OPUS 2

Scottish Covid-19 Inquiry

Day 55

June 28, 2024

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(10.00 am)

THE CHAIR: Now, just before we start a number of housekeeping matters. I'm sorry. The running order has been changed this morning or not the running order, but the timing, I suppose is a more accurate way of saying. There was a participant, Core Participant, who is going to address the Inquiry between 10.30 and 10.45, but they no longer wish to address the Inquiry. So we have simply advanced everyone up.

Now, there is a slight problem there. That had you due to speak, Ms McCall, at 10.45. But Mr Crabb is not here, I understand yet. Do you mind terribly going forward another 15 minutes? And if Mr Crabb arrives, he can come at 10.45. But I notice that he's due again at 11.15, so we may have double bagged Mr Crabb, but we will sort that out.

So apologies for all that.

The only other thing is to remind you all —— since some of you weren't here yesterday —— that there's 15 minutes allocated. The reason for the relatively short time is because of course we have the full statement, which has already been considered and will be looked at again; and, therefore, in terms of accommodating the large number of Core Participants within a confined timetable, we have to restrict it to 15 minutes; and I will keep you to 15

minutes.

So with that, hopefully not too stern, warning, could I ask Mr Anwar for Scottish Covid Bereaved to address us first, please.

Thank you Mr Anwar.

Closing statement by MR ANWAR

MR ANWAR: Thank you, my Lord.

My Lord, these are submissions on behalf of the Scottish Covid Bereaved. I am relying on our written submissions but focusing on particular issues.

The Scottish Covid Bereaved originally started out as part of the Facebook group Covid Bereaved Families for Justice, which was formed in June 2022. In September 2022, the Scottish Covid Bereaved formally left the group and became a completely separate, autonomous, group: the Scottish Covid Bereaved.

Since July 2020 and a first press Article on care homes with the BBC, the group have been a consistent and positive campaigning presence in the media and our communities.

The Scottish Covid Bereaved's political campaign ultimately led to the formation of this Inquiry.

The Scottish Covid Bereaved are a group of like-minded bereaved individuals with a common goal of not wanting their loved ones' deaths to have been in vain, and

for lessons to be learned to stop others having to suffer in the same way they have. The bereaved have identified consistent areas of concern amongst their members and have shared these concerns with senior politicians and both this Inquiry as well as the UK Inquiry where they are represented.

The Scottish Covid Bereaved have repeatedly raised the issue of the deaths of patients who acquired Covid in hospital. They have raised issues around NHS services and testing criteria focusing on the three cardinal symptoms: temperature, persistent cough and the loss of sense of taste or smell. The group also proposed that the Crown Office and Procurator Fiscal's investigation into care home deaths should also consider the issue of Nosocomial deaths.

Regards to the Scottish Inquiry, the Scottish Covid Bereaved wish to make some observations on the progress of the Inquiry to date. The Inquiry's administration and communications have been beset with problems, although the bereaved appreciate that the Chief Executive that has been appointed aimed to resolve these issues and, in the last several months, your team have worked night and day to deliver.

However, on the issue of funding, despite the award for funding of legal representations, difficulties with that funding have limited the work that can be carried

out on the bereaved's behalf. I am aware, from other Core Participants, that remains the issue for them also. The Scottish Covid Bereaved consider that, with an award for funding of legal representation in place, representatives should not be expected to work for free for the Inquiry's behalf. The bereaved hope that, given we are now some two and a half years after this Inquiry was announced, these matters can be resolved as a matter of urgency.

It is clear, when I look around the room, that the army of lawyers that act on behalf of the Government or hospitals never face such issues; yet, time and time again, it is always the bereaved, as Core Participants, who are told they will be front and centre, who face these problems.

Moving on to the Impact Hearings.

When the evidence in these Impact Hearings began to be heard, it became apparent that the Restriction Order in place was inhibiting witnesses from mentioning the names of their loved ones. It caused unnecessary anxiety, pain and difficulty for witnesses for giving evidence. Scottish Covid Bereaved call on the Inquiry to reconsider the terms of the Restriction Order. It is submitted that in its current form the order is unduly onerous and creates an unnecessary additional administrative burden on Core Participants and the Inquiry.

The Scottish Covid Bereaved are concerned that the

scope of evidence being elicited does, on occasion, also fall outwith the scope of the Module. It is submitted that the thematic approach to evidence adopted by the Inquiry can lack focus and clarity; and it is not clear to the bereaved the status, if any, of this evidence. Whilst the bereaved welcome the opportunity to tell their stories, they're conscious that it has now been over four years since COVID—19 arrived in Scotland. The UK Inquiry has powered ahead in calling politicians, civil servants, advisers, scientists and medics to give evidence. There have been three Prime Ministers and three First Ministers since the start of the pandemic. By the time this Inquiry comes to hear evidence from the key decision makers, there will already have been a UK General Election; there may have been a Scottish Parliament election. The bereaved hope that the Inquiry can capture the evidence of the key decision makers as soon as possible.

With regards to the need for evidence, the members of the group gave evidence, like many others from across Scotland, to allow the Inquiry to understand the impact of decisions made by the authorities during the course of the pandemic. The Scottish Covid Bereaved do not hold themselves out to be experts witnesses. Those are matters which it is submitted require a proper evidential basis. Whilst the bereaved can offer a lay perspective, it is

submitted that the Inquiry urgently requires to establish an evidential basis to allow it to consider whether Scotland was prepared for the pandemic.

On the submissions with regards to evidence, the group's representatives have not, as restricted by the Inquiry, been given funding to watch all of the evidence of the other Core Participants. This is considered to be particularly unfortunate given the Chair's request for submissions on that evidence and for consideration to be given to issues such as foreseeability and future investigations. However, it is submitted that there are several recurring themes which can be highlighted in respect of the evidence before the Inquiry.

These include:

The total lockdown of care homes. It is submitted that allowing at the very least one named visitor per patient would have helped staff, as those visitors would have been able to assist with the residents' care and would have had the benefits for their mental health. Care home staff, of course, suffered as a lack of PPE.

NHS24 and 111 services provided inconsistent advice and stuck too rigidity to the three cardinal symptoms for test referrals.

There was poor communication, or a complete lack of communication, with family members in relation to the

treatment for, and the wellbeing of, individuals in hospitals. This was particularly keenly felt in relation to the use of the do not attempt CPR notices.

In his submission yesterday, Mr Gale said that this is an area that will be subject to thorough investigation. The SCB are concerned that the DNACPR decisions were made on flimsy and irrelevant clinical information. In some instances we understand our members were concerned that their relatives didn't have the capacity to make such decisions, especially when they were denied the opportunity to discuss matters with them. This has resulted in our members feeling guilt and not doing enough for their loved ones.

There was problems of infection control and care in care homes, hospitals and prisons.

The issue of Nosocomial infection is a major issue for the Scottish Covid Bereaved and therefore must be thoroughly investigated by the Inquiry.

The numerous contributory issues, including testing, capacity, PPE, patient cohorting, the failure of the Scottish Government to recognise airborne transmission, ignoring asymptomatic transmission, constantly changing guidance, aged clinical environments and inappropriate clinical environments are some of the issues that the Scottish Covid Bereaved urge the Scottish Inquiry to

investigate; and of course the failure to ensure that families could be with their loved ones at the ends of their lives.

With regards to foreseeability, the Scottish Covid Bereaved do not make any claim to be experts or skilled witnesses, but it is submitted that many of the problems caused by COVID—19 were foreseeable. A pandemic was the highest natural threat risk to our society, identified for many years by epidemiologists as an inevitability.

It should come as no surprise that the years of austerity left health and care facilities understaffed, under—equipped, demoralised and barely able to cope in pre—pandemic circumstances. With no apparent attempt to fix the roof while sun was shining, our core services were not prepared when the storm arrived.

It should not have come as surprise to our politicians that when problems arise in society, it is the weakest and the most vulnerable who are the most likely to be badly affected. It is submitted that those in hospitals or care homes clearly fall within these categories, yet time and time again the Inquiry was presented with evidence which made it clear there had been no special consideration given to vulnerable groups.

As a result, seemingly nonsensical rules were put in place. For example, there was an apparently total

lockdown of care homes to avoid infections of residents; but whilst this took place they were allowing for the discharge of patients from hospitals into the same care homes without testing. No consideration was given to the realities of care home staffing who frequently worked within more than one such establishment.

The Scottish Covid Bereaved submit that those in authority who imposed rules in relation to care which could not possibly have been obtempered. Policies which resulted in the isolation of those with mental health issues or dementia showed a complete lack of planning and forethought or compassion. A failure to consider how healthcare professionals should best communicate with relatives about their loved ones in hospitals, in care or prison meant that there were no proper systems in place to allow for such communication. There is, it is submitted, no better example of this than the issues surrounding the implementation of do not attempt CPR notices.

It is no answer to these criticisms to say that those in charge do not know what the pandemic will be until it strikes and therefore only limited plans can be made. The Scottish Covid Bereaved are tired of hearing the words "with hindsight".

The Inquiry has heard evidence in relation to PPE. There was a clear lack of suitable PPE before the pandemic.

Once the pandemic hit, there were difficulties in procuring PPE and issues surrounding the quality and the suitability of the available items. Staff were not properly trained to dispose of the PPE and in the social care setting there was an insufficient risk assessment and training on how to use the items. Staff were required to reuse items of PPE and found that some of the available items had been re-directed to the NHS, with social care being treated as the poor relative.

While efforts were made to utilise technology to assist care home residents and hospital patients to communicate with their families, there were issues surrounding digital exclusion. This was perhaps most acutely demonstrated by the difficulties faced in communicating with relatives suffering from dementia.

The Inquiry has heard evidence of a great many issues surrounding infection prevention and control, whether it was a lack of guidance and education of basic IPC, such as care home staff not being trained in relation to infectious diseases, or confusions surrounding the interpretation and the enforcement of guidance. Symptomatic workers were being pressured to return to work until they were able to produce confirmed test results. Staff were being pressured to work even when contacted by test and trace workers or when they had been in contact with Covid

positive workers. The movement of patients from hospitals to care homes without testing proved to be the fatal mistake and, when coupled with a lack of testing for staff and residents, allowed for the rapid spread of disease and death.

The Scottish Covid Bereaved have sympathy for the staff who risked their own health and lives to work in these environments. They faced confusion as to the rules and the guidance which applied, particularly in Scottish care homes owned by English companies. The guidance did not take into account those working in different environments such as prisons.

Many of the bereaved felt most keenly the seemingly inconsistent rules around visitation in hospital settings. These rules appeared to differ not only across the health boards or hospitals but also within individual hospitals.

This was perhaps most vividly demonstrated when it came to the end of life care. There appeared to have been a blanket approach taken towards many elderly care home residents rather than a human rights based approach. In some cases, especially within care homes, many had reached a point where quality of life was more important than duration. Whilst lockdown was initially understandable as an effort to keep those vulnerable individuals safe, as time

went on other fundamental rights became equally as important.

The Inquiry has heard evidence that dying residents were not given the end of life care that they would normally have received and that in some cases there appeared to be a focus on providing end of life medication to residents.

In conclusion, my Lord, despite many of the difficulties we have outlined in our written submissions, the Scottish Covid Bereaved remain committed to assisting the Inquiry in any way they can. They hope that the stories the members shared with this Inquiry, often with great difficulty and pain, in the midst of their grieving, can educate the Inquiry as to the experiences of many across Scotland and to ensure that no other families have to suffer in the same manner as the Scottish bereaved have.

Thank you very much, my Lord.

THE CHAIR: Thank you very much Mr Anwar.

Now Mr Gray for Central Scotland Care Homes.

