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Scottish Covid-19 Inquiry

Day 54

June 27, 2024

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Thursday, 27 June 2024

(10.00 am)

THE CHAIR: Now, good morning, everybody. Before we start formal proceedings in a moment or two, I would just like to welcome everyone to our new hearing suite. We're delighted to be here and be able to offer, I hope, improved facilities for witnesses, legal representatives, and members of the public. We have increased the capacity, as those of you in George House will have appreciated, and we look forward therefore to offering more people the opportunity to attend our hearings in person.

In October 2023, we began taking oral evidence from people who had been impacted by the devolved strategic response to the pandemic in the Health and Social Care sector. Mr Gale will say more about that in these sessions.

Before we hear his closing submissions, I want to personally thank every witness who attended during the last several months and shared their experiences. It's not easy to give evidence in a public forum such as this, particularly when doing so involves sharing personal and often emotional experiences. What you have all told us is shaping and steering our investigations and our questions for those responsible for making and

implementing decisions. I want to assure you of the value I personally place on the information you have shared with us.

I also recognise that during these hearings on Health and Social Care, not all witnesses felt able to give oral evidence nor was it possible to invite everyone to give oral evidence. Therefore, I want to reassure you all that by written statements to the Inquiry, they have been read, analysed, and will form part of the Inquiry's digest of evidence.

Now, I'm coming to invite Mr Gale to present his submissions, but before I do, I'll play the policeman for a second and say, as you know, you've all been allocated time slots and 15-minute slots to give your submissions. I will keep you to that. I have to do it to keep the thing running on time and schedule. So I apologise, and to forewarn you, I'll interrupt you a minute or so before you get to the end of your 15 minutes and fire a warning shot across your bows.

So with that warning, can I turn please to Mr Gale and invite him to make his closing submissions.

Closing statement by MR GALE

MR GALE: Thank you, my Lord, and good morning. And good morning to everybody here in the room and to all those who are watching us online.

As has been observed by both many in these hearings and in more general commentary, the SARS COVID 2 virus confronted this country and indeed the world with the most pernicious and devastating public health emergency in living memory. The word "unprecedented" often accompanies mention of the pandemic. The word is not a synonym for "unforeseeable", and as we progress in our investigations in this Inquiry, we will examine critically the extent to which the authorities in Scotland were or should have been prepared for this pandemic.

Four years on from the start of what became known as the COVID-19 pandemic, we are now largely in a post-pandemic world. But for many people in Scotland, the effects of the pandemic and its imposed restrictions will live long in the memory and will continue to have an adverse effect through the loss and bereavement caused, and many will carry with them the distressing memories of their loved ones' last days and moments, or in many cases where they were unable to be with their loved ones at the end of life. That distress is compounded by having to speculate about those last minutes.

For others, the immediate impact was the enforced separation from loved ones in care institutions and

the isolation which came with lockdowns. For those who worked through the pandemic in the Health and Social Care sector, and those engaged in the third sector, the memories of the unremitting pressure have left their scars, the witnessing of the suffering of others while trying to protect themselves against infection.

As my Lord has said, we commenced hearing oral evidence in George House on 27 October last year in relation to the impacts of the pandemic and the strategic decisions that were taken in connection with it, all at this stage in the context of the Inquiry's Health and Social Care portfolio.

Our first witness was Jane Morrison of the Scottish Covid Bereaved Group who spoke movingly of the circumstances which led to the death of her wife Jacky and her attendant grief and loss. Since then, we have heard oral evidence on 51 days concluding on 23 May of this year. In that period, we heard from 154 witnesses. On a number of occasions, and where we considered it appropriate, we heard from panels of witnesses. Each witness, whether as an individual or in the case of panels, spoke to a written statement and in total we have 154 statements.

At the outset of this concluding statement, on behalf of the Inquiry Team, I would like to express

thanks to a number of people.

Can I begin by expressing the Inquiry's thanks to all those witnesses who have engaged with the Inquiry, both in the process of providing statements and in many cases associated documents. The Inquiry recognises that for many witnesses, particularly for those who have experienced loss and/or have spoken of distressing circumstances, that process was not an easy one.

Very few of our witnesses were familiar with the process of providing statements and then subsequently giving oral evidence, and the Inquiry has always recognised that the circumstances which the witnesses related were ones which, if they had the choice, they would have preferred not to have gone through.

The Inquiry could not have assembled the evidence it now holds on health and social care impacts without the courage and fortitude of those witnesses, and we pay tribute to them.

We would also like to thank and recognise the contribution of both solicitors and counsel, who represented various witnesses either individually or in groups, or who represented Core Participants and who contributed to the eventual presentation of the witnesses' evidence.

