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Scottish Covid-19 Inquiry

Day 59

November 12, 2024

1

               Tuesday, 12 November 2024

2 (10.00 am)

3 MR STEPHEN: Good morning, my Lord.

4 THE CHAIR: Good morning, Mr Stephen.

5 MR STEPHEN: We have one witness this morning.

6 THE CHAIR: Good morning. Thank you for coming. When

7   you're ready, Mr Stephen.

8 MR STEPHEN: I am obliged.

9   MS KELLY MUNRO (called)

10   Questions by MR STEPHEN

11 Q. Could you confirm your full name, please?

12 A. Kelly Marie Munro.

13 Q. Thank you, and you have already helpfully provided a

14   written statement to the Inquiry; is that correct?

15 A. Yes.

16 Q. Thank you. For the Inquiry's record, the reference

17   number for that witness statement is SCI—WT0221—000001.

18   Just to reiterate at the outset, Ms Munro, that

19   everything you have said in that written statement will

20   be taken into account by the Inquiry, even if we don't

21   touch on every single aspect of it in oral evidence

22   today.

23 A. Okay.

24 Q. Just a gentle reminder that the hearing is being

25   transcribed, and there will be stenographers taking

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1   notes, and no doubt his Lordship will be too, so just a

2   reminder to speak at an appropriate pace and I will do

3   the same. Thank you. Now, you're here today to give

4   evidence on behalf of the charity, Carers Trust

5   Scotland; is that right?

6 A. That's correct.

7 Q. How would you describe in headline terms the main

8   purpose or aims of Carers Trust Scotland?

9 A. We are one of the national carer organisations in

10   Scotland. We are an organisation that works with local

11   young carer services. We —— in my role, I work across

12   strategic organisations, so COSLA, Scottish Government,

13   local authorities, local young carers' services; and I

14   get to work with young carers as well, advocating for

15   their rights and listening to challenges that they have.

16 Q. Thank you, and I was going to come on to, what is your

17   job role, your title within the organisation?

18 A. My title is education officer primary and secondary, so

19   a lot of my work is raising awareness of young carers

20   throughout education and the challenges that they have.

21 Q. And how long have you held that role for?

22 A. Over five years now, 2019 I started, so June 2019, so

23   over five years.

24 Q. I think the main focus of your written statement, and no

25   doubt evidence today, is unpaid carers and specifically

            2

1 young carers. How many unpaid carers are there roughly

2 in Scotland?

3 A. So there's —— the number that we identify would be

4   66,000, but of that, young carers, there's —— recognised

5   there's at least 30,000 young carers in Scotland.

6 Q. When we're talking about young carers, what age or ages

7   are we talking about?

8 A. There's no definition in the legislation that states a

9   young carer is someone under the age of 18. Our

10   services that we work with, our local young carer

11   organisations, tend to support from ages 4 or 5, and up

12   to 18, and then you have like young adult carers which

13   are 18 to 25.

14 Q. So potentially very young then. I think the legislation

15   you're referring to, you refer to this in your statement

16   at paragraph 69, this is the Carers (Scotland) Act 2016?

17 A. Yes, that's correct.

18 Q. Thank you. How would you describe in high level terms

19   the range of responsibilities that young carers have,

20   the things that they are typically asked or undertake?

21 A. It can range anywhere from helping with housework,

22   looking after brothers and sisters, providing

23   communication, right up to personal care. They can help

24   with —— helping a member of family or the person they

25   care for get dressed. They can deal with budgeting for

            3

1   the household, they can deal with shopping for the

2   household, collecting and providing medication. They

3   can accompany the cared—for person to appointments. It

4   ranges from everything they can do an hour or two caring

5   a week, right up to 90 hours or more a week.

6 Q. I was going to ask, I mean, is that typically then quite

7   a large part of their time spent on that role?

8 A. Yes, it will vary. Every young carer is different, but

9   it will vary. A lot of young carers, it will impact

10   their day—to—day life, so everything from education to

11   their own health and wellbeing, to even spending time

12   with friends or engaging in hobbies and other

13   extracurricular activities.

14 Q. You touched on it there, but is there a reality or

15   expectation on young carers, then, that they have to

16   balance or juggle those responsibilities perhaps with

17   other things like education or employment perhaps?

18 A. Definitely. Young carers that we have worked with in

19   young carer services will report that actually they

20   often find tasks difficult, so perhaps in school, they

21   may find homework difficult if they're carrying out

22   caring responsibilities when they get home. They often

23   report that they can't take part in extracurricular

24   activities, so hobbies after school, football clubs,

25   perhaps a drama club, because they need to get home due

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1　　to caring responsibilities. Perhaps the same at
2　　weekends.
3　　　　They also sometimes take time off school if they
4　　need to accompany a cared—for person to a medical
5　　appointment, or if somebody is coming into the house and
6　　they need to translate, or perhaps they just need to
7　　support that person.
8　Q. To be clear, are you saying that will be the case even
9　　without the pandemic, and the pandemic is obviously
10　　something the Inquiry is interested in ——
11　A. Yes.
12　Q. —— and we will come on to in a moment. That's the
13　　reality for them even outwith that?
14　A. Yes.
15　Q. Thank you. Against that background, I want to turn and
16　　discuss with you the pandemic.
17　A. Okay.
18　Q. I thought to start firstly with the closure of schools,
19　　if I may, and lockdown. At paragraph 12 of your
20　　statement, you say that even in relevance advance of
21　　lockdown in March 2020, that your organisation was
22　　learning that a lot of young carers were already
23　　starting to get worried about going into school. What
24　　was the cause or causes of their anxiety at that stage?
25　A. So I think that the media had obviously been reporting,

5

1　　I think we had all seen that, but what we were hearing
2　　from young carer services and other young carers is they
3　　care for someone who would be potentially shielding, so
4　　they may have a terminal illness, they may be
5　　immuno—compromised, and they were worried about being in
6　　school and getting the virus and taking it home to that
7　　person; because with that they were saying there may be
8　　guilt, that they were passing that onus on, so they were
9　　really concerned about going into school, because there
10　　was large numbers of people congregating, and they
11　　didn't want to pass that back home to person they cared
12　　for, or other people in the house, but particularly the
13　　person they cared for, in any case they would be ——
14　　I think it was going to be admitted to hospital, or if
15　　they had —— there was real fear around getting the
16　　virus, and they didn't know outcomes of the virus at
17　　that point.
18　Q. Thank you. At paragraph 13 of your statement, you say
19　　that your organisation had not yet conducted any
20　　studies, so how were you being made aware of these
21　　concerns at that time?
22　A. So we work with local young carer organisations in every
23　　local authority in Scotland, and we were reaching out to
24　　them just to say: do you need any support, we understand
25　　it's uncertain times. Our young carers were reporting

6

1　　anything —— they need additional support, and this is
2　　what the workers on the ground that were interacting
3　　with young carers daily, this is information that they
4　　were being given and reported back to us.
5　Q. Thank you. At paragraph 14 of your statement, you say
6　　that anecdotally, you became aware that young carers
7　　stopped attending school, university and respite
8　　services, and again, this is in advance of lockdown
9　　itself. Again, what were you being told or were you
10　　hearing was the reason for that, that they were stopping
11　　going altogether?
12　A. The fear of getting the virus. They had heard at that
13　　point that perhaps somebody they knew or someone they
14　　knew had contracted the virus, and the fear was real, so
15　　they were withdrawn from school, didn't want to go in
16　　again. This was information coming through from our
17　　young carer services. They were also stopping going to
18　　their young carer services that often offered respite
19　　groups. They had withdrawn from those groups as well,
20　　from real fear of contracting the virus and taking it
21　　home.
22　Q. When you say in advance of lockdown, do you know, again,
23　　it might be roughly, how far in advance we are talking
24　　about, weeks, months ——
25　A. I think it was weeks. I don't think it was months.

7

1　　I think it was probably about three or four weeks before
2　　lockdown.
3　Q. Okay, and that was having a chilling effect, perhaps, on
4　　their attendance in an education setting?
5　A. Yes.
6　Q. Thank you. Now, if we turn then to when schools did
7　　indeed close, at paragraph 16 of your statement, you say
8　　that young carers really struggled with the closure of
9　　schools, and in that context, you cite one of the
10　　surveys that was carried out by Carers Trust Scotland in
11　　June 2020, I think published then in July 2020. For the
12　　Inquiry record, the reference for that is
13　　SCI—CTSxxx—000003. I won't take you in detail to that
14　　document itself, but I do want to ask you a few
15　　questions about it. This is the "2020 Vision: Hear Me,
16　　See Me, Support Me And Don't Forget Me". That's the
17　　document that I'm referring to. First things first, was
18　　the aim of that survey then to understand the experience
19　　of young carers during the pandemic?
20　A. Yes. We wanted to hear from young carers and what
21　　challenges they were facing if any. We wanted to hear
22　　about their lived experience during the pandemic, and
23　　also to find out what more they needed support with, if
24　　there was gaps in areas that we weren't providing.
25　Q. Do you know what the survey sample was that was taken at

8

1 that time?