Closing statement by MR GRAY

MR GRAY: Good morning, my Lord, ladies and gentlemen.

I appear on behalf of Central Scotland Care Homes or CSCH, a group of independent care home operators that was formed for the purposes of assisting the Inquiry in

fulfilling its terms of reference.

We wish to focus today on some of the impacts more fully described in our written closing statement, starting with guidance.

CSCH has highlighted the pertinent issues faced by the care home sector in dealing with COVID-19 guidance issued by a range of public bodies; but it is noteworthy that these experiences chimed with those of witnesses from other parts of the health and social care sector.

The primary issues, as our members see them, are that the guidance was issued at less than appropriate times; was lengthy and confusing; changed regularly; was difficult to disseminate to staff; came from multiple sources; and was often conflicting.

The impact of these issues upon the care sector was substantial. The approach taken was demoralising and frustrating for staff at all levels but particularly those on the front line. Workers, who had been following guidance with the best of intention, were told, sometimes multiple times on the same day, that guidance had changed. That brought quite natural fears that following the earlier guidance may have endangered residents.

Guidance was issued almost on a one-size-fits-all approach. There was no input from specialists; and the guidance often failed to recognise the different environment

in care homes. IPC guidance, for example, applied the standards ordinarily expected of acute care settings.

During the Inquiry, guidance has been described as being simply "advice" rather than a mandatory set of rules. The truth was that the status of the guidance was unknown. The approach of our members may have been, at times, to adopt a conservative interpretation, but it must be understood that the care sector is highly regulated, is subjected to a high incidence of litigation and, further, during the pandemic, operators did not have immunity.

When advice or support on guidance was sought from governing bodies, requests rebuffed and operators were told it was their responsibility to interpret it. Is it any wonder that within this sector, against that background, guidance was generally approached as mandatory rather than discretionary?

The legal status of guidance should be made clear in future. Care providers should be empowered to depart from it where appropriate.

The issues may have been avoided if there was a single centralised provider of guidance to the care sector, which could issue agreed guidance following proper collaboration with stakeholders, which brings me to the lack of consultation with the sector.

Prior to and during the pandemic there was a

disconnect between those drafting industry guidance and those required to implement it. The lack of involvement of those with a social care voice has been described as a "dangerous failure".

The social care sector is an essential part of the fabric of health and wellbeing in Scotland. We will all either know someone who uses these services, or will come to use them for ourselves at some stage in our lives.

As one witness put it "everyone in this room is an accident or illness away from needing care and we need to be thinking about how we would want to be treated if we were to end up in full-time care".

Engagement with the sector before and during the pandemic would have ensured that the rights of residents in care homes were on an even footing with those in wider society.

When efforts were made to obtain the views of the sector, the impression was that the care sector was there in ceremony only -- they "were tolerated rather than respected".

In his evidence Dr Donald Macaskill said that the current pandemic planning by the Scottish Government still does not have any participants which represent the social care sector. Our members feel that it is imperative that this is changed immediately and that this crucial sector is

involved in policy making for the responses to future pandemics.

Turning next to hospital admissions and discharges.

The relationship between the care sector and hospitals is important and delicate. It ought to be an equal relationship, but all too often during the pandemic, the care sector felt like the poor relation being told what to do and how to do it.

One concern was that, particularly at the outset of the pandemic, patients were discharged from hospital into care homes without testing. Given the asymptomatic presentation of some with COVID-19, this created the risk that patients could be a conduit for the virus from hospitals to care homes. This was a particular concern for our members; and we note that other groups referred to it as being like a "death sentence for the elderly".

The Inquiry has asked participants to identify areas worthy of further investigation. Our members believe that the determination of this issue is an important matter which would benefit from further scrutiny.

The unilateral nature of the relationship was emphasised when care homes sought to admit residents to hospital. Staff would phone ambulances who would refuse to convey residents. Those who were take to hospital found

that consultants refused to admit them because they had come from a care home.

The Inquiry has committed to taking a human rights–based approach. The refusal of hospital treatment for care home residents is a stark example of the denial of what should be fundamental rights in any modern society. The delicate relationship which exists between care homes and hospitals must be properly addressed prior to any future pandemic to ensure that residents can access hospital care where it is needed.

The care sector can, at times, alleviate pressure within the NHS, but it should not come at the expense of care home residents who may be at a heightened risk of harm.

Turning to DNACPR requests, which are a normal part of care home practice.

During the pandemic the perception was that there was a push from the NHS to get more of these decisions in place. Concerns were raised that conversations between GPs, residents and residents' families were not happening. This was a foreseeable issue which could have been prevented by engagement with residents and their families to ensure that appropriate discussions were being had about this sensitive and complex subject.

Turning next to the impacts of the increased administrative burden of the pandemic, which our members

described as "staggering" and "immense". We note that the experience of other groups was similar. This exacerbated stress and pressure on staff but also reduced valuable care resources.

CSCH acknowledges the need for external agencies to receive information to allow them to manage the overall pandemic response. However, this must be proportionate and should not impede the ability of care staff to focus on their primary duties. The effects of this could have been reduced or minimised with a single reporting channel which could be easily accessed by all relevant bodies.

Turning now to Operation Koper.

As the Inquiry has heard, reporting to Operation Koper created a huge increase in workloads. It should be remembered that this requirement was isolated to the care sector. We note that this led to nursing staff feeling they were treated differently to colleagues in other sectors. They had to shoulder the burden while continuing to fight the pandemic. We must remember that the requirement to report to Operation Koper began before the second wave of the pandemic hit.

Operation Koper had, and continues to have, a devastating impact upon the morale and mental health of care home staff. We would ask the Inquiry to reflect on the evidence of one of our members about an experienced staff

member who broke down upon receipt of an Operation Koper e–mail with the subject, "Major crime".

Turning next to inspections and external agency visits.

The approach to which during the pandemic had a significant and detrimental effect upon staff wellbeing. Those carrying out visits often had little or no experience of care homes. They would attend expecting hospital standards of infection control, with no recognition that care homes were the homes of residents.

Our members found staff leaving in significant numbers due, in part, to the approach in treatment by regulators and external agencies. Staff felt like they were being interrogated.

On the subject of lockdown decisions and visiting restrictions, it is submitted that these were an essential protective factor, but it was also not known how long the lockdowns would last.

Once the first set of national lockdown rules were relaxed, the position within care homes remained heavily restricted.

The measures eventually introduced were far from ideal. Garden visits were described as being "horrendous" with no privacy. Window visits were only suitable for residents on the ground floor and could not be introduced in

every home, creating a lottery between homes and residents.

Attempts to introduce technology were also met with mixed success, but providers were trying their best to accommodate family interactions in whatever way they could.

Restricted visiting caused stress and tension between residents, family members and staff, with the latter placed into enforcing roles which they had no prior experience of. It is an issue which could have been minimised with a better approach to the relaxation of rules in care homes when they were relaxed for the rest of society.

With that in mind, I can say that each of our members fully supports the campaign for Anne's Law. They agree that it is essential for care home residents to have the physical presence of, and connection with, their family members, and hope that we never again find ourselves in a situation where residents are without vital, nourishing contact from their families for any length of time.

Turning now to the impacts of the pandemic on care staff, who have reported high levels of stress and burnout while working in care homes during the pandemic.

The sector has always suffered from staffing issuing, but they have been exacerbated hugely by the pandemic. The Royal College of Nursing has reported that its members felt deaths in care homes were reported more

critically in the media than deaths in, for example, NHS hospitals.

Nurses found this stressful, distressing and often reported that, where other health staff were being portrayed as heroes, they felt they were seen as villains. These feelings are echoed by the staff of our members.

One care home manager said she says "friends who worked in the ... sector who left and will never return because of the way they were portrayed. They came into the sector to help people, not hurt them, or do them harm. Some have gone to work in supermarkets because it is less stressful".

In illustrating the wider impacts of the pandemic on care home staff, my Lord, we can do no better than speak the words of some of the witnesses the Inquiry has heard and received statements from.

A representative from Unite stated:

"We need to be eternally grateful for what workers did during the pandemic to ensure the people in this country survived. Health and social care workers put themselves in front of the pandemic with unknown consequences ... And now the pressures on health and social care are even bigger than they were in the pandemic because the sector has not recovered from it. Staffing levels are so low people are on their knees, they are absolutely done because they've not

had a break and not been allowed to process what they did for this country."

One experienced care home manager described the fear felt by staff working in care homes during the pandemic. Describing her memory of the pandemic she explained that "everyone was fighting ... an invisible enemy". In her youth she had travelled extensively through war-torn nations. She had been in positions of real fear and significant danger. Later in life, she had battled cancer, at one point planning her own funeral. She recalled that neither of these experiences stirred the same level of emotion that she felt during the pandemic. She stated, "During Covid I wasn't just in fear for my own life, I was in fear for the lives of the staff, the residents of the care home, my family, my friends, and the fear was intense."

In conclusion, our members will continue to contribute to the Inquiry to assist it in fulfilling its terms of reference; and our members hope that the Inquiry will bring about positive change for the benefit of care home staff, residents and their families.

To say that the pandemic was difficult for care home staff is an understatement. We have considered the evidence provided to the Inquiry and note the traumatic and distressing circumstances that were experienced by staff. We acknowledge that this was mirrored by residents and

family members.

Our members wish to thank my Lord, Inquiry counsel and the wider Inquiry team for the significant effort expended to get us to this stage. They also wish to thank the witnesses and the other Core Participant groups for the evidence heard and the contributions that have been made.

While this may be classed as a closing statement, the Inquiry is still at the beginning of a long process and COVID-19 remains a dominant presence in our society.

For the time being, we offer the following memory from one of our members' care home managers as a poignant illustration of the myriad impacts of the pandemic on residents, their families and care staff.

She stated:

"I remember, on one occasion, I stayed at the bedside of a woman who was dying of Covid. I sat with her that evening into the early hours of the morning till she passed away because I promised her family I would not leave her alone. This was the first resident admitted to the care home when I joined 10 years prior, so she was the resident that I had known for the longest. My mask was becoming compromised because I was crying into it as I sat there but there were no new ones available. I was holding her hand and holding my phone on Facetime to one of her daughters (who was also on the phone to the other daughter at the same

time) throughout the night so they could 'be with' their mum. They said their goodbyes and told her how much they loved her they spoke to her about their lives together, their memories. I felt like an intruder but I also felt so privileged to share such an intimate time. My phone battery died at 3am but I still stayed with the lady, I used her rosary beads and read it to her. I am not religious but I prayed because I knew how important her faith was to her and in some way hound some solace. I didn't leave her and her memory will never leave me."

Our members wish, once again, to express their deepest condolences to the bereaved family members and friends of all those that have tragically lost their lives as a result of COVID-19.

Thank you, my Lord.

THE CHAIR: Thank you Mr Gray.

Now, I think Mr Crabb may be here. Yes, he is. So you're saved for 15 minutes Ms McCall.

So Mr Crabb on behalf of Care Home Relatives Scotland.

Closing statement by MR CRABB

MR CRABB: Good morning, my Lord. Good morning ladies and gentlemen. I appear on behalf of Care Home Relatives Scotland and CHRS -- Loss Loved Ones -- CHRS.

I move at the start, my Lord, to adopt my written

submissions which are already before the Inquiry. In respect of the terms of reference, I submit that CHRS' evidence is of particular relevance having regard to sections 2(a), (b), (g), (h) and (i).

At the outset, my Lord, on behalf of CHRS, I would like to extend their sincere thanks to all members of the staff of the Inquiry for the respect, understanding and compassion that they've shown them throughout this process.

They sincerely hope and believe that their evidence will assist the Inquiry and that their evidence is reflected in your Lord's recommendations and findings.