We would also like to acknowledge with thanks the written closing statements which various Core Participants have filed with the Inquiry. Those have been, and will continue to be, analysed, as will any further oral statements which are made in amplification of those written statements.

In my capacity as co-lead Counsel to the Inquiry and as the counsel leading the presentation of the evidence in this session, I am under no illusion as to the amount of work that has been involved in getting the Inquiry to this day. I would like to personally record thanks to my colleagues in the counsel team, to Mr Caskie KC, Miss Bahrami Advocate, Mr Stephen Advocate, Mr Dunlop Advocate, Ms Trainor Advocate and Mr Edwards Advocate.

Each member of the counsel team has led a number of witnesses and has been responsible for leading evidence relating to particular topics. Members of the counsel team, in conjunction with members of the legal team, reviewed witness statements in draft and were responsible for the selection of those witnesses who subsequently gave oral evidence.

The Inquiry has, as has been mentioned on a number of occasions, always endeavoured to carry out its work having regard to its human rights-based and trauma-informed approaches. The Inquiry has also set

out in a statement published on its website this week its approach to considering equalities issues while undertaking its work, including hearings.

We have strived to proactively provide opportunities for everyone to participate meaningfully in the Inquiry's investigations and recognise the importance of working closely with a range of diverse participants and organisations in gathering evidence on impacts.

With all this in mind, I asked when we began this process that prior to the leading of evidence that each member of the counsel team should meet with the witness together with a member of the legal team. As we progressed this exercise, it was extended to include a member of the witness support team.

The purpose of this was to establish a connection between the witness and the counsel who would be leading the evidence and to, hopefully, reassure the witness that we would endeavour to minimise the stress involved. With time slots allocated to each witness, these meetings were useful to ensure that the significant issues that the witness wished to convey to the Inquiry and/or to elaborate on were identified.

As was repeatedly emphasised to witnesses, all the material that they provided us with in their

statements would be taken into consideration by the Inquiry in its ongoing analysis, and I would wish to repeat that point now.

I would also like to record my thanks to my co-lead counsel, Ms Van der Westhuizen KC and her counsel team of David Turner Advocate and Mary Ellen Stewart Advocate, for the assistance and support they have readily given us as we have progressed through the preparation for our hearings and the hearings themselves. And, in particular, the input which they gave where there was an overlap, as there frequently was, between the evidence that the witness was to give to our hearings and the matters which had relevance to the portfolios which the other team were concerned.

I am pleased to say that we managed to achieve, I think, a 100% record of counsel meeting with witnesses in advance of their giving evidence, and on some occasions there was more than one meeting. I can speak from my own perspective that I found these meetings extremely helpful, and I am pleased that those solicitors who acted for witnesses largely confirmed that the witnesses found this process of assistance.

I would also like to thank all the members of the legal team. Initially that team was led by Joanna Bain, then by Gordon McNichol and more recently

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

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

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

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

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

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

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

information which will inform our work going forward.

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

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

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

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

continued and invaluable input.

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

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

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

treatments, or give birth alone due to the COVID-19 restrictions.

Many experiences shared with Let's Be Heard also centred on care homes, where respondents shared the experience of losing family members, the inability to visit loved ones and the many difficulties navigating the difficult rules and restrictions. People who worked in care settings shared with Let's Be Heard the poor working conditions that were impacted by staff shortages, poor access to PPE, a lack of information and rules that they did not feel able to implement.

That material has been and continues to be analysed by the Let's Be Heard team and we would like to pay tribute to Dr Anderson and her team for the work that they have done from the very beginning of this -- of the Inquiry's existence.

We have also heard from organisations representing those with protected characteristics and other disadvantaged groups, who have told us that the impact of the pandemic was not the same for everyone, nor did it feel equal.

These insights have been instrumental in helping us consider how impacts have been felt by different communities across Scotland, and any potential disparities in that -- in these impacts.

It is appropriate at this stage that I give some indication of how the Inquiry intend to take forward the evidence and the information that we have heard and the information that the Inquiry has assembled relevant to impacts in the health and social care sector.

As was explained both in the preliminary hearing in advance of this evidential session and in the opening statement, which I gave on 24 October last year, the decision to begin the Inquiry's oral hearings with evidence from those who were and continue to be affected by the pandemic and the associated strategic decisions was a quite deliberate one, guided by the desire to understand the effects that the pandemic and the associated decisions had on individuals who were receiving health and social care services, whether they were immediately and perhaps unexpectedly affected by contracting the virus, or where contracting the virus has had long-term implications, or where they were in receipt of longer-term health and social care service provision.

We also wanted to understand and appreciate the effects of the pandemic and its restrictions had on those who were health and social care providers, whether they were in the NHS, the social care sector, the third sector or were part of the legion of unpaid carers. And

in that connection, we were anxious to hear from individuals and representative organisations.