2 A. I can't remember off the top of my head.

3 Q. No, that's fine. I think in the document itself at the

4 outset, I think it's around about 214 carers aged

5 between 12 and 25, I think. What did that survey tell

6 you then about the impact of school closures upon the

7 time, the number of hours that young carers were having

8 to spend on caring?

9 A. It showed that young carers had an increase in their

10 caring responsibilities in their home. One of the

11 figures that's in my statement relates to young carers,

12 I think they show an increase of 6% of up to 90 hours or

13 more caring, whilst still trying to engage in online

14 education. That figure rose to 11% for young adult

15 carers, so those over 18. So if they're caring for 90

16 hours, they're still trying to do their learning at home

17 alongside that, and the person they care for being there

18 as well.

19 Q. So was that in your view a significant increase in their

20 caring responsibilities?

21 A. Yes, because they would normally be at school for,

22 I would say, at least 25 hours a week if they were there

23 in full-time education where they wouldn't be -- where

24 they would be focusing on their learning, they weren't

25 in that environment, and they were then having to take

1 on caring roles at home, more responsibilities at home.

2 Q. I think that same document talks about one in ten young

3 carers seeing their caring role increasing by 30 hours

4 or more as well. Given that increase then in caring

5 responsibilities, what did young carers have to tell you

6 in that survey about the impact upon their education

7 specifically, for example, upon their ability to do

8 their schoolwork?

9 A. They were finding it really difficult to engage in

10 online education, because they felt they had to check on

11 the cared-for person more at home. They were being

12 interrupted during their online learning, if they were

13 able to get online. If they had siblings as well at

14 home, that was a really hard environment, and -- relate

15 to it later in the statement, but also there's that

16 being able to actually get online, the use of digital

17 technology if it was working or if they had access to

18 it.

19 Q. Yes, and we'll come on to digital inclusion in due

20 course. I certainly want to cover that with you.

21 I think at paragraph 51, just on this point about

22 schoolwork or homework, I think you say in your

23 statement that they were caring all day and struggling

24 to do their homework. That was the reality for them?

25 A. That's correct, yes. They would -- if they were able to

1 engage on online learning, even if it was only an hour,

2 they struggled, and then they would struggle to do

3 further study around that. So they would stress about

4 not getting their schoolwork done, but they would also

5 be worried about the person -- like not providing enough

6 care to the person they cared for, so they struggled to

7 do that because of their caring roles, or because of the

8 home environment they were in.

9 Q. Was that tension, that divided loyalties, if you like,

10 you're talking about there between their own education

11 and the person they were caring for, is that something

12 that you were hearing from young carer organisations,

13 young carers themselves?

14 A. That would be correct. They had to engage in online

15 learning for five hours or -- go and make lunch to go

16 and provide medication to the person they cared for, so,

17 yes, there was conflict there with them.

18 Q. Thank you. And you say at paragraph 17 of your

19 statement that the feedback you were getting was that it

20 was a difficult period, particularly if you were at home

21 all the time, young carers at home all the time with a

22 cared-for person. Can you elaborate on the feedback

23 that you were receiving in terms of respite, for

24 example?

25 A. So normally at school, if a young carer was at school

1 throughout the day, they tend to -- they would let us

2 know previous to the pandemic that perhaps they phoned

3 home to check on the cared-for person, they sent a text.

4 The odd young carer, if they stayed close, may go home

5 at lunchtime. However, when they were home all day with

6 the person that they cared for, even if they weren't the

7 main carer, they still felt that need to check on them,

8 to check if they were okay, if they needed medication,

9 if they needed food, if they needed anything at all, any

10 kind of support. Particularly perhaps those with mental

11 health, they perhaps needed a bit more extra support

12 during the pandemic, so they felt they needed to

13 constantly check on them.

14 Q. Thank you. Now, again, sticking with school closures

15 and moving beyond, I suppose, schoolwork itself, you say

16 at paragraph 37 of your statement, you say that when

17 schools were open, young carers would be there, I think

18 25 hours a week, you said the same a moment ago,

19 I think, and teachers who knew those young carers would

20 be looking out for them, recognising if they were tired

21 or troubled, for example, due to something that was

22 happening at home, a family issue. Did that teacher

23 supervision or pastoral role, did that go missing in

24 your view during the school closures?

25 A. In our view, yes. When a young carer is in class or any

1   learner is in class, teachers are able to identify that
2   through behaviours, in—person behaviours. Those
3   behaviours are harder to identify. A lot of young
4   carers go unnoticed because —— or don't identify
5   themselves because they're worried about social work
6   intervention, they're embarrassed, they don't know
7   they're a young carer. So for young carers that have
8   taken on that caring role during the pandemic, it almost
9   felt normal to them, or this is something they should be
10   doing.
11   So we feel like a lot —— we were informed that a lot
12   of young carers probably weren't identified during this
13   time. And I think that shows —— the SEEMis figures that
14   we'll talk about later on. I'm sure the school
15   recording system actually dropped with the number of
16   young carers identified during school, so we feel that
17   they weren't getting the support from school that they
18   probably needed during that time.
19 Q. Thank you. I think at paragraph 80, you say nobody was
20   checking on them, and nobody was recognising those
21   responsibilities?
22 A. If they weren't attached to a young carer service, and
23   they weren't known to their schools, then no one was
24   recognising the responsibilities they were carrying out
25   during this time. There was no support that they were

13

1   getting during this time; particularly if they had an
2   increase in caring responsibilities, or if they needed
3   respite, these factors weren't being identified.
4 Q. You talk in that same paragraph, paragraph 80, about
5   I think perhaps an embarrassment sometimes about young
6   carers. Is there a reticence amongst young carers
7   sometimes to want to disclose the extent of perhaps the
8   responsibilities they have?
9 A. Yes. Young carers have disclosed to us that it has
10   taken time for them to recognise they're young carers,
11   or want to say that they're a young carer for fear of
12   embarrassment. Now, the embarrassment may come around
13   the condition of the cared—for person, particularly if
14   it's mental health or addiction issues. It may be
15   embarrassment because they're having to help with
16   personal care or dressing, or it may just be that
17   actually their friends and peers don't do the same role
18   as them, so they don't want to come forward and tell
19   people what they do.
20 Q. Thank you. Again, on school closures, you talk at
21   paragraph 67 of your statement about young carers
22   struggling during the pandemic to access healthy meals
23   and food. Again, in your view, to your knowledge, did
24   the closure of schools have an impact on young carers
25   being able to access those things?

14

1 A. Yes. I would say when they're at school, they have
2   access to canteen, they have access to food, they have
3   access for those in free school meals, they have access
4   to that, to school meals, and being able to have that
5   break from their caring role —— as well. The report
6   that we published, like 35% of young carers were
7   struggling to look after themselves, and that could be
8   because they're focused on the cared—for person, so they
9   want to make sure that they're eating, and they're
10   getting their medication, and they're getting enough
11   sleep before they look after themselves to do it.
12 Q. Thank you. You mention at paragraph 68 that when
13   schools were closed, some young carers at least were
14   receiving wellbeing boxes of food. Where were those
15   boxes originating from, do you know?
16 A. So some of the boxes, I think, were provided by the
17   government or local authorities, as part of the COVID
18   pandemic, but they would often get ingredients that they
19   didn't know how to cook with or they didn't have the
20   life skills to deal with. Local young carer services
21   did have good practice initiatives where they would drop
22   bags of ingredients at their door, and then they would
23   have like an online cook—along, so they were learning
24   some life skills, where —— they would get to learn life
25   skills but also they would have the chance to be able to

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1   make a hot meal for them and their families, for
2   families that weren't sure how to do this, or perhaps
3   the young carer was the only one able to do that.
4 Q. You mention that lack of life skills. Why was there
5   that lack of life skills, do you think? Is that a
6   reflection of age, or what is the reason for that?
7 A. It could be a reflection in age. You could have like
8   10, 11—year—olds that perhaps just haven't been shown
9   how to cook meals or shop, or perhaps it was just the
10   main carer was now a key worker and out of the
11   household, and it wasn't a skill that they had learned,
12   and had to do it as you went along. So there was
13   different reasons for it.
14 Q. At paragraph 71 of your statement, you also mention,
15   I think, perhaps supermarket vouchers sometimes being
16   issued to young carers. Again, was that something they
17   were able to utilise?
18 A. So in some areas, families were given vouchers, and
19   particularly for those in poverty were given supermarket
20   vouchers to use, but if the —— if the cared—for person
21   couldn't leave the house, then the young carer had to
22   use them, but the vouchers were often for supermarkets
23   many miles away, particularly in the Highlands and
24   Islands, so either they had to travel by bus, because
25   young carers may not have been able to drive, they may

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1   not have been at an age where —— or been able to get a

2   lift , because it would have been someone outwith the

3   family, or they had to walk a few miles. It wouldn't be

4   their local supermarket that the voucher was provided

5   for. It might be one, two or three miles across town

6   where they would have to walk to and then walk back.