In respect of impact, it is submitted that the evidence has demonstrated a clear overarching impact on those residents in care homes. The restrictions imposed on them during the COVID-19 pandemic reduced their quality of life and their dignity of life.

The restrictions affected them in many different ways and to different extent but overall it is clear that care home residents are one of the groups of society that were disproportionately impacted by the restrictions.

The majority of residents in care homes are elderly, often with a range of mental and/or physical impairments; and, while they represented a high risk group in terms of both infection and death from COVID-19, they were also a group of society whose last years and months

were precious and for who contact with loved ones was often a vital lifeline.

This group are not simply confined to their homes: many lead valuable and full lives in the community -- enjoying trips out, visiting friends and family and socialising. Further, it is important to remember that not all residents are elderly; there are many young adults living in homes or supported accommodation who enjoy playing an active and valuable role in society.

The right to contact and socialisation with loved ones and to engage in wider society is one of the most fundamental human needs. Its denial and isolation is a most extreme form of punishment. All care home residents, young and old, have a right to have these rights respected. However, there were excessive and prolonged periods where significant restrictions were placed on visits and their ability to socialise outwith their homes, which impacted on their health and wellbeing as well as infringing their human rights. There was little apparent balancing of risk that the impact of such severe restrictions and isolation could have on people, particularly those with conditions such as dementia.

In this respect, it is vital to remember the impact of the many who died not of Covid but alone and craving contact from their loved ones.

The denial of contact had a devastating effect. The Inquiry has heard many harrowing tales of the ways in which basic and essential contact with loved ones was denied and the impact that this had on residents and their families. In many instances, residents, quite simply, did not understand what was happening to them. Cathie Russell's mother and Gillian Duncan's father both asked whether they were in prison; and Verona Gibson's daughter said she felt like a prisoner. Perhaps effectively they were. It should be recognised that this kind of isolation is a form of restraint.

While for many in "normal" society technology eased isolation, many in care home residence simply could not understand or operate devices, often having hearing or eyesight difficulty which made the exercise futile. Alison Leitch spoke of having to watch her mother claw at her face, as she didn't understand where her daughter's voice was coming from.

There was a clear evidence that the lack of family contact and being isolated for days on end took a physical and mental toll on many residents. Many spoke of a decline in posture, muscle fatigue and general marked change. Tracey McMillan felt that her mother was "getting lost within herself" and ultimately her treatment hastened her death.

There were also significant impacts felt by relatives of those in care homes. They felt distress and frustration at being kept away from their loved ones, particularly when the rest of society moved towards normality.

Verona Gibson explained that before the pandemic daughter's home had been an extension of her own. She could go there any time, knew all the staff and was involved in every aspect of her life.

Relatives felt powerless and were overcome with a sense of guilt. Some felt that they should have pushed more to see changes in conditions. Frequently families felt like troublemakers or a nuisance if they challenged or sought to question decisions. Families were learning quickly that we had to learn to be compliant. While all parts of society endured limitation on interaction during the pandemic, it is submitted that care home relatives experienced a disproportionate limitation and were discriminated against, particularly towards the end of 2020 and 2021, when the rest of normal society was returning to social interaction, there was no justification for continued restrictions in care homes.

Donald MacAskill, Scottish Care, said "such extended periods of isolation are unacceptable disproportionate, unnecessary and hugely damaging".

Now, what were the reasons for those impacts? There was a clear lack of understanding of the life, realities and priorities for those in care home settings, their families and staff by decision and policymakers. It is clear that for people who did not have a loved one in a care home they simply did not know what it was like on the ground.

There was a misconception about who lives in care homes. Nobody else was taking account of other harms that were happening. The fact that Public Health Scotland produced Covid guidance that amalgamated care homes with prisons demonstrates clearly such a lack of understanding.

There was also a clear lack of understanding that people in care homes live full and valuable lives, they visit in the community and engage in activities across society.

There was also a failure to understand and appreciate the importance of family members as essential care givers as members of the care team. Similarly, there was a failure to understand that family members would always have a paramount interest in keeping their relatives safe and indeed were often already experts in infection control.

There was a clear lack of planning. If there had been pandemic planning in relation to care homes, few witnesses, if any, spoke of being involved. It was said

that if they had any plan at all, it was to do nothing to reunite people and wait on a vaccine. The evidence demonstrated that the Covid response was based on a knee jerk reaction about just slamming the gates shut, which had the effect of terrifying people. There was a lack of leadership.

It should not have taken the formation of CHRS in August 2020 for the Scottish Government to take residents' and their families' rights into account. As stated by Sheila Hall, "we needed someone to be that spokesperson, to provide clear and consistent advice and not treat care homes as institutions or clinical settings where residents were treated like dogs in quarantine".

CHRS had to be formed to push and to defend those rights, but even then their solutions were not implemented.

Guidance was not consistently interpreted or implemented. The evidence demonstrates a widespread failure to consistently interpret and apply guidance. This ended up often being the responsibility of individual care home managers and, given the lack of clarity, managers would often err on the side of caution, to the detriment of residents' rights.

The evidence demonstrated that visiting was a postcode lottery in respect of the interpretation and implementation of guidance and the lack of consistency

related in unfairness. Alison Leitch commented that "until Anne's Law is in place relatives and friends will always be at the mercy of someone making a decision, just because they can".

In CHRS' submission, Anne's Law would have minimised many of the impacts suffered by them and their loved ones. Anne's Law, properly implemented, would safeguard all of their fundamental human rights.

Now, CHRS is aware of senior counsel's position yesterday; and, of course, while they respect his submission they do not agree. CHRS has campaigned for Anne's Law for many years. They will continue to advocate, strive and fight for this right to be enshrined in legislation.

The evidence of interference with human rights from individuals and organisations is both compelling and overwhelming and is supported by academic research which is before the Inquiry. The overall impression is that the Inquiry is to have a human rights based approach. But the pandemic showed that people did not have human rights.

As a result, I would submit that the Chair is well placed to make findings and recommendations based on systemic adverse impacts on human rights. Of course the recourse to an effective remedy is an essential and undeniable element of any human rights compliant response to a future pandemic.

The evidence heard during these Impact Hearings demonstrated eloquently the desperate and compelling need for Anne's Law to be implemented. Residents of care homes should have a right to appoint an essential care giver, a family member or a special contact or friend, who would form part of their care team; and they should be able to have contact with and access to them at all times.

As part of the team, these unpaid carers would be subject to the same restrictions and rules of paid carers, particularly during periods of specific control requirements. As the Inquiry has already heard, these people are often already knowledgeable and expert in infection control. They should be seen as having a positive and enabling role and not as posing some sort of threat or hindrance to care.

The Inquiry has heard the futile effect of guidance or letters from officials or ministers. What is required is a cast iron right that could form the basis, for example, of judicial review, if necessary. Guidance or deference to Public Health Scotland is not good enough. It should be noted that the guidance continues to fail to acknowledge the concept of an essential care giver. It should be Anne's Law we're talking about and not Public Health Scotland's law.

Because Anne's Law is not yet enacted in

legislation, there remains no guarantee that another prolonged lockdown, which would imprison care home residents and deny them access to loved ones, could not happen again.

There has been widespread cross party support for Anne's Law; and this Inquiry has heard no evidence to suggest that it should not be enshrined in law.

On 7 September 2021 then First Minister Nicola Sturgeon pledged that "we will introduce Anne's law, giving nominated relatives or friends the same access rights to care homes as staff".

However, the current provision, as set out down in section 40 of the National Care Service Bill, does not fulfill this pledge and would not deliver Anne's Law. It is an insipid provision which simply directs Ministers to issue visiting directives. There is no specific provision that offers to confer any right. While this Bill claims to embody a human rights approach, this is not the case as no right is conferred; and recent communications from the current First Minister with CHRS have not reduced their concerns.

This Bill is currently proceeding through the legislative process at Stage 2. This is accordingly a critical phase in the development of the provision and the Chair could play an important role at this stage by making recommendation.

The Chair is accordingly invited to make this recommendation: that there should be clear and specific provision for residents in care homes or in supported accommodation to have a right to access to and contact with one named essential care giver, who will have the same rights and responsibilities as paid carers.

Thank you.

THE CHAIR: Thank you very much, Mr Crabb.

Now Ms McCall for Bereaved Relatives Group (Skye).

Closing statement by MS McCALL

MS McCALL: Thank you, my Lord. The Bereaved Relatives Group (Skye) welcome the opportunity to make this closing statement to supplement our written submissions.

The impact of the response to the pandemic on those who had loved ones in care homes and those who worked there was profound.

Each individual who has given evidence to the Inquiry recounted their own personal story, but what is striking is the commonality of their experiences and the foreseeability of many of those outcomes.

The Inquiry heard some witnesses speak of concerns around the apparent misuse of do not attempt CPR notices. This directly engages Article 2 of the European Convention and is a matter of grave concern.

In addition, although in a pandemic some excess

deaths are to be anticipated, what was not anticipated and what was not inevitable was the sheer numbers of excess deaths in care homes.

The Inquiry has heard evidence about the transmission and spread of the virus into care homes and the apparent inadequacy of infection control measures. Again, Article 2 is engaged.

The Inquiry has heard about conditions in some of the care homes. Witnesses described the neglect of residents and their environment. The Inquiry has heard concerns about the lack of basic hygiene, issues around food safety, residents being injured as a result of being unattended. While of course it is understood that there were pressures on care home providers resulting from the pandemic, including around staffing, in our submission, the extent of the deterioration of conditions may have breached the Article 3 rights of residents.

No less serious than these Article 2 and Article 3 issues was the impact of the lockdown and the accompanying visiting bans and restrictions. Residents were suddenly cut off from family and friends who play an integral part in their care. The effect, particularly on those with dementia, of this isolation, as well as the removal of their personal items, cannot be overstated.

The approach to lockdown was nothing short of a

callous disregard of people's right to family life. The impact on residents' mental health and physical wellbeing was devastating and that impact was, we say, entirely foreseeable.

Unlike other citizens, residents were not allowed to bubble with a family member. Care homes were not equipped to facilitate effective remote communication. Little or no alternatives were put in place for residents with cognitive impairment or communication issues. Garden visits were monitored closely making families feel like their residents were prisoners.

There was no consistency in the approach to end of life visits as between the different care home providers. The denial of such visits to some close relatives continues to cause great distress. At such times people should not have to fight for their right to see a dying loved one.

There was a chronic failure in communication. Not only does it appear that Government guidance was interpreted differently across different care providers, it appears that providers may have implemented their own, sometimes stricter, policies. None of it was properly communicated to families. There was no independent reliable source of information to tell residents and relatives what their rights were.

So, as the Inquiry progresses to the next phase of

its investigation into health and social care, there are a number of questions that need to be answered by those who made the decisions around policy and those who implemented the policies.

In relation to Article 2, the Inquiry must find out during the currency of the pandemic what instructions or guidance were issued about the signing of do not resuscitate notices by residents or their welfare attorneys. If such instructions or guidance were issued specific to the pandemic, why was that thought necessary? What was its purpose? And how did it differ from the approach prior to the pandemic?

What oversight was there to ensure that proper and lawful processes were being followed and that people were not pressured into agreeing to something they did not want?

In relation to the transmission of the virus into care homes and the spread within, how did policymakers and those with organisational responsibility for the provision of care take into account and meet their obligations under Article 2 in implementing various infection control measures?

In relation to Article 3, in the absence of routine visitors and routine inspections, what steps did care home providers take to ensure that standards of care were being properly maintained in their homes? What

oversight was there to guard against the neglect?

In the context of Article 8, in deciding to lock down, what consideration did Government give to ensuring the maintenance of family life for those in care homes? What preparations did care homes carry out in order to enable family relationships to be maintained during a lockdown? What reasonable adjustments were made to enable those with communication difficulties or cognitive impairment to maintain relationships? How did the inconsistent approach to end of life visits come about?