As the Inquiry has made clear, we intend to progress from this evidential basis in the health and social care context to consider -- to a consideration of the implementation of the strategic decisions and the decision-making processes themselves which underpinned those decisions.

As has been previously stated, decisions have consequences and an understanding of those consequences is, in the view of this Inquiry, an essential element in assessing the decisions that were taken and the way in which they were implemented, and will, in our view, assist in the Inquiry's task of determining whether lessons can be learned should there be a future pandemic.

Having assembled the evidence from these hearings as well as the other information to which I have made reference, the Inquiry is reinforced in its view that the sequence in which evidence has been taken has been conducive to providing a wealth of informed and detailed evidence, which the Inquiry can take forward to the next stages of our investigations.

It is the Inquiry's intention to proceed to produce a detailed written narrative relating the evidence and

other information that it has received in relation to impacts in the areas of health and social care. This will be just what I have said, it will be a narrative record, narrating all the impacts that the Inquiry has heard about. It will not be a report in the sense of a document reaching conclusions, and in particular will not include conclusions on matters of controversy where witnesses and informants have criticised matters of decision-making and implementation.

It will also -- it will, however, provide a context in which decision-making and implementation will be critically examined by the Inquiry. It will also provide an enduring record of the impacts of the most significant public health emergency experienced by the people of Scotland in living memory.

It is our intention to provide a draft of this narrative by the end of this year and to publish a narrative on our website in Spring 2025.

As I have probably already indicated, the purpose of this closing statement is not an attempt to provide a comprehensive review of all the evidence that has been heard. The purpose is to identify certain of the significant themes which have emerged during the evidence and which we intend to pursue in our investigations going forward.

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

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

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

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

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

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

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

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

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

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

does not comply with the human rights—based approach for which the legislation contends.

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

In support of that submission, CHRS maintains that:

"There would be no need to hear further evidence (eg of policy makers) to make such a recommendation; the clear, consistent and overwhelming evidence during these hearings would be sufficient."

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

argument has been informed and has been passionate.

The role of the Chair of a public inquiry does include, where appropriate, the making of recommendations as to possible legislative innovation or improvement. In the circumstances presented by this application by CHRS, it is, in my opinion, and would be my advice to your Lordship, that a recommendation should not be made at this stage.

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

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

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

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

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

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

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

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

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

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

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

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

We also analysed the range of ages of those who died

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

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

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

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

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

stands, as at the 16th of this month, at 18,880.

Can I give now some further data regarding Long Covid, which of course has been something about which we have heard a good deal of evidence.

We have heard a great deal of evidence concerning the impact caused by developing Long Covid and its varying and debilitating effects on individuals. That evidence has come from individuals, including a number of individuals who contracted COVID in the course of their work in the Health and Social Care sectors and also from individuals speaking on behalf of their children.

We have also heard from representatives of organisations speaking of the impact that Long Covid has had on workforces, particularly within the Health and Social Care sectors.

Given that evidence, it seemed to us that we should seek to obtain some data regarding the prevalence of Long Covid in Scotland during the period of our remit. Beyond a simple extrapolation from the number of people who have self-reported Long Covid across the UK, our researchers have drawn to our attention certain research, which I will expand on in a moment, but which, subject to certain caveats, suggests that in the period between 1 March 2020 and 26 October 2022, some 90,712

individuals had Long Covid, representing 1.8% of the population.

This figure has been produced by the Usher Institute at the University of Edinburgh and is entitled -- I'll give you the full title of the work, "Prevalence and risk factors for Long Covid among adults in Scotland using electronic health records: a national retrospective, observational cohort study".

The study looked at the electronic health records of all adults, being those aged 18 or over, and who were registered with a general medical practice in Scotland between the two dates that I have indicated. That cohort of individuals represents 4.7 million adults, or 98-99% of the population. Four different methods were used to identify Long Covid cases. These were as follows.

Firstly, clinical codes where Long Covid was specifically entered into a patient's records by their GP.

Secondly, free text in primary care records, which would include notes or non-coded information recorded into a patient's records by their GP, for example, about the symptoms they are experiencing.

Three, sick notes.

Four, using a novel operational definition. This is

a definition of Long Covid developed by the study team at the Usher Institute based on patients having a positive COVID-19 test and two or more features, being either symptoms, clinical investigations or prescriptions recorded in the patient's records which are or were suggestive of Long Covid.

This information does come with a number of caveats which the Usher Institute themselves issue. It is thought that the findings are likely to be a substantial underestimate of the number of people who have been and continue to be affected by Long Covid. This caveat reflects some of the challenges in diagnosing Long Covid, about which we have heard a good deal in evidence, and inconsistencies in recording information in the Electronic Health Register -- records.