7 Q. Thank you. I want to move on then. With the closure of

8   schools, delivery of education then moves online. At

9   paragraph 18 of your statement, you say that a lot of

10   young carers reported struggling with online learning.

11   We'll come on to digital inclusion more broadly in a

12   moment, but I wanted to start by asking, in your

13   experience, was the home environment for young carers,

14   many young carers, was that suitable for online

15   learning?

16 A. The feedback that we received from young carers and

17   young carers' organisations was that it was difficult

18   for them to engage in online learning. We held a focus

19   group with young carers, and during that time, a few of

20   the young carers disclosed that if they had a sibling

21   that had a learning disability , was neurodivergent, even

22   a physical disability , was keen to be in the same room,

23   be on the Google Classroom with them, there was constant

24   interruptions for them, and they wouldn't have had this

25   interruption had they been in a physical classroom in

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1   the school. So they found it really difficult to engage

2   in online learning. Sometimes they just wouldn't go to

3   the class if they thought it was going to be too

4   chaotic, or they would have too many interruptions,

5   because they couldn't focus on their learning.

6 Q. And is that a lesson learned, do you think?

7 A. Yes, I definitely would say it was a lesson learned

8   particularly for young carers, I think, that they had no

9   other choice. I don't think they were able to take a

10   laptop and go to a different room. I think that

11   scenario would still work out the same, I think, but if

12   they had access to school hubs, then it would make life

13   easier for them, not to say that every young carer would

14   have went to a hub, but the opportunity would have been

15   there for them to get a break and been able to engage in

16   online learning.

17 Q. We'll come back to hub schools, but moving more to

18   digital inclusion more generally, at paragraph 30 of

19   your statement you say that numerous young carers and

20   young adult carers were isolated , due to being digitally

21   excluded.

22   Now, I understand at paragraph 27, that was an issue

23   that was highlighted to the Scottish ministers in a

24   letter of 11 June 2020. For the Inquiry's record that

25   document is SCI—CTSxxx—000005. For completeness, at

18

1   paragraph 28, you say that your organisation received a

2   response to that letter in July of 2020, and again for

3   the Inquiry record, that reference is SCI—CTSxxx—000007.

4   I don't want to go into the detail of that exchange

5   because the Inquiry will move on to implementation and

6   decision—making phases in due course. But what I do

7   want to ask you is are there any particular examples of

8   digital inclusion or exclusion that you would like to

9   highlight to the Inquiry. I think you cover a couple of

10   these in your statement, but it would be helpful to hear

11   those?

12 A. We heard from some young carers. One young carer had to

13   use her mother's mobile phone to access education,

14   online classrooms, because they had no other device in

15   the house. They also didn't have wi—fi, so they were

16   using mobile data, and she found this really difficult

17   because some —— certain apps weren't supported on it, so

18   the young person couldn't use that —— within there ——

19   there was another young person who was missing some

20   online classrooms because the family only had one

21   device. His mother was a full—time university student,

22   and they were also trying to use that device for the

23   cared—for person's hospital appointments. Despite

24   asking the school for further —— and the local young

25   carers' organisation also asked for help with devices,

19

1   the school had said that these devices had been passed

2   to other vulnerable children , and unfortunately there

3   was nothing else available for them. They repeatedly

4   asked for printed copies of schoolwork, and this was

5   never delivered .

6 Q. And to sum up then, what was the consequence for them

7   being able to undertake their education at that time?

8 A. They were digitally excluded. They weren't able to

9   access online education, or if they were, it was very

10   limited , being able to access, so therefore they didn't

11   have the same —— the same access as their peers that

12   would have laptops or mobile phones, or —— so it had an

13   impact on their education. They felt that they didn't

14   get exam results that they wanted or access to study

15   that they needed, so they felt that that had a big

16   impact on their education and further education.

17 Q. And just to be clear, these examples that you have

18   given, these were highlighted to the

19   Scottish Government; is that right?

20 A. Yes, in the letters we sent to them.

21 Q. Thank you. In your experience then, was there a

22   consistent approach by local authorities to digital

23   inclusion for young carers in Scotland?

24 A. No. Every local authority was different , and every

25   young carer had a different experience. One of the ones

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1   that I do highlight in my statement that we heard a
2   positive story was in Stirling, every person, every
3   pupil learner in first year is given a laptop which sees
4   them through the whole of secondary school. So they all
5   have equality, they all have the same chance to have
6   that.
7   In other areas, this wasn't —— there wasn't the same
8   rules applied. They had to —— young carers were trying
9   to get digital devices from their school. Their local
10   young carer service managed to get some refurbished
11   tablets or refurbished laptops from local businesses.
12   Perhaps they got given grants which they were able to
13   then purchase technology online, and give a loan to
14   young people.
15   The other thing that we have seen was where schools
16   may be like: here you can have a laptop or a tablet or a
17   digital device, they were in areas where they couldn't
18   get wi—fi, or it was really poor wi—fi or poor mobile
19   data. So they were given the mobile phone dongles, but
20   actually that wouldn't connect, so they would have
21   enough to perhaps download one document, but they
22   couldn't engage in a video classroom.
23 Q. Thank you. I think at paragraph 29 of your statement,
24   I think the phrase you use is a postcode lottery; that's
25   your view in terms of digital inclusion across local

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1   authorities?
2 A. Yes, I would agree with that; there wasn't a consistent
3   approach, and young carers were disadvantaged, depending
4   on what local authority they lived in.
5 Q. Thank you. Now, you touched on it there, but I will
6   come back to it now. At paragraph 34 of your statement,
7   you highlight young carers in rural areas of Scotland,
8   and I think you just said that perhaps their access and
9   use of digital devices was not necessarily a
10   straightforward one; is that correct?
11 A. That's correct. So although they may have had the
12   hardware, like in regards to a laptop or a tablet or a
13   device, there was a lack of consideration given to young
14   people in remote areas and the lack of infrastructure
15   there as well, because it's all very well given a dongle
16   or a mobile wi—fi device, but if you're in a really
17   rural area and can't get on, they had no option. They
18   just had to not engage in their education.
19 Q. Is it your evidence, then, that those in rural areas
20   might have been more affected than those perhaps living
21   more centrally in terms of digital inclusion?
22 A. Yes, and means to get online, yes, I would say so.
23 Q. Is that a lesson to be learned, do you think, for the
24   Inquiry to consider?
25 A. I would say definitely in the future that infrastructure

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1   has to be there. If there's going to be more home
2   learning or online learning, then infrastructure has to
3   be there and has to be given consideration, particularly
4   in very rural areas of Scotland.
5 Q. You mentioned grants for technology, and those perhaps
6   were used, I think you say, for laptops, tablets, things
7   like that. At paragraph 33 you talk about that. In
8   your, or to your knowledge, was that application process
9   for young carers to obtain those devices, was that a
10   straightforward application process?
11 A. The grants from their local young carers' service that
12   they had to apply for —— so I wouldn't say the young
13   carer had to apply for that grant. It would be done
14   through a third sector service, it may not be a local
15   young carer service. But actually, that was additional
16   resources that the service needed, so they were already
17   quite stretched. It was during a pandemic, and then
18   they had to do further resourcing of —— it was
19   Connecting Scotland, so they had to go through the
20   application, I think somebody had to register to be like
21   an online contact for them as well. So although there
22   was grants available, it relied heavily on the third
23   sector organisation supporting the young carers applying
24   for those grants, buying the technology and then
25   distributing that technology for them.