And, more generally, because the Inquiry is taking a human rights based approach, it should ask what human rights impact assessments were undertaken by Government in determining the non-pharmaceutical measures that were put in place in relation to care homes. And in implementing Government policy, what human rights impact assessments were undertaken by care home providers in relation to each residential setting. How did the public authorities ensure compliance with their Article 14 obligation not to discriminate against those resident in care homes in respect of their right to life, their right to be free from degrading treatment and their right to family life?

The Bereaved Relatives Group (Skye) looks to the Inquiry to get to the truth; to hold to account those who failed in their human rights duties; and to ensure that

lessons are learned.

It is their fervent hope that no one in need of care, no family or care worker, will have to repeat the experiences of this pandemic.

I'm grateful.

THE CHAIR: Thank you very much Ms McCall.

Very good. We will take the break now. We're a few minutes early. So we're due back at 11.15. Thank you very much.

(10.52 am)

(Short Break)

(11.15 am)

THE CHAIR: I think we're next going to have a presentation on behalf of PAMIS; and, again, it's Mr Crabb.

Closing statement by MR CRABB

MR CRABB: Thank you, my Lord.

I appear on behalf of PAMIS —— Promoting A More Inclusive Society.

Again, I adopt my written submissions.

In terms of the Inquiry's terms of reference, I would submit that PAMIS' evidence is of particular relevance to parts 2(a), (b), (g), (h) and (i).

The impacts felt by persons with profound and multiple learning difficulties (PMLD) and their families, engage their fundamental human rights. Accordingly, the

impact of the strategic response to the pandemic on their Convention rights should be at the forefront of the Inquiry's mind.

My Lord will note that in the written submissions there is also reference to further areas for investigation by the Inquiry and PAMIS' support of Anne's Law. PAMIS aligns itself with the submissions of CHRS. Anne's Law should equally apply to people with PMLD who are cared for in different care settings, such as supported accommodation.

In the time available, I intend to focus on the points which PAMIS considers should be at the forefront of the Inquiry's mind.

In respect of impact, people with PMLD were disproportionately impacted by the strategic response and the pandemic restrictions. Their quality of life was greatly reduced in a sudden, unplanned, chaotic and traumatic manner. Much of that impact, sadly, is still felt today.

Members of PAMIS and personal carers explained eloquently that this group was, and remains, invisible, and marginalised in society. Additionally, there's been a failure to understand the group's diversity and the particular needs of individuals within it.

The evidence before the Inquiry in respect of impact can be seen in four interrelated aspects.

Firstly, the withdrawal of services, including health and social care services and the lack of access to allied health professional services.

This crucial framework built around individuals and families crumbled overnight. Schools closed. Day services ceased. Crucial therapies were withdrawn. Vital services for family carers were also withdrawn. And there has been a significant and long-term impact caused by the loss of services, both in terms of quality and quantity of available support.

By November 2022, day services were at 75% capacity and respite services at 68% of capacity. The cuts in service provision have resulted in significant financial burdens for families.

Secondly, the denial of contact with family and loved ones.

For people with PMLD a connection to and contact with their family and socialisation can be vital. Although many are non-verbal and their understanding and responses may not be readily understood, that is not to say that they do not crave, need and enjoy social contact.

Due to the very specific communication of individuals, families will have expertise in understanding and translating their communication, which allows individuals to be listened to and part of life. Families

were and remain key to providing meaningful engagement and activity.

During lockdown those individuals in care homes or supported living accommodation faced the horror of summarily being denied contact with loved ones. Many would simply not understand why. Witnesses spoke to the unsatisfactory nature of measures, such as garden visits, or the use of technology. People with a profound learning disability could not understand what was happening or why. For those living away from their families, many people enjoyed regular visits home. And this was all removed from them causing distress to all.

Thirdly, there was a decline in health. Several witnesses spoke of the marked decline in the health of their loved ones physically and mentally. Individuals had services such as physiotherapy withdrawn, which had an impact on physical conditions.

Furthermore, there were no regular checkups on a range of health conditions, such as epilepsy, and outgrowing equipment, which led to injuries. If injuries were suffered this added complexity. Due to limited communication, a person could not tell staff they were hurt or injured and therefore falls or other injuries remained undiagnosed.

Postural care is a key aspect of care for people with PMLD. There is a dramatic effect when it is reduced.

Michelle Morrison explained how this is something that most people take for granted and learn instinctively; but for many with PMLD that is not the case. Poor posture can have a consequential effect on the body and, importantly, on respiratory function, which was of particular importance during the pandemic.

Stephanie Fraser spoke of seeing those with cerebral palsy suffering increased pain and stiffness, with a decline in function because the person was not able to keep as active.

There was also evidence that the Covid restrictions have caused a long-term impact on the mood and behaviour, with a loss of confidence and a decline in cognitive ability, leading to irretrievable loss of skills.

Fourthly, the impact on families. The Inquiry heard about the dramatic impact on families who were brought to their knees during the pandemic as virtually overnight they were denied the help and support that they'd previously relied on.

For individuals who lived away from their family, there was an overnight loss of contact. Lorraine Mackenzie explained that her main job was caring for her son. She was considered part of his care team; but when the Covid restrictions were put in place, she felt this was a slap in the face. Pat Graham found it insulting to be told that she

could not care for their daughter.

For those who had a person with PMLD living with them, they became their full time carers overnight. They became exhausted, with no respite and were denied the basic service provision which they had relied on. Academic research confirms that family carers' health was impacted by factors including tiredness, stress, disturbed sleep, feelings of depression, being short tempered and physical strain.

Why did this happen? Pat Graham explained in her evidence "if you don't understand the value of a person's life, then you can't possibly appreciate what COVID took away from them". Put short, people with PMLD were and remain an invisible and forgotten group in society.

The impacts felt by them during the pandemic came from the following sources: firstly, there was a lack of understanding about PMLD. Lorraine Mackenzie remarked that "I've always said that I would like one of the top politicians to do an eight hour shift in a care home or in supported accommodation, which would give them a little bit of understanding".

Many health professionals also did not understand what it means to have PMLD, or to be a family carer who has a relative with it.

There was a failure to understand the importance

of people with PMLD being engaged in physical and multisensory activity or that being trapped indoors was incredibly difficult for them. The mental health of people with PMLD was not considered. The importance of postural care would still not be understood if there was another lockdown tomorrow.

Finally, there was also a failure to understand the need for multiple agency input and care.

The assumption on the part of those making decisions that families would be able to cope without all the services and support that enable caring for a person with PMLD was particularly distressing.

People with PMLD were lumped in with other groups. There was a lack of real understanding of what distinguishes them from others. For example, with PMLD in supported accommodation they should have been treated as if they were in their own homes, but that took a very long time to filter through.

Secondly, there was a lack of preparation.

In the response to a question from your Lordship, Jenny Miller confirmed that PAMIS had never been asked about a thought process which might have outlined possible responses in the case of a pandemic.

Thirdly, the guidance was diluted, changed and ignored, to such an extent that there were 32 versions of

the truth as each local authority chose how to interpret national guidance.

Finally, there was a lack of accountability when the guidance and the rules were not followed.

Pat Graham stated that response to complaints were typified by a lack of empathy, flexibility and understanding.

So what could have minimised those impacts? A proper understanding and a will to understand what distinguishes people with PMLD from others. That means being properly listened to and engaged with.

As stated by Jenny Miller, "We were listened to, but in the end, nobody heard us properly. By listening to understand you achieve more. There is also a need for a collaborative risk assessment to support our most vulnerable communities".

Secondly, a recognition of the importance of family carers as an essential part of the care team for people with PMLD.

Thirdly, guidance should be clear, unambiguous and consistently interpreted. This would have reduced stress and anxieties felt by families and also would have ensured greater accountability.

In conclusion, it is submitted that the evidence demonstrated the considerable value of third sector

organisations, who demonstrated reliance, flexibility and a can do attitude to seemingly impossible situations. PAMIS was a valuable source of information, advice and support to those caring for people with PMLD. The Inquiry should recognise this.

Furthermore, public bodies should also recognise that value and work collaboratively moving forward.

Finally, my Lord, PAMIS would like to thank the Inquiry, the Chair, Inquiry counsel and staff for their positive engagement throughout this process. They've felt listened to and valued. They hope their evidence will assist the Inquiry and will be reflected in your Lordship's findings and recommendations.

Thank you.

THE CHAIR: Thank you very much, Mr Crabb.

Now, Mr Webster on behalf of Long Covid Kids.

Closing statement by MR WEBSTER

MR WEBSTER: Good morning, my Lord, Mr Gale.

My Lord, Long Covid Kids Scotland's interest in this Inquiry is to seek to give voice to the experience, fears, challenges and frustrations of children and young people with Long Covid and those who help and support them.

So can I, first of all, begin by recording and commending the Inquiry for seeking advice and accepting that Long Covid falls within the terms of reference of the

Inquiry, at least so far as encompassed within the strategic elements of the handling of the pandemic, as specified in the terms of reference. That includes the Scottish Government's planning, without restriction of time, and all other terms of reference during the periods of the years 2020, 2021 and 2022.

Of course Long Covid remains an ongoing issue for many; and the prospect of Long Covid remains for those who may yet be infected. Whilst for many lockdowns and restrictions of movement are a thing of the past, for many children and young persons they may never go back to what they had before. Long Covid is an aspect of COVID-19 that continues to require attention as a realtime problem, not one just to be viewed in the rear view mirror of a public Inquiry.

We note with interest the Royal College of Nursing in Scotland has written to the First Minister seeking an amendment to the current terms of reference to the Inquiry to explicitly include Long Covid. Mr Gale KC has understandably advised the Inquiry awaits the First Minister's decision on that matter and it will comply with any variation directed.

However, I submit that, until that decision is taken, the Inquiry should not falter in its consideration of Long Covid in the context of the existing terms of reference

up to the 31 December 2022. For even if the Inquiry must bring its Long Covid investigations to an end at that point in time, its findings will provide a valuable point of reference for discussions that might take place elsewhere as to the adequacy of ongoing actions and support.

So what of the evidence that the Inquiry has heard? Well, it has heard and, in its background reports, it has been advised that the prospect of long-term sequela from SARS-type virus was known prior to the arrival of SARS-CoV-2.

The prospect of long-term symptoms was raised in NERVTAG as early as March 2020. We know that the Cabinet Secretary acknowledged long-term effects in May of 2020. Yet, despite that, the Scottish Government's December 2020 policy document "Framework for Decision-Making Assessing the Four Harms of the Crisis", was depressingly devoid of any analysis of Long Covid, far less specific to the interests of children who might succumb to the illness.

The Inquiry has also heard eloquently of the devastating physical and emotional reality of Long Covid; and in due course the Inquiry will hear of the educational challenges for children with Long Covid. The Inquiry has also heard of professional and institutional scepticism regarding Long Covid. The Inquiry has heard of the shock and fear of parents seeing their children's health

deteriorate so quickly and so dramatically, not relieved when they faced a professional lack of knowledge and, at times, hostile suspicion.

Despite what the Scottish Government tell us in their written submissions as to money allocated for the future, the evidence before the Inquiry painted a picture of unsatisfactory paediatric Long Covid care during the period of the terms of reference of this Inquiry. The evidence was of sparse, variable and, at times, unsympathetic care provision and, at times, ignorant and uninformed dismissal of symptoms.

There was evidence of a Kafkaesque difficulty in getting a positive Long Covid diagnosis in the absence of a positive test for Covid, when, at the time of apparent infection, testing was either not available or not offered due to the age of the child.

