SWRO have seen the hugely negative effects these
 22 delays have had on the mental health of victims and
 23 survivors leading to increased stress and anxiety for
 24 women, and for health and social care workers, the vast
 25 majority of whom are women, the Inquiry has heard

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1 numerous reports that their mental health and wellbeing
 2 was significantly affected by the pandemic. We also
 3 know that women are more likely to experience post-viral
 4 illness and are disproportionately likely to have
 5 Long Covid, a condition which not only affects their
 6 current daily lives but their long term future, their
 7 earning capacity and their financial security.

8 The final key area of concern relates to
 9 the financial impact on women.

10 The SWRO submit that pre-existing occupational
 11 segregation in Scotland drove the unequal impact of
 12 the pandemic with women more likely to be employed in
 13 lower paid unstable jobs. This included many women
 14 working in the health and social care sector and in
 15 essential retail where they were at higher risk of
 16 contracting COVID, as well as working in sectors that
 17 were more likely to be shut down, such as hospitality.
 18 Throughout the pandemic, there was a significant
 19 increase in unpaid work as schools and nurseries closed
 20 and statutory services were severely curtailed. This
 21 moved the responsibilities of the state on to
 22 the shoulders of others and those others were
 23 overwhelmingly women. Women took on a disproportionate
 24 amount of unpaid childcare, home-schooling, housework
 25 and caring responsibilities for vulnerable relatives.

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1 This increased the pressure on women, particularly if
 2 they were seeking to juggle these responsibilities
 3 alongside paid work, which was often not flexible, and
 4 this was particularly difficult for single mothers.
 5 The mental and emotional toll of this increased workload
 6 over a sustained period during the pandemic must not be
 7 underestimated.
 8 In conclusion, my Lord, the SWRO submits that
 9 the Inquiry must not only recognise the unequal impact
 10 on women during the pandemic, but also acknowledge
 11 the failure to foresee and mitigate against these
 12 unequal impacts. Women suffered disproportionately
 13 during the pandemic, and in particular those who were
 14 already in vulnerable situations, or marginalised, such
 15 as disabled women, racially minoritised women, single
 16 parents and survivors of sexual violence or domestic
 17 abuse. This outcome ought to have been predicted by
 18 public bodies, and it would have been avoided if
 19 Equality Impact Assessments had been done at the outset
 20 of decision-making processes by those competent to
 21 undertake gender analysis. Instead, considerations of
 22 gender were either rejected outright as being
 23 superfluous, or at best were added or corrected
 24 following interventions from non-government bodies.
 25 The SWRO urge the Inquiry not to subsume

1 the experiences of women and girls within considerations
 2 of the population as a whole, but rather to recognise
 3 the structural inequalities which were exacerbated, and
 4 the additional harms that women and girls suffered.
 5 Thank you.
 6 THE CHAIR: Thank you, Ms Smeaton.
 7 Very good. That brings to an end this afternoon's
 8 proceedings and hearings. I'm grateful to all of you.
 9 I'm grateful, I should say, for the written submissions,
 10 which are of course far longer than the presentations
 11 you made this afternoon. As has been said repeatedly,
 12 they have all been considered, and will continue to be
 13 considered and guide us in our continued deliberations.
 14 In the meantime, I simply adjourn until tomorrow morning
 15 -- I check my paper -- at 10 o'clock. Thank you all.
 16 (3.43 pm)
 17 (The hearing adjourned until Friday, 28 June 2024 at
 18 10.00 am)
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