<center>23</center>

1 Q. Thank you. I want to move on then to hub schools which
2   you have mentioned slightly earlier on in your evidence.
3   At paragraph 21 of your statement, you say that your
4   organisation learned that the criteria for attendance
5   for hub schools was set by each local authority. In
6   your view or experience, were those criteria clear and
7   consistently applied?
8 A. No, it was different in every local authority area, so
9   in some areas, young carers were able to attend hub
10   schools, they were part of the criteria, and it was open
11   to them if they wanted to attend. In other areas they
12   couldn't attend unless they met specific criteria, so if
13   they were a looked—after child or young person was one
14   example we were given.
15 Q. Because at paragraph 22 of your statement, I think you
16   say that your organisation had a good relationship with
17   certain local authorities who were flexible in approach,
18   so that in that instance, young carers were able to
19   attend hubs; is that correct?
20 A. Yes, we had a meeting in one local authority, online
21   meeting with their quality improvement manager, who ——
22   and the local young carer organisation who actually
23   said, yes, they would open that up to young carers, and
24   would there be specific young carers. Also, they were
25   asking if there was any additional support they could

<center>24</center>

1 give to a young carer; for example, did they prefer to
2 be in a separate room so they weren't with other young
3 people to increase the risk of the virus. But it was ——
4 I'll go back to my previous one, it was a postcode
5 lottery. The criteria was different in every local
6 authority area, and I think for learning in the future,
7 I think there needs to be national guidance rather than
8 local guidance, so that young carers aren't
9 disadvantaged.
10 Q. At paragraph 23 of your statement, you highlight that
11   there were some young carers, I think you say those that
12   were caring for those with mental health conditions or
13   addiction, being denied attendance at hub schools. Do
14   you know or were you told the reasons as to why that
15   was?
16 A. They just —— they were told that young carers, being a
17   young carer wasn't part of the criteria. They had
18   limited spaces within hubs, and young carers didn't meet
19   that criteria. If they had another criteria, then they
20   could apply under that, but they couldn't go because ——
21   just because they were a young carer. It wasn't part of
22   the criteria. They feel their education suffered from
23   not being able to get respite from those caring roles
24   and the trauma that they had to go through, particularly
25   for those with addiction issues and mental health issues

25

1 during that time. In two local authorities, that was
2 highlighted to us.
3 Q. Thank you, I want to move on then now to the reopening
4   of schools. At paragraph 76 of your statement, you say,
5   based on anecdotal information, that many young carers,
6   I think around three—quarters is what you say, were
7   hesitant to go back to school. What was causing that
8   hesitancy?
9 A. I think it was the same reasons for withdrawing from
10   school. Before lockdown, I think the virus was still
11   very much present. They were scared they were going to
12   go back to school and pass it on. They were scared that
13   people wouldn't be wearing masks and that they had built
14   up this bond with the cared—for person, so they were
15   also worried about, if they weren't going to be there,
16   who was going to do all these caring responsibilities
17   that they had been doing during that time.
18 Q. At paragraph 50, I think you highlight a tension that
19   you mentioned earlier. You are talking about a Young
20   Carer Voice online event for young carers, where I think
21   the topic for discussion was the reopening of education
22   or establishments, and you say that:
23   "If young carers did return, they had to think not
24   about their education but the health and safety of the
25   relative they were caring for."

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1   Was that a choice that young carers were making you
2   aware of, that they were wrestling with?
3 A. Yes, they were worried about going back. I think ——
4   they had to think about mixing with people, people not
5   wearing masks. I think they were doing —— like the hand
6   washing, some young carers were reporting back that they
7   were changing again before going into school in case
8   they were taking this virus back. And they were
9   highlighting again that —— who was carrying out the
10   caring responsibilities that they had been delivering or
11   they'd been doing while they were off school and at
12   home. So a lot of this is going round in their head
13   when they're back, and this anxiety is very real for
14   them when they're back in education.
15 Q. At paragraph 77 of your statement, you say that there
16   were worries about the ventilation within schools. I
17   just wanted to ask if you could elaborate upon what
18   those worries about ventilation were at that time?
19 A. I think some of the young carers were reporting back
20   that if they wanted windows open, then people were
21   saying it was too cold, or it was too hot because some
22   of the schools' ventilation system, the —— one young
23   carer had reported back that perhaps she had heard about
24   ventilation carrying the virus, and they were worried
25   about that. So that's the information that we had

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1 around ventilation.
2 Q. Did all young carers return to school?
3 A. No, we've heard that some young carers withdrew from
4   education completely, I think around that anxiety of
5   bringing the virus back, or just their experience during
6   lockdown, and they were already withdrawn from online
7   classrooms; and I think also for those caring
8   responsibilities, they felt that they were unable to
9   return to school because the care wouldn't be there,
10   replacement care wouldn't be there while they were in
11   education.
12 Q. I think at paragraph 66 of your statement, you say that:
13   "Some of our young people lost their way in
14   education and did not return..."
15 A. Yes.
16 Q. Thank you. I would like to move on now to the impact of
17   the cancellation of the exam diet. This is something
18   that you talk about in your statement and the
19   development of the alternative certification model. At
20   paragraph 40 of your statement, you describe that policy
21   change as causing worry to young carers. What were the
22   main reasons for that concern?
23 A. So a lot of young carers were worried about the change,
24   because perhaps they hadn't done so well in their
25   prelims. It may have been due to something had happened

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1   with the cared—for person. It was a really anxious
2   time. They weren't able to study as much. Perhaps
3   their caring role had increased during that time, but
4   following the prelims, they tried to make up for that.
5   They tried to be in class more, they tried to be part of
6   study more, so they were also worried that the results
7   that teachers would give them may be lower because of
8   their attendance due to caring responsibilities.
9   So that was —— they were reporting back that they
10   were quite anxious and stressed about that, as it was
11   going to determine their future on the grades that they
12   got.
13 Q. Were those concerns, those worries, something that was
14   made known by your organisation to the Scottish
15   Government?
16 A. Yes. We sent a briefing to the Scottish Government to
17   highlight these worries around the exams. We also
18   worked with SQA. We were part of a working group.
19   However, the policy wasn't going to change around that,
20   and we were informed to let them know about appeals
21   processes, should they want to do that. We let all
22   young carer services know that as well, and provided
23   additional support.
24 Q. That briefing paper you mentioned, you have provided a
25   copy of that to the Inquiry, so for the record that

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1   reference is SCI and then xxx—000009. Given what you
2   have just said, how would you describe the impact of
3   that policy change upon the educational attainment of
4   those young carers?
5 A. They were really concerned. We don't hold what grades
6   they got in school, we don't know what their attainment
7   exam results were, but we did hear that through our
8   local young carer services, that some young carers
9   didn't get the grades that they were expecting and went
10   through an appeal process.
11 Q. I think you say at paragraph 38 that the impact of this
12   was life—changing for some young carers, is the way you
13   put it?
14 A. Yes. If they were hoping to get a certain grade to get
15   into college or university and didn't get that grade,
16   then it was life—changing for them. They had to go down
17   a different path than they wanted to go down.
18 Q. Thank you. I wanted to move on now to, I suppose, the
19   change in the role for young carers during the pandemic.
20   For example, at paragraph 19, you talk about how for
21   some young carers, the pandemic changed the caring
22   dynamic within the household. I think the example you
23   give is if a principal carer was a key worker, they
24   would then be out of the house more.
25   Then at paragraph 24, you also talk about how young

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1   carers were having to backfill for paid support. You
2   highlight that as an issue. So my question really for
3   you is, given those increased caring responsibilities,
4   and this gap in paid support that you've highlighted,
5   what respite was available for those young carers at
6   that time?
7 A. The young carers didn't have any respite. They were at
8   home 24/7 with the person they cared for. I think when
9   the legislation changed and they could get out for an
10   hour a day, if they were able to do that, then they
11   could do that. But I think even then, if they were with
12   someone that was shielding, they wouldn't leave the
13   house.
14   There was occasional respite where they could
15   perhaps go on a tablet or listen to music or —— but they
16   were in the home with the cared—for person 24/7. We
17   talk about it in my statement later on, but young carer
18   services would provide wellbeing boxes with perhaps like
19   bath salts and colouring books for younger ones, or like
20   sweets and hot chocolates and things like that, but
21   there was no respite from the home. That would just be
22   a small respite or a small luxury for them within the
23   house.
24 Q. In your view, is that backfill in paid support something
25   that young carers should have had to do?