However, it is thought that this study does appear to represent the most complete data source for estimating the number of positive diagnoses rather than an estimate depending upon self-reporting.

The study also discloses that several groups have been and continue to be disproportionately affected by Long Covid. These groups include females, those aged in the general population between 38 and 67, those who are overweight or obese, those who are living with two or more underlying health conditions, those who are

immune-suppressed, those who were advised to shield, those who were hospitalised within 28 days of testing positive for COVID-19 and those who were tested positive for COVID-19 before the Omicron variant became the dominant variant in the UK.

I turn now to another background issue, but one which has been relevant throughout really all of our hearings and which is, in our view, very significant, and that is grief and bereavement.

We would like to say something about the information that the Inquiry has garnered and heard about concerning grief. Dealing with grief in the context of the pandemic and its restrictions has been a recurring theme throughout this -- the evidence we've heard. We of course recognise that grief was poignantly expressed by those who lost loved ones to COVID-19, but it also affected those who were denied proper basic contact with their loved ones during the pandemic and those who cared for residents and patients and who observed their suffering and in many cases death in distressing circumstances.

The Inquiry has had regard to research carried out into grief experienced during the pandemic and in particular to Prolonged Grief Disorder, PGD as it is referred. In this regard, the Inquiry considered

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

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

The work by Harrop and others focused on the factors which have an influence on PGD. These factors included the relationship to the person who died, the cause, expectedness and place of death, the circumstances of death and the disruption of the grieving process. The authors state as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) The information which Alzheimer Scotland

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

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

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

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

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

social activities.

(g) Being confronted with staff wearing face masks would likely have had an impact on the wellbeing of residents. Again, I quote from Mr Simmons:

"Someone living with dementia, even advanced dementia, struggles to have a sense of time, place and person. When looking after someone with dementia you need to help them with a sense of self and wellbeing using reminiscence techniques, social stimulation, cognitive stimulation. That is all mainly done in a care home environment in a group basis."

That statement is from paragraph 74 of his statement.

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

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

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

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

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

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

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

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

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

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

the transmission of the virus by airborne means.

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

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

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

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

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

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

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

"Current evidence suggests that the virus spreads mainly between people who are in close contact with each other for example at a conversational distance. The virus can spread from an infected person's mouth or nose in small liquid particles when they cough sneeze speak sing or breathe. Another person can then contract the virus when infectious particles that pass through the air are inhaled at short range (this is often called short range aerosol or short range airborne transmission) or if infectious particles come into contact with the eyes nose or mouth (droplet transmission). The virus can also spread in poorly ventilated and/or crowded indoor settings where people tend to spend longer periods of time. This is because aerosols can remain suspended in the air or travel

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

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

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

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

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

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

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

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

It will be appreciated that residents in care homes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

longer.

MR GALE: Yes.

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

MR GALE: Thank you, my Lord.

THE CHAIR: Thank you, all.

(11.22 am)

(A short break)

(11.45 am)

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

MR GALE: My Lord, yes.

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

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

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

those who wanted to visit and from those who required to act in accordance with this guidance in providing care facilities .

A recurring criticism was that the guidance was subject to constant change, such that all who required to understand the guidance had difficulty in knowing what, at any particular time, was the current guidance, and this was frequently compounded by guidance being issued at the end of the week.

Also of concern was the criticism made by many witnesses that the framing of the guidance was designed for —— or more for application to the circumstances of acute clinical settings and did not properly take account of the care settings in which mainly elderly residents, many of whom suffered some level of dementia, could not be expected to observe the restrictions more appropriate for clinical settings.

This is an area of communication between authorities and the public which is, in the Inquiry's view, a significant one having regard to our Terms of Reference. The Inquiry is, going forward to its investigations around implementation and decision—making, conscious of the informed criticisms made by parties and witnesses in the impact hearings. The Inquiry does not think that it can be disputed that

there exists and existed an obligation on governments and authorities to express guidance with clarity and certainty.

The Inquiry has recently considered the report issued in May of this year by the Independent Commission on UK Public Health Emergency Powers published by the Bingham Institute for the Rule of Law. While relating principally to the use by governments of primary and secondary legislation in the context of dealing with the pandemic, the Commission makes the following comment in its Executive Summary:

"Legal certainty is a key aspect of the rule of law. In order for people to understand what the rule of law requires them to do legal rules must be sufficiently clear, stable and accessible, and should enable people to foresee with reasonable confidence when they might be sanctioned for not following the law."

The main areas of legal uncertainty that arose during the COVID—19 pandemic include, one, uncertainty caused by the manner of making and frequently amending large numbers of public health regulations; and, two, uncertainty caused by the way legal requirements and public health advice were communicated by the government, often without clearly distinguishing between the two.