Not the least disheartening, we've heard evidence of parents having to seek and pay for private healthcare, the ultimate abjuration of the ethos of our National Health Service. The Inquiry must look to see whether there was an inappropriate reluctance on the part of those working in the NHS to diagnose Long Covid and, if so, what the reason for that was.

So what do LCKS wish the Inquiry to focus on? Well, firstly, planning. As the Inquiry has heard, the

prospect of long-term health consequences from a Coronavirus pandemic was known and foreseeable prior to the arrival of COVID-19. It ought to have formed an integral part of the planning for the national response to a Coronavirus pandemic. Decisions, as Mr Gale observed yesterday, have consequences.

What the public expect this Inquiry to do is to investigate and assess the quality of the strategic decision-making that was undertaken. LCKS looks to the Inquiry to ascertain what information was available to the Scottish Government and the NHS in Scotland as to the long-term health risks of Coronavirus especially as regards children. And then to ascertain, in addition, to what extent, if any, that information was taken into account in determining priorities for care and protection from risk.

Harm exists in more than one dimension. The protection of life does not necessitate the abrogation of consideration of other achievable protections. It does not excuse a failure to be sophisticated in approach. And urgency in the face of a pandemic that has arrived does not excuse a failure to plan in the calm space before the storm.

Yesterday I encouraged the Inquiry to approach its investigations around three As -- awareness, assessment and actions -- so as to inform the issue of accountability. It will come as no surprise that I continue to advocate and

encourage that approach. The Inquiry needs to identify what the planners were and ought reasonably to have been aware of; what assessments they made of that information; and the reasonableness of the action that was identified as appropriate in response.

As I did yesterday, I submit that the Inquiry's terms of reference, whilst not explicit on the issue of NHS Scotland's strategic planning, for the terms of reference to be fulfilled the Inquiry should and must at least consider the state of preparedness of the NHS in Scotland as at 1 January 2020, in order to comprehend fully the quality of the response then and thereafter.

Second, beyond planning, the same investigatory approach should be adopted towards the policies and actions of the Scottish Government and the NHS in Scotland once the pandemic was upon us. The Inquiry should investigate and ascertain, on a time line basis, the developing professional knowledge and literature as to long-term sequela on Covid infection, particularly as regards children; then ascertain the extent to which the relevant decision-makers sought and/or were provided with that information, considered it and applied the learning from it. Was their response informed? Was it timely? Was it reasonable?

Within that, particular enquiries, I say, should be focused as following:

1. The criteria for assessment of infection. As the Inquiry has heard, there can be significant problems in diagnosis of Long Covid if there is no primary diagnosis of Covid itself. Children do not present symptoms as adults do. That was foreseeable. So the question that arises is whether, in the light of the same, the criteria and time line for testing set by the Scottish Government and the NHS in Scotland was sensitive to that foreseeable challenge.

2. Access to health and social care. A child in Caithness is entitled to the same protection and support and healthcare as one in the central belt of Scotland; but it is foreseeable that without proper sharing of information, analysis and learning, care provision may not fairly be made available throughout the country. So did the Scottish Government and the NHS in Scotland rise to the challenge of developing knowledge? Did they bring together the learning?

As respiratory and geriatric disciplines took the brunt of the impact, did Scotland's professional paediatric community, coordinated by the NHS centrally, rise to the occasion created by the closure of wards, to accommodate an anticipated influx of Covid patients, to contemplate the science, the risks and their ability to provide appropriate and valuable long—term care to all of Scotland's children, wherever they might be? Or did they take their eye off the ball?

Scottish Government tells us of the money being allocated now, but that is, with respect, to distract from the issues of learning from and accountability for what was done or, perhaps more correctly, not done earlier. Better to avoid the consequences that have now having to be responded to.

3. Professional scepticism. The issue here is of the mentality and mindset of clinicians and of those in support professions within the National Health Service. Long Covid is real. I shouldn't have to say that, but the evidence before the Inquiry suggests that some people have still not got that message.

The concern here is pervasive as it affects not only the ability to access healthcare but also other services, such as education support and social welfare support. What hope is there of an informed response to the needs of children with Long Covid if the very existence of the illness is doubted?

I submit that the Inquiry, in order to fulfil its terms of reference, must debunk, once and for all, this attitude of disbelief. It should set out the facts and knowledge relating to Long Covid, identify the shortfalls of the provision of health and social care and of course, in due course, education for children with Long Covid so as to put an end to the scepticism of the naysayers and the

doubters.

4. Mitigation measures.

It is well known that children were treated differently from the rest of the population. The perception that they were at less risk resulted in greater interactions and larger gatherings. Air transmission rates were infamously considered to be effectively achieved by cutting the bottom off of classroom doors.

Having regard to the foreseeable risks of long—term sequela for children, the Inquiry should ask whether the specific arrangements for children, in terms of masking, assembly of attendance at school and for making schools a safe place of study, were reasonable, proportionate and adequate.

And, finally, 5, I turn to the issue of support for Scotland's children with Long Covid. The virulence of the virus may have waned but the risk of Long Covid remains; and, with each infection, the risk of developing Long Covid increases.

Yesterday —— yesterday —— Public Health Scotland advised that it had detected an increase in Covid in waste water for the last few weeks, accompanied by a rise of laboratory confirmed PCR and self—reported cases.

Covid has not gone away. So, in order to inform the national response to the pandemic, the Inquiry should

look at what the Scottish Government and the NHS in Scotland has done to ingather information to understand the illness and how it might best be combated. What exchange of information has been coordinated? Has there been an international engagement and learning?

The terms of reference are, at least for now, limited in point of time; but an assessment by this Inquiry of the state of coordination at the end of 2022 will, as I've said before, provide an appropriate benchmark to test the adequacy of what has been done since. The discussion can then be continued elsewhere and in an informed manner.

One aspect of that discussion is likely to be the adequacy of the financial supported to be provided to those who care for children with Long Covid.

As Long Covid was foreseeable, significant and avoidable or ameliorable for many, and its effects can be physically, emotionally and economically debilitating, it is, in my submission, appropriate for the Inquiry to consider, and report, on the financial support available to Long Covid sufferers and their carers and to make recommendations as to whether, in response, a cause exists for better State financial provision to be made available to them.

As I did yesterday, my Lord, may I remind the Inquiry of what I said in my opening statement: the children

of Scotland should be able to thrive and look forward to a positive future. The Inquiry may be their best opportunity to have their voices heard. They are the future. The obligations on your Lordship's shoulders sit no more heavily than they do for Scotland's children.

THE CHAIR: Thank you Mr Webster.

Now, Ms Merchant is going to address us twice, first on behalf of Scottish Hazards and then on behalf of the STUC. I think you can probably just stay there for the whole time. It will perhaps be clear, but tell us when you're changing from one to the other please. Thank you.

Closing statement by MS MERCHANT

MS MERCHANT: Thank you, my Lord.

Firstly on behalf of Scottish Hazards, I would use this opportunity to adopt my written submissions, which the Inquiry already have.

By way of background, Scottish Hazards are a charity focused on the advancement of health and safety at work. It is in that context that these submissions, relating to the impact of the pandemic and the strategic response on health and social care, are presented.

My Lord, Scottish Hazards had good engagement with the Scottish Government during the COVID-19 pandemic. They had funding which allowed them to provide a telephone helpline for non-unionised workers. It is from this direct

evidence that much of Scottish Hazards' evidence to this Inquiry comes.

Further, Scottish Hazards were a member of the Scottish Government's Covid Safer Workplaces Group, which was set up to consider workplace issues during the pandemic.

However, despite this good engagement, and the apparent willingness on behalf of the Scottish Government to engage with Scottish Hazards, the issues that arose in health and social care workplaces mainly derived from the lack of enforcement of guidance and/or employers' lack of knowledge with regard basic health and safety requirements.

It is Scottish Hazards' view that the impact of the pandemic and the strategic response was felt greatest amongst those health and social care workers who were most vulnerable; women, black and ethnic minority workers and those working in the non-unionised care sector were disproportionately affected, exacerbating long-standing socioeconomic differences and inequalities.

Turning, first, to the lack of enforcement of guidance. My Lord, health and social care staff went to work during the pandemic. Workplaces were one of the few places that people were allowed to go during the pandemic; and that being the case, Scottish Hazards believe that more consideration ought to have been given by decision makers to COVID-19 as an occupational health matter.

The impact of not considering COVID-19 in this way was that employers and enforcement bodies focused almost exclusively on community spread; and this ignored the fact that, for a significant proportion of Scotland's population, Covid was spread and contracted in the workplace.

Turning to the guidance itself, Scottish Hazards believe that the reason that some employers were so willing to ignore the guidance was because of a lack of monitoring and enforcement. Put simply, there was insufficient monitoring. There was no penalty and no consequence for employers who failed to follow it.

Further, in situations, which have been outlined by other Core Participants, Scottish guidance differed from UK guidance, meaning that Scottish workers were, in effect, unable to secure those workplace protections set out for them here in Scotland.

That lack of enforcement is akin to another set of circumstances described by witness Pat Graham from the charity PAMIS. There was a passage of Ms Graham's evidence, my Lord, that struck me as essentially summing up the issue. It was on day 23 of evidence.

Ms Graham and my Lord had an exchange around a letter which had been sent from the Cabinet Secretary to various NHS bodies and social care partnerships, in line with PAMIS' main aim that those with profound learning

difficulties were supported by their carers at hospitals.

Ms Graham's evidence was despite the letter being sent, PAMIS' experience was ignored. There was a lack of, as Ms Graham said, being able to make somebody do it. The witness confirmed that this was because there was no legal power. My Lord posed the question:

"If the Government think that it is that serious, you could argue that they should ensure that it is mandatory."

In my submission, that is exactly the situation that we find ourselves in with workplace guidance. And also in relation to the Social Care Fund, which the Inquiry has heard much evidence of to the effect that some employers refused to use it, some have said it didn't apply, some delayed in paying wages until they had recouped the money from the Scottish Government.

In my submission, this is yet another example of the limits of a non-mandatory scheme. The impact of these measures was lessened because it was not legally enforceable.

Scottish Hazards do accept, however, my Lord, that the regulatory regime is complicated and some of these matters undoubtedly fall out of scope of this Inquiry. However, what does strike at the heart of this Inquiry and, therefore, in my submission, is in scope is the impact of

the decisions made by the Government on health and social care workers. And it is Scottish Hazards' position that the impact of the guidance issued by Government, aimed at protecting workers, was weakened by the fact that it was not backed up by a clear monitoring and enforcement regime. The lack of this regime meant that social care workers were left under-protected and unnecessarily exposed to contracting and spreading COVID-19.

While accepting that the Scottish Government were, of course, limited in relation to matters involving health and safety, which remains reserved to Westminster, Scottish Hazards believe that there were powers which the Government could and should have used to enforce measures in workplaces. As the Inquiry moves to consider the implementation and examine decision-making in relation to healthcare, Scottish Hazards consider that the Inquiry require to review the lack of investigations, monitoring and enforcement of guidance.

In particular, the Inquiry should seek to understand the reasons for this, including the legal and practical limitations of the enforcement regime. In my submission, this is particularly important as we seek to learn lessons for the future.

Scottish Hazards believe that Scotland cannot go into another pandemic with a regulatory regime that has

enabled some employers to ignore guidance with impunity. Such a system raises huge questions about the confidence and integrity of the system by which we are governed and Government information and guidance in general.

Moving on to the lack of understanding of health and safety requirements amongst employers. Ian Tasker, the Chief Executive of Scottish Hazards, said in evidence at the outset of the pandemic workers calling the hot line were aware that their employers should have been taking some action but were unaware what protections were being put in place.