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1 A. No. Young carers were disadvantaged by being —— having
2   to do that back support, but they felt they had no
3   choice. When support was cancelled, when day centres
4   were cancelled, they had no one else to turn to to do
5   that support, so they took it upon themselves to do
6   that.
7 Q. Given what you have said about the respite or lack
8   thereof, was the social isolation of young carers a
9   concern that was brought to your attention to your
10   organisation?
11 A. Yes. Young carers reported loneliness. They had no one
12   to talk to about their caring role. They had no friends
13   to socialise with. They couldn't really talk about
14   their caring role, if it was with a support worker or
15   with friends, because more often than not, the cared—for
16   person would be in the room with them or in another
17   room, where they may have heard, so they felt it
18   really —— they felt it was really difficult to talk
19   about their caring role and any challenges they were
20   having.
21 Q. What about the ability of young carers to look after
22   themselves in terms of their physical wellbeing? What
23   were you hearing on that?
24 A. We were hearing that actually they were using all their
25   energy for the cared—for person, so when it came for

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1 them, there was very little sort of time and energy they
2 used on themselves. They probably didn't eat the best,
3 they were struggling with sleeping, there was
4 increased —— in that report, the one that we referred to
5 earlier, the Hear Me, See Me, Support Me And Don't
6 Forget Me, they report increase in stress and anxiety of
7 being at home.
8 Q. I think you mentioned in your answer earlier the welfare
9 checks, and that's something you talk about in your
10 statement at paragraphs —— 41 and 42. I think that's
11 something you say was another challenge for young
12 carers. You say that prior to the pandemic, young carer
13 support workers would have carried out welfare check—in
14 sessions with young carers. What was the aim of those
15 checks pre—pandemic?
16 A. So pre—pandemic, if a local young carers' service and
17 worker, if a young carer was registered with them, they
18 would often go into school and do check—ins, just to see
19 how they were getting on with their caring role at home,
20 to see if they needed more support perhaps with
21 schoolwork, if they needed more respite, if they were
22 wanting some group work, if they were perhaps going on a
23 trip away from their caring role, or they just wanted
24 somebody to talk to. Perhaps they were getting referred
25 for counselling in more one—to—one sessions, or they

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1 would often have guest speakers come in and speak to
2 them about certain conditions. So maybe like
3 Deafblind Scotland would come in and speak about that.
4   And then during the pandemic, the young carer
5 workers weren't able to talk to them. It would just be
6 through phone, and just to repeat what I said earlier,
7 they were really reluctant to come forward and talk. I
8 think if the young carers' workers were quite
9 innovative, then they set up different, like, WhatsApp
10 groups and chat groups where they could talk to one
11 another, but it wasn't the same as having that
12 face—to—face discussion.
13 Q. So pre—pandemic, these would have been face—to—face, but
14 then schools close, and then I think alternative ways
15 have to be found, as you have just described.
16   I think you also go on to say, I think when
17 restrictions ease, I think this is paragraph 44 of your
18 statement, there was then —— walk and talk was then
19 possible, people could actually leave?
20 A. Yes, they were allowed to —— I think it was when you
21 were allowed to see one person per day or two people per
22 day, they could go out and do a walk and talk. Young
23 carers were desperate to get out of the house. They
24 would get a take—away hot chocolate. Even if it was
25 raining, they were happy to walk around the park with an

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1 umbrella, but the young carer workers reported getting
2 some, like, very detailed information for them because
3 it was maybe the only person they had seen all week, and
4 they were being really honest about their caring role.
5 So the young carer worker would often just take notes on
6 their phone, because it was quite hard, when they were
7 walking round the park, to try and get notes, and they
8 noticed a massive change in this from only being able to
9 talk for one to two minutes online or on the phone, to
10 actually —— these young carers being able to express
11 themselves and any challenges they were facing.
12 Q. And prior to the pandemic, school would have been one of
13 those safe spaces where these meetings could have taken
14 place?
15 A. Yes. Young carer workers would often set up in a room
16 within a school and speak to four or five young carers
17 within a day.
18 Q. Thank you, I want to now move on to mental health of
19 young carers. You state at paragraph 53 that that was a
20 key concern of your organisation at that time. Again,
21 we'll go back to the survey that we touched on in your
22 evidence earlier on. At paragraph 55, you say that
23 there was survey research done into the impact of the
24 pandemic restrictions upon those young carers and the
25 mental health. What were the key findings that came out

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1 of that survey?
2 A. So some of the key findings were that young carers were
3 reporting that their mental health was worse than before
4 the pandemic. One in four young carers were unable to
5 take any break from their caring role. I think it's 74%
6 young carers felt less connected to others since the
7 pandemic, and 69% of young carers reported that they
8 felt more stressed. One quote from a young carer says:
9   "It's hard to care for someone when I can't care for
10 myself."
11   That's within the survey.
12 Q. To your knowledge, was there a particular group of young
13 carers who were most or more adversely affected by
14 mental health issues during this time?
15 A. I would say that they would all be affected by mental
16 health. I would say particularly those that were caring
17 for someone with a mental health condition or those with
18 an addiction were more —— they were highlighted more,
19 and probably that was one of the areas that we were
20 seeing young carers report on, if they were caring for
21 someone with mental health or addiction issues.
22 Q. Thank you. At paragraph 58 of your statement, I think
23 you highlight that young carers not being in school when
24 they were closed could mean that in some instances, they
25 were missing out on referrals to mental health services;

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1　is that right?

2　A. Yes. Some young carers were saying that actually they

3　had previously perhaps had a referral to CAMHS, child

4　and adolescent mental health services, but we feel that

5　others who would have benefited from it were perhaps

6　being missed during this time, and they weren't getting

7　the referrals that they otherwise would be getting, or

8　additional support within the school that would be

9　happening if there wasn't a pandemic, and they weren't

10　at home.

11　Q. At paragraph 56, I think you also mention school nurses,

12　and I think when schools were open, referrals for

13　wellbeing assessments would be possible, but again, when

14　schools closed, is that something that was off the

15　table?

16　A. Yes, young carers were referred to school nurses ——

17　well, no young carers that had reported to us that they

18　had any referrals to school nurses, whereas within the

19　school, if the young person particularly is going

20　through a bad time, or if they feel they need more

21　support, then they should be having a wellbeing

22　assessment, if the young carer agrees, obviously, but

23　that didn't happen during the pandemic.

24　Q. What coping mechanisms for mental health were available

25　then, given what happened?

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1　A. I would say that they had their local young carer

2　service who did do the check—ins that were available.

3　They had wellbeing boxes. Young Scot provide a local

4　young carer's package where they were able to get —— it

5　used to be in—person, that they could access like

6　in—person discounts, in—person cinema vouchers and

7　things like this. But this moved online, and they were

8　able to access —— sort of like mental health apps, they

9　were able to access subscriptions to —— certain, like,

10　movie subscriptions or music subscriptions, but a lot of

11　the time, they would pass this on to the cared—for

12　person, because they felt that they needed it more,

13　rather than use the respite for themselves.

14　Q. Thank you. Now, moving on then to the lessons learned,

15　I suppose, section of your statement, there was one I

16　specifically wanted to ask you about. At paragraph 84,

17　you identify a lesson to be learned. You say there

18　needs to be more robust data around young carers in

19　school, a more accurate recording of their attendance

20　and attainment. Why do you consider that to be

21　important?

22　A. Because I feel that if more young carers were recorded

23　within schools, if there was more accurate recording,

24　then they could get more support that they're entitled

25　to. Young carers weren't identified during the

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1　pandemic, and I think even those that were recorded in

2　school could have —— should have had more support, so if

3　all education professionals are trained to identify

4　young carers, then they will receive the support they're

5　entitled to. I think stronger working partnerships with

6　the third sector, particularly young carer service in

7　schools, would also provide more support and more young

8　carers being identified .

9　Q. Thank you. Are there any other particular lessons to be

10　learned or things that we haven't covered today that you

11　would like to mention at this stage?

12　A. Just that I think that all children and young people

13　should have access, equal access to digital technology

14　and digital literacy to allow them all to have equal

15　opportunities within education, and increased

16　availability of counselling within schools, because the

17　pandemic was a traumatic experience for them.

18　MR STEPHEN: Thank you. My Lord, I don't have any further

19　questions for the witness, subject to anything you may

20　wish to add?

21　THE CHAIR: No, I have no questions, you'll be pleased to

22　know, Ms Munro. Thank you very much for your attendance

23　and your evidence today, and that brings an end to this

24　session and we'll come back in a short time at 11.15.