The Inquiry will, as I have said, investigate the way in which guidance was presented and communicated to the public, and, in particular, we will examine the status, whether actual or apparent, given to that guidance.

On a more micro, but no less important level, the Inquiry has in these hearings heard considerable evidence concerning the way in which care institutions communicated with relatives of loved ones who were in care, and who, understandably in circumstances where they were unable to see their loved ones wanted to know about their conditions.

The evidence that we have heard has disclosed varying levels of communications. There have been instances where communication and the information conveyed were both helpful and compassionate. There were, however, concerning instances where calls went unanswered or were responded to only after numerous repeated calls. On other occasions, responses were non—specific and formulaic, with the words such as, "Yes, he/she is fine", deemed to be sufficient to satisfy a concerned relative. Even allowing for the exigencies under which staff were working, such responses of that nature could be —— we pose the question: could those responses be considered either

adequate or appropriate?

A specific issue regarding communication arose in connection with the presence on the records of a patient/resident of a DNACPR notice. It will be appreciated that the Inquiry's Terms of Reference direct that we should investigate the strategic elements of the handling of the pandemic relating to the delivery of end—of—life care and the use of DNACPR.

For a number of witnesses, it was accepted that such a notice had been discussed either with them or with the patient/resident and had been included in the records on an informed basis. A number of witnesses, however, expressed both shock and distress to discover that a DNACPR notice existed in respect of their loved ones. That such should have been the case without apparent consultation with the patient and/or family members is a matter of concern, and the Inquiry will take forward the detailed evidence of these witnesses to our future consideration of Term of Reference 2(i). We will also, in consideration of implementation and decision—making, consider the protocols and guidance that were in place concerning the use of DNACPR notices.

The pandemic led us all to communicate through different methods and using, with varying degrees of

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

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

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

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

There were people who, for various reasons, did not

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

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

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

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

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

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

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

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

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

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

It has been important to secure from these witnesses

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

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

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

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

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

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

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

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

(12.00 pm)

(The short adjournment)

(2.00 pm)

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

Closing statement by MR MITCHELL

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

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

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

On behalf of the Scottish Government, we also pass

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

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

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

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

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

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

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

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

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

nature of guidance, the isolation experienced by residents and the continuation of restrictions as the rest of the nation emerged from the pandemic.

Evidence was also heard of the experiences of those suffering from different forms of dementia. Anger and guilt were frequently mentioned emotions, the grief of witnesses who were not able to say goodbye to their loved ones was palpable and moving.

It has to be remembered that decision-making in this area was detailed and complex, taking place amid a dynamic and rapidly changing situation. In the early stages of the pandemic, due to the concern of the risk of rapid infection within care homes, measures were focused on trying to prevent ingress of an infection and on minimising transmission. It must be remembered that at this time, there was no vaccine and limited availability of testing, therefore it was recommended that routine visiting should be paused, but that essential visits for end-of-life or distress should be supported.

The complexities surrounding decisions and visiting was discussed in a report prepared in late 2022 by the chief medical officers of the United Kingdom. The CMOs commented that:

"Reducing risk of transmission in care homes

involved some of the most complex trade-offs of risk to individuals of any part of the pandemic. These included considering the needs and rights of individuals as well as those of the wider resident population. This in turn meant balancing the risk of COVID-19 outbreaks in a very vulnerable group with maintaining staffing, access to healthcare, close contact needs of residents, visiting by relatives and friends in what are often the last months of life and dignity and quality of life among a group with high prevalence of dementia."

Bearing all that in mind, I turn to some of the points made in evidence and in the written submissions. The point has been made that guidance for care homes changes frequently. In the absence of specific clinical COVID-19 guidance for care homes and in response to a request from the adult social care sector for specific guidance, the Scottish Government issued such guidance.

Understanding of the virus and its effects developed rapidly. There was a clear need to update the guidance as new data and evidence emerged, whilst recognising that it was challenging for care homes to respond to changing guidance, it was essential for the guidance to be updated to reflect new developments and our understanding of it.

More broadly, it is important to have regard to the actual guidance that was produced by the Scottish Government in contrast to the measures that individual care homes chose to put in place. For example, Scottish Government guidance to care homes did not restrict end-of-life visiting. From the outset of the pandemic, the Scottish Government was clear that end-of-life visits should be supported.

A focal point of the evidence was that residents should have the right to receive in-person visits. In April 2022, two new health and social care standards were introduced that set out the expectation that people living in care homes should be able to see someone who was important to them, even during a pandemic, and be able to name a person who can directly participate in meeting their needs. But that approach has to be embedded in legislation.