This was the start for them of much evidence that showed that employers appeared to be unaware of their legal duties around health and safety; in particular their requirements to consult their workforce about measures and to carry out risk assessments.

As Mr Tasker said in evidence, there was little of consultation, rather communication of management instruction. That is not the same thing; and does not take account of the views of those carrying out the work and therefore requiring the protection from COVID-19.

The impact of this on workers was an increased sense of fear and panic. The difference that that consultation would have made: it would have given workers a voice and it would have allayed many fears, in particular

like simply knowing that things were being considered would have gone a long way; instead workers were seeking information and were getting nothing back.

Scottish Hazards are deeply concerned by some employers' failure to conduct adequate risk assessments or indeed risk assessments at all. The impact of this was that risk assessments did not adequately address the concerns raised by employees or adapt to an ever changing situation.

This left Scotland's workers exposed to COVID-19 with no control measures being identified. Scottish Hazards believe that the impact of this could and should have been mitigated, had employers carried out their legal obligations.

From Scottish Hazards' helpline it was clear, my Lord, that the pandemic has affected those in health and social care workers who are most vulnerable and working in the most of precarious of employments. Within social care those working in the non-unionised private care sector were particularly vulnerable. The helpline provided the need for a central point of advice. The lack of such made it difficult for the non-unionised workforce to seek independent advice that they needed to keep themselves safe and to prevent the spread of the virus at work. Scottish Hazards believe that an independent advice resource should be central to future pandemic planning; and it may be that

this covers advice both to employers and employees.

Within the social care workforce, Hazards picked up concerns, particularly from workers who were going into households to treat patients. This Inquiry has heard similar evidence in relation to the allied healthcare professions and other workers who went in and out and between people's homes. For example, workers would attend to provide care at someone's home and family and friends would be there. This might have been when gatherings were restricted. The individuals might not have been wearing masks. These situations put workers at risk of contracting and spreading COVID-19.

The guidance in relation to the care at home sector, which was eventually issued by the Government, did not apparently appear to appreciate the fact that workers were in fact going in and out and between people's homes. It appeared that there was little consideration given to the fact that they were going into an entirely uncontrolled environment. Simple issues such as social distancing, relatives and friends not being in attendance during care visits wearing masks, were not considered. Those were all essential measures to keep workers safe.

The impact of this was that workers were entering service users' houses unsafe from COVID-19 with the potential to then spread it throughout their community.

Workers did, as the Inquiry has heard, seek advice from their employer in relation to these matters, but too often they were —— in the words of Scottish Hazards —— instructed to enter houses and perform their duties regardless.

The effect of this was that workers were put at risk. Some employers failed in their duties to keep their staff safe; and the gaps in the guidance on the issue hampered the ability of the workers to protect their own and their clients' health.

Pregnant women were also vulnerable during the pandemic, many seeking advice from Hazards in relation to risk assessments, as required by law when a woman advises her employer of pregnancy. This, during the pandemic, included additional consideration of the COVID—19 risk to the health of the worker and her pregnancy. Unfortunately, in Scottish Hazards' experience the generalised lack of risk assessments was also true for pregnant women. As Mr Tasker said in evidence, pregnant women were often being asked to choose between continuing to work and risking the health of their unborn child. This increased their stress levels, put them at risk of contracting Covid, thereby risking their and their unborn child's health and wellbeing.

In my submission, this is an impact which was foreseeable. It was avoidable had basic health and safety

and pregnancy related legislation been followed. In any event, at the start of the pandemic, given the lack of knowledge about the impact of COVID—19 on pregnancy and pregnant women, the precautionary principle should have been applied.

Another vulnerable group were those who required to shield. Scottish Hazards provided advice to shielding workers, particularly after the requirement to shield was lifted. This decision and the failure to provide any guidance for employers or workers had a significant impact on shielding workers.

When considering shielding workers you have to remember that these workers essentially had been told to stay at home for months. They'd had limited contact with anyone because they were told of their increased risk to serious illness if they became infected with COVID—19.

From those contacting Scottish Hazards, as you would imagine, their main concern was contracting the disease. Again, Scottish Hazards found that when individual risk assessments were carried out —— if they were —— employers would often ignore the outcome and/or refuse the measures necessary, such as allowing workers to work from home.

In Scottish Hazards' experience, control measures, such as reallocation of tasks, removing an individual from a

customer facing role, were basic control measures which would have been reasonable to keep previously shielded workers safe, but many employers were reluctant to do this.

And, in my submission, that is another example of some employers failing to fulfil basic current health and safety legislation.

That, my Lord, essentially sums up Scottish Hazards' position in relation to the handling of the pandemic. Guidance, while lacking in places, was there. What wasn't there was an enforcement regime to back it up; and this was compounded by a lack of understanding by some employers of basic health and safety requirements.

When looking back at this pandemic and this Inquiry, in times of a future pandemic, hopefully in many years to come, decision makers and politicians of the future must have the opportunity to learn lessons. The response to the next pandemic must be better than this one. We cannot go into another pandemic where compliance with guidance is voluntary because we all know that some —— not all but some —— will look at this pandemic and they will think there was no consequence for not following guidance last time, so why should we follow it this time? And that, my Lord, in a world of ever increasing disinformation, scepticism of science and Government guidance in general, could be very dangerous. Government decisions and guidance must mean

something; and, therefore, they must be enforced.

That concludes my submissions on behalf of Scottish Hazards.

THE CHAIR: Thank you.

MS MERCHANT: In relation to the Scottish Trade Union Congress, the submission focused on the strategic response to health and social care.

I think at the start of this submission it is important to put on record that COVID—19 resulted in a myriad of impacts for health and social care workers, some of which, while undoubtedly significant, did not come from strategic decision—making and the strategic response.

The focus, however, of these submissions is on the impact from strategic decisions, rather than generalised impacts on workers.

The STUC would like to highlight overarching themes this morning.

1. The failure to understand the roles carried out by those working on the health and social care front line.

2. Occupational exposure in workplaces and decisions of employers.

As with many of the other Core Participants, within both of these sections, the disparate impact on the low paid is indefinitely intertwined.

Turning first to the roles carried out by health and social care workers. The Scottish Government's failure to understand and consult with those workers working on the front line has been demonstrated throughout this section of the Inquiry. It is a thread that runs through decisions on many of the key issues including guidance, PPE, essential workers, what procedures were carried out.

As stated in our written submissions, and heard in various closing submissions yesterday and today, much of the guidance appears to have been influenced predominantly by its application in the acute clinical setting. The impact of this, in my submission, was felt most by those working in social care and the allied healthcare professions. The guidance did not reflect the reality of their work or their workplaces.

It is the STUC's position that this impact could have been minimised and potentially excluded had those drafting the guidance, firstly, prioritised their understanding of these key job roles and secondly consulted with those doing the job.

The Inquiry has heard much evidence on this point from a variety of different workers, so I would only seek to draw the Inquiry's attention to two today.

Care homes.

In relation to care homes guidance was described

by witnesses as unrealistic, as an impossibility, as a failure to recognise patients' conditions, particularly around dementia, as highlighted by Mr Gale yesterday. It failed to recognise a care home as a residence home.

Car sharing.

This meant that care staff and prison staff, despite having worked a 12—hour shift together, were unable to travel together in the way that they usually would. The financial impact of that and the mental health impact of travelling long distances alone cannot be underestimated.

Moving on to PPE.

The Scottish Government restricted FFP3 masks to those responsible for carrying out aerosol generating procedures. However, again, due to the lack of understanding about job roles, about medical procedures and what jobs did what procedures, there was unnecessary conflict at employer level. This led to things like ambulance staff and speech and language therapists not being given FFP3 masks and, therefore, left unprotected and vulnerable, despite a job requirement to carry out AGPs.

"Pound shop protection" was how the GMB ambulance members would describe the PPE they were provided with; leaving ambulance workers, in the words of one witness, "like lambs to the slaughter".

Other witnesses describe a hierarchy of PPE

whereby lower grade blue collar staff, for example porters and domestics, were not provided with sufficient PPE. And this was despite the fact that porters were in direct contact with patients and domestics were responsible for the cleaning of Covid positive wards.

The STUC consider that the Inquiry is required to investigate why PPE was issued in this way.

My Lord, the intersection between the workers who were not provided with adequate PPE and the social economic gradient cannot be understated.

The Inquiry has heard much evidence that those working in low paid, arguably less valued roles, such as care home staff, home carers, porters and domestic had to fight to secure adequate PPE.

In my submission, this was summed up by Peter Hunter of UNISON who said that care workers were telling them they would use bin bags: they would cut them up, they would wrap themselves in them. They would welly boots or they would use Marigolds. They would improvise. In contrast, Mr Hunter said, "I don't remember an NHS nurse contacting us with that level of distress or with the examples of extreme improvisation".

The STUC considers that the Inquiry is required to investigate why FFP3 masks were limited to staff carrying out AGPs. Why were they never provided to all health and

social care staff? And to what extent were those decisions around PPE led by science, when compared with other considerations, such as cost and supply?

For care at home workers, at the start of the pandemic there was no PPE guidance; and this was despite the fact that these workers go in and out of and between people's homes. They provided care at home to some of the most vulnerable in our society. And when considering the impact of this on these predominantly women workers, it is important to remember back to the early days of the pandemic. We didn't know what we know now. The crisis was escalating. People feared contracting the virus. They feared their relatives contracting the virus. People were told to go home, stay at home, not go out, not mix with others. And it was that context that these women —— care at home workers —— were going in and out of and between people's homes providing crucial care.

The Inquiry has heard much evidence about this. However, put simply, care at home workers were working at great risk to themselves, their service users and their family. At the start of the pandemic they were terrified that they would become vessels of Covid. They feared contracting Covid from service users or giving it to service users. They feared spreading it amongst service users. They feared taking it home to their families and spreading

it in their communities.

When the PPE guidance was issued for this group of workers, the fear was compounded. The protection proposed was less than other workers. Care at home workers were told that they didn't require to wear a mask unless they were dealing with patients who were showing signs of Covid.

An example of the stark reality of that message was a care at home worker going to provide care in a service user's home at the same time as a community nurse was leaving that person's home. The community nurse was wearing full gown, mask, gloves; and yet the care at home worker was being told not to even wear a mask —— that same mask, my Lord, that everyone was wearing on the bus and in the supermarket within a matter of weeks.

This led to the workforce losing confidence in the Government. They did not believe they were being taken seriously; and, more importantly, their work was not being valued.

On 4 April 2020, 1,500 care workers sent a letter to the First Minister, and I quote:

"We do not feel safe at work. You have lost our confidence by publishing guidance without consultation with front line workers and by forcing us to work with insufficient PPE."

Following the publication of that letter, much

media coverage, and repeated questions at the First Minister's regular press conferences, the guidance was changed and the Cabinet Secretary did apologise.

The STUC believes that this shows this crisis in care at home was avoidable. It was avoidable had the Government prioritised this group of workers, understood their job roles and protected them accordingly.

Looking again at occupational exposure. Research suggests that exposure at work was around four times higher amongst workers in health and social care when compared to the average rate across industries. Further data suggests that a disproportionately high number of those who died from COVID—19 were engaged in the care sector when compared to the average for all occupations.

Exposure at work, my Lord, was foreseeable during the pandemic and it was known before the pandemic.

The STUC are concerned that the difference in death rates across the workforce appears to reflect occupational risk and the social class gradient.

The intersection between occupational exposure and socioeconomic inequalities is another significant part of where the uneven impact of the pandemic can be found. The STUC agrees with the Health and Safety Executive where they say that there was widespread under—reporting of COVID—19 workplace deaths.

The guidance placed the onus on employers to make a judgment as to whether workplace exposure was an issue. The impact of this was to minimise that obligation, leading to under—reporting of workplace deaths.