25　Thank you all very much.

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1　(10.54 am)

2　　　　　　(A short break)

3　(11.15 am)

4　THE CHAIR: Good morning, Ms van der Westhuizen.

5　MS VAN DER WESTHUIZEN: Good morning, my Lord. Our next

6　witness is Mr Glenn Carter who is the head of the

7　Scotland office of the Royal College of Speech and

8　Language Therapists.

9　　　　　　MR GLENN CARTER (called)

10　THE CHAIR: Very good. Good morning, Mr Carter.

11　A. Good morning.

12　THE CHAIR: Right, when you're ready.

13　　　　　　Questions by MS VAN DER WESTHUIZEN

14　MS VAN DER WESTHUIZEN: Thank you, my Lord. Good morning,

15　Mr Carter.

16　A. Good morning.

17　Q. Could I please ask you to confirm your full names?

18　A. Glenn Alan Carter.

19　Q. You gave a witness statement to the Inquiry and, my

20　Lord, that statement can be found using reference number

21　WT0643. Mr Carter, you say in your witness statement

22　that you're a qualified speech and language therapist

23　and that you have worked in the NHS in Scotland for

24　23 years; is that correct?

25　A. That's correct.

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1 Q. For how long have you been in your current role as head
2   of the Royal College of Speech and Language Therapists
3   in Scotland?
4 A. Two—and—a—half years, almost three years.
5 Q. And immediately before that, you say you led a
6   children's speech and language therapy service in NHS
7   Forth Valley; is that correct?
8 A. That's right.
9 Q. I understand from your statement that the Royal College
10   of Speech and Language Therapists is a professional body
11   representing speech and language therapists in the UK,
12   and it has approximately 22,000 therapists in the UK, of
13   which approximately 1,100 are in Scotland; is that
14   right?
15 A. That's correct.
16 Q. Could I please ask you to outline broadly what the aims
17   of the Royal College of Speech and Language Therapists
18   are?
19 A. Yes. Broadly, the aims of the Royal College of Speech
20   and Language Therapists is to promote the speech and
21   language therapy profession, and to improve the lives of
22   people with communication and swallowing needs.
23 Q. Thank you, and how does it do that? I'll come on to ask
24   you about the role of speech and language therapy but
25   broadly, how does the Royal College do that?

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1 A. It's a number of ways, one of which is professional
2   support, so we develop guidance, tools, resources and
3   training for speech and language therapists. Also, we
4   promote and support quality research and evidence to
5   advance the effectiveness of speech and language
6   therapy, and also policy and advocacy where we seek to
7   influence national and local government to ensure the
8   policy is high quality, mature and that it represents
9   the needs of people with communication and swallowing
10   needs.
11 Q. Thank you. Before I go on to ask you about the role of
12   speech and language therapy in educational contexts
13   specifically, please could you explain briefly what
14   speech and language therapists do more generally?
15 A. Yes, so it's a broad remit. So people talk about it
16   from a cradle to grave service, but sometimes it's
17   pre—birth, where we're supporting new families to
18   understand the importance of speaking to their babies
19   and promoting language development. But right the way
20   up to end of life, where that could be working with
21   cancer patients, stroke, motor neurone disease and
22   everything in between.
23   So speech and language therapists, there is two main
24   areas they work in. There is communication and eating
25   and drinking, which is known as dysphagia. On the

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1   communication side, 20% of the population will
2   experience some level of communication need in their
3   lifetime. That is a very broad range. So for children,
4   it could be around their ability to produce sounds,
5   speech sounds for instance. Traditionally, people view
6   it as difficulties with stammering or lisp, but it's
7   broader than that. So it could be with children, some
8   children struggle to understand and express spoken
9   language, it's as if it's a different language for them,
10   but also there's issues with voice, how they use their
11   voice, and social communication.
12   For adults, there can be acquired neurological
13   conditions that affect communication like stroke, motor
14   neuron disease, Parkinson's, dementia. And on the
15   dysphagia side, eating and drinking, there's one in 17
16   people will experience some level of eating and drinking
17   difficulties in their lifetime.
18   For children, that could be about their ability to
19   suck, to wean, to manage solid foods, sensory issues
20   around that. For adults, again, quite a high proportion
21   of acquired conditions can come with dysphagia. For
22   instance, stroke patients, 50 to 75% of them will have
23   some form of eating and drinking difficulty. And speech
24   and language therapists work in a range of places, so it
25   can be in the home, in nurseries, in schools, care

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1   homes, acute hospitals. Also justice settings as well.
2 Q. Thank you. In your witness statement in particular at
3   paragraphs 11 and then at 16 and 18 to 19, you refer to
4   the importance of communication and spoken language
5   skills for children's development and for longer term
6   outcomes. Could I ask you, please, to spend a bit of
7   time explaining some of what is known about this?
8 A. Yes. Communication is core to who we are as humans, and
9   the important aspect is that —— it is about the ability
10   to connect with others. So when communication is broken
11   down or hasn't developed, then that can cause distress.
12   So that can be a range of issues where either there can
13   be increased behavioural difficulties or challenges with
14   interacting with others, with learning etc. And so the
15   distress can lead to behavioural issues or indeed low
16   mental health and depression.
17   So there's lots of evidence to show that
18   communication is core to children's ability to learn, to
19   their mental health and their future life chances. We
20   know that if children have difficulties with their
21   vocabulary at the age of 5, they are more —— they are
22   three times more likely to have mental health
23   difficulties when they're older. We know that 88% of
24   young, unemployed men have communication needs, and 60%
25   of young people in contact with the justice sector have

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1   communication difficulties.

2   Q. Thank you. At paragraph 11, specifically you refer to

3   the fact that:

4   "If a child has a communication difficulty, then

5   that is likely to affect their ability to learn and

6   access the curriculum, their ability to interact with

7   peers; and to manage and navigate the playground. The

8   impact is wide reaching, and it is important to prevent

9   harm."

10   Would you care to elaborate a little bit on that,

11   please?

12   A. Yes, I think it's important to know how important spoken

13   language is for learning within that context, so it's

14   the foundation on which learning is built. Much of

15   teaching and learning is predicated on language of some

16   degree, whether that's spoken or written language, and

17   therefore children who struggle to communicate in any

18   forms I have described will find navigating the school

19   and the curriculum very challenging. Communication is a

20   dynamic skill. It's one of the most complex skills that

21   humans learn, and therefore being able to make friends

22   and navigate friendships, navigate the challenges of the

23   playground and understanding what's said and what's not

24   said can be quite difficult for children with

25   communication needs.

<div align="center">45</div>

1   Q. Thank you. You've already touched on it in your

2   explanation about the consequences of it, but mental

3   health in paragraph 18, you say:

4   "... is closely linked with communication skills ...

5   also a connection between spoken language abilities and

6   behaviour. All behaviour is a form of communication,

7   and we know when children have communication

8   difficulties, they can become distressed and will find

9   different ways to convey that their needs aren't being

10   met."

11   You say that this is manifest:

12   "... in low mood, disengagement with learning, or in

13   more disruptive behaviours."

14   We'll come on to discuss some of the studies that

15   were undertaken during and just after the pandemic, but

16   is there anything more that you would like to elaborate

17   on on this link between communication skills and mental

18   health?

19   A. I think the nature of communication difficulties is lots

20   of children can go under the radar, particularly if

21   they're not making —— acting out in school or at home,

22   and their mood is quite low, and they just get by and go

23   under the radar. I think the challenge of behaviour is

24   that it can mask a lot of difficulties, so if a child

25   has particularly challenging behaviours, then that's

<div align="center">46</div>

1   what the focus is on, rather than the cause of

2   behaviour, rather than how they're feeling about the

3   lack of contact and connection within the home or school

4   environment.

5   Q. Thank you. I would then like to move on to ask you

6   about the role of speech and language therapy and

7   educational contexts pre—pandemic. If I could ask you

8   first to please explain some of the different types of

9   speech and language communication difficulties that

10   speech and language therapists work with, with children

11   in particular?

12   A. Yes, so in terms of education settings, whether that's

13   nursery or school, there's very wide range of

14   difficulties that can present. So with the... I

15   mentioned speech sound difficulties, some children can

16   be quite unintelligible, and find it difficult to get

17   their point across, which can lead to high levels of

18   frustration and anger. Interestingly, with the speech

19   sounds, that's very closely linked with the ability to

20   read and write, because it's about phonemes and sounds,

21   and so their ability to distinguish between sounds, to

22   process what's being said, and anything that happens

23   within spoken language is translated into written

24   language.