The Inquiry will be aware that the National Care Service Bill is currently at stage 2 of its Parliamentary process. During stage 1, the Parliament took extensive evidence from a range of stakeholders at which time the Anne's Law provisions received in depth scrutiny.

The Scottish Government values the support of Care Homes Relative Scotland in helping develop and

deliver Anne's Law. It is currently considering the feedback from that organisation, amongst other organisations. This process includes consideration of ways to strengthen Anne's Law, as well as assessing the potential for alternative legislative mechanisms to deliver Anne's Law more quickly.

Evidence was given regarding a lack of consultation between the Scottish Government and care sector representatives prior to the taking of decisions or issuing guidance. In fact, there was widespread consultation at senior official administerial level with care sector groups, relatives and unpaid carers in addition to stakeholder participation and a range of Scottish Government-led social care advisory groups.

Of course, where urgent decisions or guidance was needed, consultation might not have been as detailed or lengthy as would otherwise be the case and as with any consultation a range of views would often be provided, not all of which could be accommodated.

Turning to Long Covid.

The Inquiry has heard evidence of the pernicious impact of Long Covid on the lives and health of both adults and children suffering from the illness who have struggled to have their voices heard, have faced difficulties in obtaining a diagnosis, and suffer

feelings of isolation and abandonment by the medical profession.

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

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

Turning to the impact on care providers, charities

and the third sector.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you.

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

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

Closing statement by MS TONER

MS TONER: My Lord, good afternoon.

THE CHAIR: Good afternoon.

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

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

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

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

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

My Lord, it will be important for the Inquiry to

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

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

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

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

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

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

My Lord.

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

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

Closing statement by MS BURKE

MS BURKE: Good afternoon, my Lord.

THE CHAIR: Good afternoon.

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

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

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

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

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

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

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

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

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

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

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

The guidance often did not take account of the variety of settings in which social care services can be delivered, nor was it framed in a way which allowed staff flexibility to make assessments about what was in the best interests of those they cared for. Viv~Dickenson, CEO of CrossReach, described feeling like the guidance was coming down in an NHS directive model rather than in a way which took into account the nuances of different settings.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Staff and managers worked long hours, taking additional staff —— taking additional shifts to provide cover when colleagues were required to isolate. They had to take on additional responsibilities, including comply with increased infection prevention and control requirements and new reporting requirements, and staff also missed the valuable assistance that visitors provided when caring for their loved ones.

The pressures encountered by staff has led to burn—out and staff leaving the sector, creating further staff shortages. The Inquiry has heard evidence that those in

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

Family members also provided evidence about the treatment of care workers. Dr Wightman agreed, when asked by Mr Gale KC, that those who worked in care homes were unfairly treated or castigated, noting that care homes were treated as isolation hospitals.

The impact that the pandemic had on staff, health and wellbeing is significant and continues to have a detrimental impact on the provision of social care in Scotland.

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

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

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

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

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

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

(2.33 pm)

(A short break)

(2.50 pm)

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

Closing statement by MS DONALD

MS DONALD: Good afternoon, my Lord.

THE CHAIR: Good afternoon.

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

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

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

the Inquiry's own report.

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

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

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

The guidance -- others have referred to this, the guidance was also constantly being updated,

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

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

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

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

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

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

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

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

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

itself with their comments.

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

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

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

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

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

My Lord, those are my submissions.

THE CHAIR: I'm very grateful. Thank you very much indeed.

Now, the Royal College of Nursing, Ms Shand.

Closing statement by MS SHAND

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

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

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

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

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

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

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

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

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

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

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

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

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

Further, across the UK, the prevalence of Long Covid among staff working in health and social care is significantly higher than in the wider population. There are nursing staff who contracted Long Covid, who have been unable to return to work, or have had their working hours reduced.

The impact of Long Covid on the workforce, along with continuing psychological symptoms being experienced by many RCN Scotland members, means that there is a cohort of the registered nurses and nursing support workers now unable to practice, or who have had to reduce the hours they work. Not only has this impacted on their earnings, but RCN Scotland's position is that this reduction in staff has had a consequential adverse effect on the quality of care capable of being delivered to patients and care home residents.

RCN Scotland's position is that without an adequate number of nursing staff with the right mixture of skills, who are able to deliver the appropriate standard of patient care to meet the demand of the country at the present time in the absence of a pandemic, then there is no prospect of the demand created by any future pandemic coming close to being met.

On the matter of Long Covid, which I mentioned, the RCN has this month written -- RCN Scotland has this

month written to the First Minister seeking an amendment to the current Terms of Reference to the Inquiry to explicitly include Long Covid. This is with a view to ensuring that evidence about the foreseeability of long-term, post-viral symptoms, such as those arising from Long Covid, the impact of Long Covid on individuals and its impact on the already depleted nursing workforce, are fully part of the Inquiry's investigations and report.