In the STUC's submission, that was foreseeable. It was unsurprising that few employers reported in these circumstances, instead choosing to judge that outbreaks were a result of exposure outside of work premises.

Again, the Inquiry has heard a wide range of evidence on this point, from British Medical Association, the Royal College of Nursing and Unite the Union.

The STUC consider that the Inquiry, when looking to its next stages, require to consider what was the thinking around the role of occupational exposure when taking decisions and developing guidance. Was the guidance regarding the reporting of workplace deaths adequate?

The STUC also consider that the Inquiry should review why legally required risk assessments were not carried out by employers and what consideration was given to employers to prevent and report workplace deaths.

Moving on to employers failing to follow guidance. As the Inquiry has heard in evidence, workers in health and social care were often met with employers who failed to follow the guidance. In some care homes the theme of low paid women workers being ignored and forgotten continued.

Staff had to fight for PPE. A witness before the Inquiry described how the management of a care home she worked in, and I quote "rolled their eyes and had an attitude that we were being ridiculous and dramatic" when they asked to wear their own masks at work because their employer failed to provide them.

These decisions left staff fearful, under—protected and under—appreciated. Even when PPE did arrive, the Inquiry, again, has heard a myriad of evidence about PPE being rationed, PPE being kept in a locked cupboard, staff being told to reuse PPE. And in specific relation to care homes this was compounded by the Scottish Government's decision to discharge Covid positive patients into care homes without testing, placing social care staff and care home residents at significant risk.

The impact of this decision meant that care staff were exposed to unprecedented levels of death and suffering. The impact of these decisions on this group of low paid workers cannot be underestimated. This is the same group of workers that the Social Care Fund was established for.

The Social Care Fund was established after significant trade union campaigning to force the Government to understand that a system of guidance, which was predicated on low paid workers losing pay due to the self—isolation requirement, did not survive contact with

reality. Most social care workers were entitled to statutory sick pay only. In 2020 to 2021 this was £95 a week; and it was only payable after a three day waiting period -- three days where these weekly paid workers would receive no pay.

As witnesses before the Inquiry have said, many social care workers were scared to test in case it was positive meaning they required to stay at home, meaning they would not be paid. The guidance put workers in an impossible position: financial jeopardy on one hand, versus potentially taking COVID-19 into their workplace, a workplace where they were looking after vulnerable and elderly residents, and where they did not think had sufficient PPE on the other.

The problems with employers and the Social Care Fund are well-known and, given the time constraints, I don't intend to rehearse those arguments here. Except to say that the STUC consider the Scottish Government were restricted in what they could do to compel employers to use the fund. Employment law is reserved to Westminster. The Scottish Parliament can't pass legislation which says: you have to pay workers X number of pounds for X number of work. We accept the intricacies of the devolution settlement are not in the scope of this Inquiry.

However, the limitations on the powers of the

Scottish Government meant that the fund was less effective than it could have been. Its impact was lessened because of the devolution settlement.

In conclusion, my Lord, the STUC believes that the evidence heard by the Inquiry points to a clear link between the social gradient and the impact of COVID-19. The poorest had the least ability to work from home. They were more likely to be exposed to Covid at work, on their way to work on public transport. They were more likely to have underlying health conditions, meaning they were more susceptible to COVID-19.

Those attending work, many of whom already faced economic disadvantage, faced increased occupational exposure and risk of death, when compared to those who could work from home.

Through this Inquiry, the STUC have highlighted instances of concerns being raised by workers who simply didn't believe that the circumstances of their workplace had been given sufficient consideration. Many of those workers lost confidence that they were being sufficiently protected by their employers and through their trade unions those workers raised the alarm. And, as the Inquiry moves to its next phase, in my submission it needs to look at when the Government recognised that the alarm was ringing how long it took the Government to respond to the alarm; and whether or

not the alarm ought to have been required to have been rung at all. Because in the STUC's view the protection of front line workers in health and crucially in social care ought to have been sufficiently planned for.

Unless I can be of any more assistance, those are my submissions.

THE CHAIR: Thank you very much indeed Ms Merchant.

Now, next we have Mr Di Paola for CrossReach.

Closing statement by MR DI PAOLA

MR DI PAOLA: Good afternoon, my Lord, ladies and gentlemen. I'm here to day on behalf of the Church of Scotland in the guise of CrossReach.

CrossReach welcomes the opportunity to provide a closing statement to the Inquiry. Since the Health and Social Care Impact Hearings commenced back in October 2023, CrossReach has willingly participated in and paid close attention to the evidence as it has emerged during the course of the Inquiry.

The evidence has shown that organisations across the country involved in care sector provision and their dedicated teams of staff faced an unknown and unenviable task during the entirety of the pandemic. And that impact is still being felt across the sector today.

The people whom the care sector is there to

support -- many of them vulnerable -- suffered greatly as a result of the pandemic, as did their friends and families, many of whom have also given evidence of that impact.

CrossReach provides its statement in accordance with the directions of the Chair, focusing on (1) impacts which we consider to be foreseeable; (2) impacts which were most significant and/or detrimental; and (3) impacts which might have been minimised or excluded had reasonable steps been taken to do so.

1. Impacts which CrossReach considered to be foreseeable.

The fragility of the care home sector was already under discussion with the Scottish Government before the pandemic hit. Protection, including financial underpinning of essential residential care services, was needed. It was a much rehearsed mantra that the NHS should not become overwhelmed with capacity being built like additional hospital units at the SECC.

However, what was lost in this principle was the importance of the social care sector to health provision and the critical nature it plays in preventing the need for access to acute services.

When a protective ring was eventually thrown round care homes as the impact of COVID-19 on a frail, older community became starkly clear, it became more like a noose.

We believe that the consequence of isolating residents from their families for longer than necessary should also have been foreseeable, given the mental health repercussions of isolation in the community generally and caused unnecessary additional suffering to those in care homes, many of whom who are without capacity and their families.

However, social care does not just exist as an adjunct to the health service. It is there to help people in situations where additional support is required, often as a result of physical disability or mental health issue, to overcome challenges and live life to the full, whether in a residential setting or in a community.

This has also been the subject of discussion with the Scottish Government. It is accepted that everybody had their freedom curtailed, but it was reasonably foreseeable that those in greatest need of support to live a normal life would feel the greatest impact of a pandemic and deserved special consideration.

2. Impacts which were most significant and/or detrimental.

Guidance.

The guidance at various times, and particularly initially, did not cover all areas and was open to differing interpretations. It lacked consistency and clarity and changed too frequently to reasonably be kept pace with by a

nurse or care worker.

As guidance was issued to social care settings by the Scottish Government, it became clear that there was not a full understanding of the range of care settings that existed or that these were not all clinical settings. There was a lack of distinction between distinct types of setting and a failure to take into account the fundamental differences in these services caused difficulties.

Changes in regulations and guidance also had a significant impact. It took a significant effort to interpret and implement guidance which came thick and fast and often needed further clarification as it was unclear, sometimes unhelpful, and came with short implementation windows.

The sector representatives, CCPS and Scottish Care, had to intervene to stop critical guidance notes from being issued by the Scottish Government late on a Friday with an impossible short lead in time, often involving a Monday morning.

There was no clear distinction between regulation and guidance, to the point that CrossReach decided that the only safe course was to treat both as regulation. The default applied by CrossReach was to comply with everything or to go beyond it. On the few occasions that the guidance was not followed because it simply did not make sense to

apply it in the way suggested, this was approved at the highest level within the organisation.

The sheer quantity of guidance from a number of regulators, combined with the frequency of changes, made this overwhelming; and the inability to have sufficiently quick, cost appropriate, independent scrutiny and guidance led to feelings of powerless and frustration.

Scottish Government lack of understanding of the nature, extent and purpose of social care.

Care homes are not short-term, high level clinical settings. Care homes are people's homes. The people who are supported by social care services are not patients and the staff are not clinicians. Good social care is about supporting people in vulnerable situations and whatever challenges they face to live as independently as possible and to live life to the full.

The command and control structure adopted for the NHS was not appropriate for social care, which needed a different approach when it came to keeping supported people and those supporting them safe.

There was a failure by the Scottish Government to distinguish between different types of care setting. Recommendations which made sense from a Covid infection control perspective and were appropriate in an ordinary setting did not work where other risks to health or

wellbeing specific to the context were overlooked.

3. A clinical standard of inspection.

Infection protection and control, IPC, was a critical activity for CrossReach services. It was a focus of Care Inspectorate inspections. During the pandemic, inspections were often accompanied by IPC specialists with care homes being expected to meet clinical standards of inspection.

Inspections using clinical standards impacted CrossReach by increasing the burden on care staff and managers as the way in which the guidance was applied by IPC specialists accompanying the Care Inspectorate on visits meant they were directed to seek out the specific brands of cleaning fluid, rather than simply meet the standard required composition of chlorine solution.

It also created a sense of disempowerment leading to a lack of confidence at a critical time by being over-prescriptive for staff who were well-versed in IPC methods as they had to manage seasonal flu, Norovirus and other types of infection on a regular basis. Inspections using clinical standards, also reduced care inspection evaluations.

4. Vulnerability of care home staff and care home managers.

Deaths in social care services were referred to

the Crown Office and Procurator Fiscal service and are being investigated by the police. Some managers continue to have the prospect of potential prosecuting hanging over them some four years after the pandemic began. This was not replicated in the National Health Service, where the majority of Covid deaths actually occurred and where all of the infrastructure to support the critically ill was in place.

This was particularly difficult given the pressures on care homes because the infrastructure to deal with the pandemic simply was not there; and the guidance at the time was that older people in care homes, who were suspected to have COVID-19, should not be hospitalised, despite the fact that some people who were untested were being moved from hospitals to care homes and, in fact, increasing the risk there.

The NHS was given priority and protection, leaving care services to fend for themselves in these initial days of the pandemic, and we still face the consequences today.

NHS staff were applauded for their efforts during the pandemic, whereas care sector staff became the subject of media scrutiny and were blamed and shamed for Covid deaths which occurred in their homes.

One further area of difficulty in care homes was the complete cessation of visits. Managers could see

significant deterioration in some residents, particularly with dementia, which might have been ameliorated should some controlled visiting have been allowed.

4. PPE -- demand and financial difficulties.

Care homes were effectively requisitioned by the Scottish Government. However, the supply of PPE, initially at least, was a matter for the front line service to deal with under their normal purchasing arrangements, as the procurement and use of PPE was not new to care homes, who were used to taking infection control measures and dealing with infectious diseases on a routine basis.

However, because of the unprecedented quantity of PPE needed, much earlier effort was directed by the organisation in sourcing good quality PPE and trying to take the burden off managers directly.

While residential care settings were eventually prioritised, housing support and daily support services felt relegated. These services, in particular, experienced financial difficulties obtaining PPE. Managers reported that it took three days to get supplies, but even then visors could not be provided; this is despite them being required by the guidance.

5. Self-insurance.

CrossReach experienced both income shortfalls and extra costs not adequately covered by the Scottish

Government payments. There was a rise in insurance premiums and major difficulties in renewing cover which eventually led to the withdrawal of cover for COVID-19 incidents.

The latter was due to the COPFS investigations into COVID-19 deaths and the level of loss of society awards seen in Scotland, as against lower, fixed bereavement awards in England and Wales. This ultimately required the Church of Scotland to underwrite CrossReach for risks arising from COVID-19, effectively forcing it into self-insurance in this respect. The sector called for the same indemnity as offered to the NHS in these circumstances, but this was denied.

6. Disruption of services.

Service users in our adult care services in particular experienced a diminution in the services provided by the public sector. Where service users attended external day centres, Crossreach staff were not required during the day because of these alternative arrangements for their care.