25   There are children with issues such as developmental

<div align="center">47</div>

1   language disorder. I think people understand dyslexia

2   far better than developmental language disorder.

3   Dyslexia is obviously a specific difficulty in reading

4   and writing, whereas developmental language disorder is

5   a specific difficulty in the ability to express and

6   understand spoken language, but it also has an impact on

7   written language. These children, some of them are very

8   good non—verbally, they're good socially, and they're

9   good at copying their peers.

10   So sometimes right up to P3, their difficulties

11   aren't apparent because they get by by navigating the

12   environment, being hypervigilant about what's going on

13   and anticipating what they should do. However, when the

14   attainment levels increase and the demands on them

15   increase, then that's when it starts to become much more

16   difficult for them.

17   So the speech and language therapist will seek to

18   observe children in the context of education, identify

19   what strategy they're using, what strategies would be

20   helpful to navigate the educational context, and also to

21   assess their communication and understand what —— the

22   range of vocabulary that they have, their ability to

23   understand what's being said, can they follow complex

24   instructions or not, and do they understand the nuance

25   of social communication.

<div align="center">48</div>

1 Q. You talk about the types of speech and language
2   difficulties and communication difficulties you work
3   with in paragraph 25, and specifically , you talk about
4   you're assisting children with delayed spoken language
5   skills who present as much younger than they are when
6   they come to school or nursery. You say that there are
7   quite a lot of environmental factors that play a part in
8   that. Would you care to elaborate on that, please?
9 A. Yes, so our members and educators are saying there's a
10   large number of children coming to school with
11   inadequate spoken language skills for learning . That
12   can be presented in lots of different ways, but the
13   reasons for that are complex. I suppose it's important
14   to understand the different types of needs that they can
15   present with. They can present with specific
16   difficulties or difficulties that you might expect a
17   younger child to present with.
18   So those environmental factors are really important,
19   and the pandemic shone a light on some of that. It's
20   around their access to quality interactions , their
21   experience of the world, how high quality adult—child
22   interaction is within the home or within the educational
23   placement. It's a complex situation, but a lot of
24   factors impact the child's ability to learn that
25   language and whether they have been exposed to enough

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1   words or enough high quality words.
2 Q. Thank you, and you also say that you assist children
3   with specific speech and language difficulties where
4   there is a genetic element, and they are born with those
5   needs. What type of needs —— could you give us some
6   examples of what those look like?
7 A. Yes, so there are children who are born with risk
8   factors , whether that's genetic, biomedical,
9   neurodevelopmental. Those children —— sometimes
10   described as disordered, so atypical communication
11   needs, whether that is children on the autism spectrum,
12   attention deficit disorder , speech and language ——
13   sorry, speech disorders, language disorders, voice
14   challenges, disfluency , a huge range of needs.
15 Q. You also say that you work with children who have very
16   high complex need levels —— high level needs where you
17   might have to use augmented and alternative
18   communication. Could you please elaborate a bit on that
19   as well?
20 A. Yes, that's right . There's children who have complex
21   needs, whether that's physical and learning disabilities
22   who are perhaps nonverbal, or who have very limited
23   verbal communication. Speech and language therapists
24   will seek to facilitate their communication to a range
25   of means; that could be low—tech aids which could be

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1   pictures , it could be high—tech aids where children
2   utilise eye—gaze devices, where they can look towards a
3   particular picture and the device will say the word, and
4   high—tech aids where there can be lots of complex
5   programmes on ipads, where children can access through
6   switches or accessing with their finger to touch a range
7   of pictures to get —— communicate their point and their
8   needs and their wants.
9 Q. Thank you. Just continuing in relation to the role of
10   speech and language in educational contexts
11   pre—pandemic, you note at paragraph 7 of your witness
12   statement that speech and language therapists are
13   primarily employed by the NHS, but that most local
14   authorities —— sorry, I'll wait until we get there. You
15   say that they are primarily employed by the NHS, but
16   that most local authorities have a service level
17   agreement to provide SALT services within educational
18   contexts.
19   Could you please just describe how speech and
20   language therapy services are traditionally provided
21   outwith educational settings?
22 A. The traditional model of speech and language therapists
23   would be within community clinic settings, where the
24   families attend the clinic in a central position , and it
25   would be one—to—one therapy where the therapist works

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1   alongside the parent or a therapy partner with that
2   child to identify and support and provide therapy for
3   their particular needs.
4 Q. Could you please then explain how and to what extent
5   speech and language therapy services were integrated
6   into educational settings in Scotland prior to the
7   pandemic?
8 A. This was variable across Scotland and does depend on the
9   level of funding that the local authorities provide, so
10   it 's quite patchy. I would say that the majority of
11   local authorities in Scotland do have a service level
12   agreement with the NHS to provide those services, to
13   provide speech and language therapy in mainstream
14   schools or in more complex special schools. Funding for
15   speech and language therapy is reducing from local
16   authorities and from health boards, actually, which is
17   impacting their ability to provide some of these
18   services in an educational context, and has been
19   reducing for a number of years. So that will affect how
20   consistent or how much speech and language therapy can
21   provide in that context. Sometimes if the threshold
22   resource is not sufficient , then they have to centralise
23   and provide speech and language therapy within a
24   community clinic for instance.
25 Q. Please could you explain what speech and language

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1   therapists do in educational settings, and the different
2   levels of speech and language therapy support that is
3   provided within those settings, and specifically prior
4   to the pandemic, and I think you refer to universal,
5   targeted and individualised therapy. If you could
6   please explain a bit about each of those?
7   A. So we described the traditional form of speech and
8   language therapy. Evidence and practice has moved on
9   from then to show the importance of providing support
10   and approaches for children in the context in which they
11   function, whether that is in the home or nursery or
12   school. That is to acknowledge how key communication is
13   for learning and wellbeing, which —— the key outcome for
14   education, but also to acknowledge that the biggest
15   impact sometimes happens within the education context,
16   so by that, I mean the dynamic and varied environment
17   which children function in, we have to ensure our
18   approaches and our aims are relevant for that child, and
19   that we are working on what's most important for them.
20   What are the barriers to them learning, what are the
21   barriers to them interacting and then participating in
22   an education context.
23   The model which we have described as —— what we
24   should expect is high quality provisions at universal,
25   targeted and individualised. The traditional model is

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1   that whenever there was a concern, it would go straight
2   to the individualised, but what we know from research is
3   how important it is to have the whole environment
4   supported around the child.
5   So universal offers, we know, for instance, if you
6   improve children's vocabulary, you improve their
7   attainment, whether they have communication needs or
8   not. In the context of an early years setting, you
9   would hope that adults are interacting with children in
10   a way that will promote their language development, and
11   not get in the way of that.
12   So that could be universal offer where speech and
13   language therapists can work with early years
14   practitioners to support and promote behaviour change
15   and how they're interacting, and that could be about
16   getting down to the child's level, commenting on what
17   the child is doing, repeating back what the child is
18   saying and adding language to it and avoiding lots of
19   questions.
20 Q. Could I ask you just to pause there, so practically what
21   is the role of the speech and language therapist,
22   compared to the early learning and childcare
23   practitioner, for example? How do they interact to
24   deliver this universal support?
25 A. So in that context, the speech and language therapist is

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1   a facilitator, where they're functioning within the
2   environment. We know how important it is for them to
3   develop relationships and trust to make it feel safe for
4   those practitioners to change their practice, so they
5   will there —— in a coaching and modeling role. We
6   sometimes use video feedback. We video the interactions
7   of the practitioner with the child, and then we spend
8   time dissecting that and discussing ways in which to
9   facilitate communication. So in that context, a speech
10   and language therapist is there to facilitate and
11   promote and develop the skills of the practitioner.
12 Q. Then if you could move on to explain a bit more about
13   targeted, what sort of children would require targeted
14   interventions, and what do those look like in practice?
15 A. So what we would hope is we can meet the needs of quite
16   a lot of children at the universal level. If that's not
17   adequate, then it would move up to targeted level, and
18   that's about giving a bit more concentrated support for
19   a group of kids, perhaps, who require a bit more
20   additional input. Sometimes that can be working with a
21   practitioner to give advice about how to promote the
22   needs of these children.
23   Practically speaking, that could be facilitating
24   group interventions around developing vocabulary, having
25   fun with words, improving their ability to tell stories.