The second area I wish to highlight, my Lord, is the adequacy and hierarchy of the provision of PPE. From the beginning of and throughout the pandemic, RCN Scotland regularly expressed its concerns in correspondence to the First Minister of Scotland regarding the difficulties its members had in accessing adequate supplies of PPE.

Care homes were particularly affected by lack of PPE due to not being able to access their usual supplies and suppliers. RCN Scotland consider that the evidence has highlighted that there appeared to be a hierarchy in terms of the supply of PPE. RCN Scotland members were reporting that they consider there was a prioritisation of PPE, in particular of the more so-called heavy duty PPE, such as FFP3 masks, in the intensive care units and some parts of the acute sector.

PPE in the care home and community care sector, both in relation to the procurement and provision thereof, was considered by RCN Scotland to be inadequate. This inadequacy resulted in RCN Scotland members having to reuse PPE, which was intended for single use only, or in some cases procure their own PPE.

Further, the "one size fits all" approach in the design of protective equipment had been a problem for frontline health workers who had to wear this life saving equipment for up to 12 hours at a time. Face fitting was an issue, as many people had not been properly trained to carry out this. And this was exacerbated by the fact that a number of brands were not producing masks which fitted female faces, nor took into consideration workers who may have religious headwear. As a result of issues of this type, the masks were often ill-fitting for those individuals and, as a consequence, the masks did not form a seal and allowed air to get in at the side of the mask.

RCN Scotland contend that it was a foreseeable consequence of insufficient and/or ill-fitting PPE that it would increase the likelihood of contracting the virus.

RCN Scotland observes that a further recurring concern expressed by its members was in relation to

the confusion regarding the guidance on use of PPE. The evidence led supports the position that the guidance on PPE changed frequently, leading to confusion on how to apply it. Many RCN Scotland members reported that this caused them a dilemma over whether they could or could not treat patients without wearing PPE. The frequency at which PPE guidance was updated caused inconsistency in its application, which in RCN Scotland's view, will undoubtedly have contributed to the transmission of the virus.

Third, my Lord, mode of transmission of COVID infection.

Intrinsically linked to the issues of adequacy in the type and provision of PPE were the consequences of the Scottish Government strictly following the advice of anti-microbial resistance and healthcare associated infection are high, an advisory group which continually reported that COVID was a droplet spread infection rather than an airborne infection. Health boards therefore only routinely offered higher levels of protection, such as FFP3 masks, in the areas where Aerosol Generating Procedures were routinely performed.

From early in the pandemic, the RCN raised this issue throughout the workforce senior leadership group -- that's CRCN Scotland -- and other pandemic strategic

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

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

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

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

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

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

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

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

Scottish Government and employers was lost.

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

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

Thank you, my Lord.

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

Closing statement by MR WEBSTER

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

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

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

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

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

The Inquiry has endeavoured to allow many voices to

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

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

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

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

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

Firstly, the immediate response. The Inquiry has heard from witnesses as to the inadequate provision of PPE in the early stages of the pandemic, including shortcomings in the assessment of the need for PPE masks generally, shortcomings in the provision of PPE, shortcomings in the assessment of individual need for PPE, shortcomings in the arranging of fitting of appropriate PPE, shortcomings in the need to identify the need for PPE based upon individual protected characteristics.

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

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

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

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

Beyond planning, the Inquiry must also look at how

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

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

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

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

the Inquiry is encouraged to consider the extent to which health boards and other public sector health and social care providers undertook timely, rigorously and properly informed risk assessments with particular regard to staff health and protected characteristics. Were those assessments reviewed, as knowledge improved, as to the effect of the pandemic was having on those with identifiable protected characteristics?

And what of the workplaces themselves? The Inquiry is encouraged, when considering the provision of healthcare services generally and care and nursing homes' handling of the pandemic, to consider whether there was any prior or timely consideration given and whether future consideration ought to be given to ensuring that in health and social care settings, adequate provision exists to provide any state that can properly provide a safe working environment in workplaces that pose risks from airborne infection during a pandemic.

I turn then to occupational health. In my opening submissions to the Inquiry, I referred to the debt owed by the nation to our health and social care workers, those who put their lives at risk in order to help those in peril, but find that they have succumbed to the very disease that they sought to protect us from, and who are

therefore worthy of our utmost care and support.

It is not the least disheartening aspect of the evidence that we have heard from health and social care staff, who did not falter in their employment duties in the face of the virus, but who became infected and ill, to find employers who were ignorant, indifferent or unsympathetic to their plight. And in that regard, I have particular regard to those who have or are suffering from Long Covid.