Suddenly, as these were withdrawn, there was a requirement to support people 24 hours per day and this was often only achievable by using agency staff. The cost of the additional staffing hours was eventually recoverable from Covid funding but it took resources to evidence the extra costs, and there was a significant delay in costs

being reimbursed under the sustainability payments which led to cash flow pressures.

Pressure was placed on care homes and services to undertake Covid testing of residents. However, we resisted this because we felt that it was a clinical task. This was particularly important when considering the prevalence of dementia in the care home population.

Lastly, impacts which might have been minimised or excluded had reasonable steps been taken to do so.

Guidance.

Requirements and expectations were put on care services that were unfair and unrealistic; and whilst it is acknowledged that it would have been impossible for the Scottish Government to provide regulations and guidance covering all settings and all scenarios, there should have been more effort put in engaging with the sector.

CrossReach is grateful for the opportunity to have contributed to the health and social care impact theme of the Inquiry. We look forward to hearing the Inquiry's response to the pandemic, learning lessons from it and to making recommendations for the future.

Thank you.

THE CHAIR: Thank you very much Mr Di Paola.

And then the last submission is for Refugees for Justice, Mr Kiddie.

Closing statement by MR KIDDIE

MR KIDDIE: My Lord, I appear, again, as junior counsel for Refugees for Justice, as instructed by that group's solicitors, Birnberg Peirce. My learned senior, Hugh Southey, is also instructed.

This oral submission is supplementary to the written closing statement already submitted for Refugees for Justice, which I here by formally adopt.

I would also refer back to our opening statement, our oral submissions of 24 October, our witnesses' testimony of 15 March, and their documentary evidence and included in their documents Baroness Helena Kennedy's 2022 report on the Independent Commission of Inquiry into Asylum Provision in Scotland.

First, therefore, turning back to Baroness Kennedy's report, your Lordship will remember that she speaks of the vulnerability of asylum seekers and refugees, where she says, in her report, for example:

"It is the current systems of asylum determination and support that makes them vulnerable" and "it places people into marginalised social and economic situations without adequate support and leaves them there with ever diminishing hope for the future".

And "for those who have experienced trauma, this same system can compound the problem. We've heard almost

countless stories of re-traumatisation and further trauma as a result of treatment".

Therefore, in my submission today R4J's witnesses' testimony bears all of that out. And that in the context of the experience of asylum seekers and refugees during the Covid pandemic at the material time of interest to this Inquiry -- 1 January 2020 until 31 December 2022.

First we heard from Savan Qadir, one of Refugees for Justice's founding members, and himself a former asylum seeker. He told us that before April 2020 Scottish asylum seekers lived in safe housing, mostly in Glasgow, while they also received financial support, could take care of their own basic needs and could integrate into Scottish society at large.

However, with Covid all of that changed. Asylum seekers were summarily rounded up and relocated into hostel-type accommodation in six Glasgow city centre hotels, all as orchestrated by the Mears Group plc under appointment by the Home Office. And they were relocated, thus, sometimes on as little as one hour's notice.

And Mr Qadir spoke of lack of regard for their mental health, at the outset of this relocation, and throughout the entire experience in these hostels; abdicating any meaningful concern for mental wellbeing, Mears simply referred back to the asylum seeker's initial

screening interview, itself cursory in nature. Therefore, mental health problems, including severe problems, went unrecognised at the point of relocation and were often exacerbated by that very relocation itself. And, thus, it didn't take long for tragedy to strike.

When in May 2020 one asylum seeker took his own life, followed soon after, in June of that year, by another who had sought help many times yet was shot dead by police during a stabbing attack.

Meanwhile, Mr Qadir reminded us that financial support was often entirely withdrawn, creating a situation of almost complete reliance on the hostel, despite it being poorly appointed. Food was provided but was often inadequate or culturally inappropriate. Yet there was no alternative besides starving. Asylum seekers were also, in effect, forced to self isolate in their rooms, unable to contact those they needed to, including advisers and family.

Meanwhile members of Mears' staff would summarily enter rooms unannounced invading privacy and undermining any sense of security. Asylum seekers also faced fresh difficulty registering with new GPs which prompted Mr Qadir to e-mail the First Minister. Yet when her office replied simply to say GPs must allow asylum seekers to register, it was clear that the Scottish Government simply failed to understand Home Office policy; thus indicating general lack

of information sharing and lack of communication across the board.

In closing Mr Qadir also spoke of the Scottish Government's New Scots refugee integration strategy for the years 2018 to 2022 and of the Government's failure to give effect to this, including during lockdown. Now, I'll return to that later.

But, moving on, the next witness of Refugees for Justice to give testimony was Amanda Purdie of AMMA Birth Companions. She spoke of experience of pregnant and new mothers who, along with their babies, were also summarily relocated by Mears and into re-purposed bedsit accommodation which hitherto had been used for single homeless men, yet had been deemed unsuitable for them.

This was the so-called "mother and baby" units. The summary nature of their relocation which was typically on less than one week's notice was contrary to the Scottish Government's own guidance; and rooms were much too small, open plan, overcrowded and hazardous for babies crawling around. Social distancing was virtually impossible, thus forcing non-compliance with official guidance for pregnant and new mothers and their babies. The rooms were also dark, poorly ventilated, not suitable for cooking, fire alarms occurred sometimes almost daily. There was no television, no wi-fi, no means of entertainment or distraction.

In particular, lax security was a major source of anxiety for those who had previously experienced the trauma of human trafficking.

R4J's next witness was Pinar Aksu. She told us of the experience of third sector organisations attempting to help asylum seekers during lockdown. The Scottish Government had failed to put the third sector on advance notice of plans for asylum seekers. Had it done so, in her view, the third sector could have done more. As it was, it tried as much as it could to help, such as by way of advice, providing data for mobile phones, handing out internet devices, arranging transport to shops and hospitals, and money for school uniforms and school meals.

However, despite these interventions the same problems would recur time and time again, due to our public authorities failing to recognise them time and time again.

Refugees for Justice also produced one witness whose identity was not made public under a Restriction Order. She, herself, had been an asylum seeker residing in the hostel at the time of said stabbing tragedy and had found the entire experience of hostel life to be utterly dehumanising.

In my submission, all of Refugees for Justice's witnesses spoke frankly, knowledgeably and with conviction. There can surely be no doubting their honesty. Their

evidence provides a reliable account of the experiences of asylum seekers during lockdown and should be recorded in the Inquiry's official digest of evidence.

It should be recorded, as it appears, that from the very outset of lockdown asylum seekers came from a background of trauma, were vulnerable and had particular needs, including human rights needs. Yet during lockdown their particular group dynamics were ignored and unaddressed.

Those apparent facts being a matter of record, at this point, should serve as a basis for shaping and steering the further progress of this Inquiry and our Scottish public authorities' response to it as we move forwards.

Therefore, moving forwards on that basis, the Inquiry should be in a better position to consider what could have been done differently. However, as part of this, it's also important to take a moment of pause for reflection on what Scottish public authorities could competently and legally have done differently in the context of asylum law, at large, being a reserved matter in terms of the devolution settlement.

R4J must, and does, accept that some of the decision-making that led to the experience of asylum seekers in Scotland is outside the scope of the Inquiry. However, not all of it is.

The Scotland Act 1998 operates by way of specific reservation, rather than by way of specific devolution. Thus, any sphere of Government not specifically reserved to the UK is axiomatically devolved. This means, in effect, that Scottish public authorities did have relevant powers at the material time, including in the fields of housing, Social Services, health and education, for example. Therefore, examples of questions moving forwards include as follows.

In the sphere of housing, did Scottish public authorities fulfil their functions in enforcing the tolerable standard for the types of accommodation to which asylum seekers were relocated? Also did they fulfil their functions under planning and building controls, such as with regard to change of use? And in the sphere of public health, did Scottish public authorities, including Public Health Scotland, do enough, for example, with regard to asylum seekers' mental wellbeing, particularly given their said vulnerability?

More generally, did the Scottish Government do enough to engage and cooperate with the UK Government regarding the experience of asylum seekers here? Did it share information? And did it seek to contribute to decision-making by means of sharing information?

Finally, as an example of questions, yet by no

means least and, indeed, of crucial importance, and as already mentioned by Mr Qadir, since before lockdown the Scottish Government has had a New Scots refugee integration strategy for integrating refugees into our society.

A lengthy official policy document, this shows that the vulnerability of asylum seekers was not only foreseeable but had actually already been foreseen pre-lockdown, and states, for example, that:

"The New Scots strategy aims to support refugees and asylum seekers in Scotland's communities ..."

And that:

"Asylum policy is reserved to the UK Government ... However, the Scottish Government has control over a range of matters that relate directly to the asylum process ..."

At the core of the New Scots strategy is recognition that refugees and asylum seekers have particular needs and vulnerabilities; and that is important because, in our submission, it imposed legal duties on Scottish public authorities to act or at least to take account of the plight of asylum seekers in our country.

The evidence so far tends to show that the Scottish Government and other Scottish public authorities did not do enough under the foregoing powers available to them. By contrast, the overall impression is that during

lockdown our authorities simply took the view that asylum seekers were already taken care of by the Home Office; thus, they could be, in effect, conveniently forgotten about. They could be simply locked away, in effect, in six Glasgow hotels —— one less thing for the Government to worry about.

Yet, as the evidence also shows, they were far from being cared for and that despite their being a vulnerable group.

Accordingly at the heart of the Inquiry's role moving forwards should be, in our submission, with respect, your Lordship's anxious concern to ask whether that impression, given by the evidence, reflects the actual reality of our Government's attitude and approach to asylum seekers during lockdown and, if so, why was that the case? And how can this situation be improved for the future?

That concludes the oral submissions for Refugees for Justice. Thank you very much for this opportunity —— we're very grateful for it —— to make the submission today.

THE CHAIR: Thank you Mr Kiddie.

Now, with that submission, that brings to an end our hearings examining the public impacts of the COVID—19 pandemic on the health and social care sector. Again, I want to thank everyone who has contributed to the Inquiry's hearing so far.

Before finishing today, however, I want to set out

the Inquiry's focus for the rest of 2024.

In the autumn the Inquiry will shift its focus to examine the public impacts of the pandemic on two other themes: first, we will examine evidence looking at the impact of the pandemic on education, certification and young people. Then we will examine the impact on financial and welfare support offered to businesses and individuals in Scotland. Dates for these will be —— for these hearings will be published very shortly on our website.

I also want to assure you that the Inquiry's work continues when we are not in public hearings, as we're not going to be for the next several months. Our investigative work on all the Inquiry's terms of reference remain a priority. This includes the examination of tens of thousands of documents already received by the Inquiry and requests for further evidence where that is necessary.

The Inquiry will also examine written statements provided by witnesses and help those witnesses selected to give oral evidence at the Inquiry's future Impact Hearings.

I would like to reiterate what I said at the start of this week's session. Given time and cost constraints not every witness will be selected to give oral evidence at a public hearing; but rest assured all written statements will be continued to be read and analysed and these written statements form part of the bank of evidence that will

ultimately be considered and instruct the Inquiry's findings.

In addition to all that, the work of Let's Be Heard, the Inquiry's public participation project, continues. Let's Be Heard has been gathering personal experiences from across Scotland and will continue to analyse the 5,500 responses received so far. Let's Be Heard has entered its next of stage of focused engagement that will help broaden the Inquiry's understanding of the pandemic's impact on communities across Scotland.

We and the Inquiry have some very busy months ahead of us and I'm grateful for your continued support and contribution to the Inquiry. Thank you all for attending these hearings.

That brings an end to these hearings.

(12.45 pm)

(Hearing Concluded)

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