This Inquiry has heard evidence of workers' frustration upon being told that because of insignificant —— insufficient testing at the start of the pandemic and the absence of an early positive test, Long Covid could not be diagnosed despite symptoms otherwise consistent with Long Covid. And further frustration at being told that, whilst they may have worked in a COVID-19 rich environment, it can't be said that their symptoms were indeed as a result of occupational exposure as opposed to exposure outside the workplace, on the bus on the way to work.

So my third broad issue, which I say is worthy of further investigation by the Inquiry, is the extent to which, in the provision of healthcare services and social care support, there was proper respect for health and social care workers to retain employment and

continue to provide for the care and welfare of the nation as a whole.

Were health boards and other healthcare and social care providers properly appraised of Long Covid? For too many, the reality of a COVID infection has been the blight of Long Covid. The research referred to by my learned friend Mr Gale this morning would seem to confirm what has been the reality for many in respect of this illness.

So in its planning, was the Scottish Government aware of that risk? Did it factor it into its planning? Similarly, did the NHS in Scotland do the same? Did the Scottish Government and NHS Scotland centrally inform health and social care providers of the risk? Did they take steps during the acute phase of the pandemic to in-gather information, assess it and provide information to inform decision-making at the employer level? Were occupational health measures fairly and proportionately deployed in the face of someone suffering from Long Covid? Were fair and reasonable adjustments offered to the workforce returning to work?

Did health boards, the NHS in Scotland more generally and the Scottish Government reasonably and responsibly in-gather, coordinate and disseminate

learning as to Long Covid to inform workplace risk assessments, work requirements, and return to work arrangements? And was such work done and were steps put in place during the period of the Terms of Reference to ensure that such collaborative effort was effectively delivered?

Significantly, I ask the Inquiry when considering the strategic handling of the pandemic to consider whether there were deficiences in the state's response that now justifies the recognition of Long Covid as an occupational illness and the provision of welfare assistance to those who now suffer from Long Covid.

That, therefore, takes me to my fourth broad area of concern: the extent to which Long Covid is recognised outwith the workplace, although the issues that I raise are perhaps of broader import.

For those who have lost their employment as a consequence of Long Covid and for those who fear that possibility, there is a distinct issue as to the support provided to them by the state. For health and social care workers, the issue is particularly sensitive for it may well be that their illness was caused by having to work in a health and social care environment in which COVID was present.

For those there may be difficulties in identifying

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

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

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

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

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

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

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

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

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

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

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

approach by the Scottish Government. It's regrettable, standing the direction that your Lordship issued, that the Scottish Government has not directed the Inquiry to lines of investigation that might demonstrate proactive and engaged government. The reference to --

THE CHAIR: You're straying over time, Mr Webster, I have to tell you.

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

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

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

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

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

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

Closing statement by MS SMEATON

MS SMEATON: Thank you, my Lord.

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

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

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

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

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

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

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

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

the impact on women would have been very different.

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

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

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

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

The second key area of concern relates to domestic abuse and gender—based violence.

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

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

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

The SWRO's third key area of concern relates to

the impact on women's health.

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

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

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

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

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

This increased the pressure on women, particularly if they were seeking to juggle these responsibilities alongside paid work, which was often not flexible, and this was particularly difficult for single mothers. The mental and emotional toll of this increased workload over a sustained period during the pandemic must not be underestimated.

In conclusion, my Lord, the SWRO submits that the Inquiry must not only recognise the unequal impact on women during the pandemic, but also acknowledge the failure to foresee and mitigate against these unequal impacts. Women suffered disproportionately during the pandemic, and in particular those who were already in vulnerable situations, or marginalised, such as disabled women, racially minoritised women, single parents and survivors of sexual violence or domestic abuse. This outcome ought to have been predicted by public bodies, and it would have been avoided if Equality Impact Assessments had been done at the outset of decision-making processes by those competent to undertake gender analysis. Instead, considerations of gender were either rejected outright as being superfluous, or at best were added or corrected following interventions from non-government bodies.

The SWRO urge the Inquiry not to subsume

the experiences of women and girls within considerations of the population as a whole, but rather to recognise the structural inequalities which were exacerbated, and the additional harms that women and girls suffered.

Thank you.

THE CHAIR: Thank you, Ms Smeaton.

Very good. That brings to an end this afternoon's proceedings and hearings. I'm grateful to all of you. I'm grateful, I should say, for the written submissions, which are of course far longer than the presentations you made this afternoon. As has been said repeatedly, they have all been considered, and will continue to be considered and guide us in our continued deliberations. In the meantime, I simply adjourn until tomorrow morning -- I check my paper -- at 10 o'clock. Thank you all.

(3.43 pm)

(The hearing adjourned until Friday, 28 June 2024 at 10.00 am)

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