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1   The therapist, again, it's always about building the
2   skill of the people who are there all the time with the
3   child, rather than a therapist who could be coming in
4   once a week or once every three weeks, and if that's not
5   adequate at a targeted level ——
6   Q. Before you move on to the individualised, could you
7   please just describe some of the communication, speech
8   and language issues that would require targeted
9   intervention?
10 A. So the type of difficulties you may come across are
11   children who have got a very limited vocabulary. They
12   have got —— they use perhaps very general words rather
13   than specific words to get their point across. The use
14   of verbs is very important. That's the core of a
15   sentence. So if they're using very general purpose word
16   verbs like "doing", it makes it very difficult for them
17   to get their point across. So it's about expanding
18   their vocabulary of nouns, but also verbs, and being
19   able to help them structure a story in such a way that
20   they can communicate it in a well and complex way, which
21   will then support their reading and writing in later
22   years.
23 Q. That targeted —— that type of targeted support, would
24   that be for a group of children?
25 A. Typically, it's a group of children who require more

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1 than the universal offer, or in addition to the
2 universal offer. So those children can have identified
3 needs of specific speech and language difficulties, or
4 they could present with communication needs that are
5 behind what we would expect for their age.
6 Q. Then if I could ask you to move on to discuss the
7 individualised support?
8 A. So the individualised support in the context of an
9 education could be the speech and language therapist
10 comes in, observes the child in the real context, works
11 out how they're interacting, if there's any barriers to
12 their ability to participate fully in that setting,
13 meeting with their key person, or with the teacher, and
14 giving advice and strategies about how to promote that
15 child's communication in that context.
16 Sometimes that requires individual assessment where
17 the child is seen by the therapist. They provide
18 standardised assessments to work out even what their age
19 equivalent is on comprehension or expression, and then
20 using all of that information to develop a plan in
21 partnership with educators, to see how do we promote,
22 what aims are we going to be working on for these
23 individual children. They're the children who require a
24 bit more specific attention. Perhaps their needs are a
25 bit more complex, and it needs a coordinated approach.

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1 That could also involve actual therapy about
2 identifying what the need is, and providing support, so
3 an example of that would be colour—coding sentences to
4 be able to understand what needs to be in a sentence,
5 whether that's the subject, the doing word, the verb and
6 the where and the when. And we can do that in lots of
7 fun ways, which includes signing, colour, and a huge
8 range of activities which promotes children's
9 communication. It should feel fun to the child.
10 Q. Is that delivered one—to—one; is that delivered to an
11 individual child?
12 A. That's right. So some of those interventions I've just
13 described could be delivered even at a whole class or at
14 a small group, but also at a one—to—one, but the
15 children one—to—one perhaps need a bit more focused
16 attention, more regular input, more reinforcement or
17 differentiation for those activities.
18 Q. In terms of embedding of speech and language therapy
19 within educational settings, what are some of the
20 benefits of doing that?
21 A. This is —— having done this for many, many years, the
22 key to embedding these type of approaches where people
23 feel empowered to support and promote spoken language,
24 it's all about getting the speech and language therapist
25 in the context regularly and building up relationships

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1 with teachers, with early years practitioners. So
2 you're working alongside them, you're able to have those
3 conversations in the staff room, those corridor
4 conversations where you check in with each other and
5 you're building trust.
6 So the therapist is learning from the educators, the
7 educators are learning from the speech and language
8 therapist. So it's not about giving the educators more
9 work to do. This is about everybody's business to
10 promote spoken language, and the therapist is there as a
11 facilitator and, yes, to provide quality provisions at
12 all the levels we've described, but it's the
13 relationships and the trust that's key that supports the
14 effective development of children's communication.
15 Q. Thank you. You've already touched on and suggested that
16 it's not consistent or that provision pre—pandemic was
17 not consistent across Scotland prior to the pandemic
18 especially in relation to education settings.
19 I think in your witness statement, you talk about
20 some of the reasons why it was not consistent, and you
21 talk about depends on funding available. You also talk
22 about recognition in an Equity for All report that
23 highlighted this variability. Could you please
24 elaborate on some of the reasons for that variability
25 and what was recognised in terms of this lack of

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1 consistency pre—pandemic?
2 A. Equity for All was a report commissioned by the Scottish
3 Government, where for the first time in the world that
4 we know, we were able to map the needs of a country, and
5 so because we have got high quality prevalence data, we
6 are able to map the need across Scotland, align it with
7 local information about deprivation, et cetera, and able
8 to demonstrate that there's 275,000 children with
9 predicted communication needs in Scotland.
10 That report was able to demonstrate that for the
11 areas of highest need in Scotland, there was the lowest
12 level of speech and language therapy resource. It also
13 identified that the —— there was areas where speech and
14 language therapy provision was inadequate to meet the
15 needs of the population of that local area.
16 So that points to postcode lottery, if you like, in
17 terms of the level of support and provision in place
18 across Scotland, and where the resource should be
19 positioned. So there's definitely inequity across
20 Scotland, there's inequity in terms of funding from
21 health, but also local authorities in terms of level of
22 funding, and the funding —— the transformation and
23 working that way is important, but you need a threshold
24 resource to be able to do that.
25 So where the resource isn't available, it forces the

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1　hand of the service to centralise speech and language
2　therapy, and perhaps bring it towards community clinics
3　and be working in a more isolated way than a more
4　integrated way, which is where the research and practice
5　suggests it should be delivered.
6　Q. Just in relation to differential service provision, you
7　also refer in paragraph 21 to the fact that there was
8　pre—existing inequality which was exacerbated by the
9　pandemic. We'll come on to discuss the impacts of the
10　pandemic. But you say:
11　"... in respect of the level of provision provided
12　in areas of socioeconomic deprivation, ie, areas with
13　the highest need have the lowest level of speech and
14　language therapy resource available. Families living in
15　poverty really struggle to access services where they
16　have to travel distances or to pay for that travel.
17　This is another reason why it is so important that
18　speech and language therapists can work where children
19　are situated."
20　Would you care to expand on that pre—existing
21　inequality? Is there anything to add to what you have
22　in there?
23　A. I think the very concerning element of this is that we
24　should be providing the highest quality support for
25　those in greatest need, and typically families living in

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1　poverty are one of those groups, and our concern is that
2　even pre—pandemic that was not the case. We weren't
3　able to provide that high quality service for the most
4　in need, and people living in poverty find it very
5　difficult to get to particular central places, or to get
6　to buses or to engage in speech and language therapy to
7　follow it up, given how stressful their lives can be,
8　and the impact of lack of income to be able to support
9　that type of approach. So that just underlines the
10　challenges we are facing from pre—pandemic.
11　Q. Further in relation to inequalities pre—pandemic, at
12　paragraph 15, you talk about:
13　"There were inequalities for children and young
14　people with speech and language difficulties
15　pre—pandemic."
16　You say:
17　"One of the most prominent inequalities relates to
18　delays in spoken language skills."
19　You referred to a Scottish study finding that 50% of
20　children who start school present with inadequate spoken
21　language skills.
22　You go on:
23　"As a speech and language therapist I observed
24　children who were 15 to 18 months behind their peers in
25　respect of these skills. From the very beginning, these

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1　children have to play catch up."
2　Was that pre—pandemic?
3　A. That was pre—pandemic. That study is actually quite
4　old. It has been refreshed recently but it points to
5　something our members and educators are saying, that
6　this was in place. We were seeing a lot of children
7　coming to school with inadequate spoken language skills
8　for learning, and well behind what you would expect for
9　children of that age.
10　So even before the pandemic, you would experience
11　some children coming to school with very, very little
12　spoken language, and therefore struggling to catch up
13　with their peers and to try and close that gap.
14　Q. Were there any particular groups of children manifesting
15　in these difficulties?
16　A. Yes, typically it's the children living in poverty,
17　areas of social deprivation, that were presenting with
18　more of those spoken language difficulties pre—pandemic.
19　Q. Is it known what the reasons for those difficulties are?
20　A. Yes, so that is related to their exposure to new
21　experiences, the level of interactions, the exposures to
22　words, their access, or how consistent their access was
23　to early years placements prior to coming to school, and
24　the stress that the families were experiencing at that
25　point.

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1　Q. Thank you. Could I then ask you just to explain briefly
2　the role that health visitors play in identifying and
3　referring children to speech and language therapy
4　services, please?
5　A. Yes, health visitors have a very important role in
6　identifying need. They get alongside families and visit
7　them regularly, and they measure a number of areas of
8　child development and identify communication needs.
9　Quite often they are the first port of call. Speech and
10　language therapy receives a lot of requests for
11　assistance or referrals from health visitors for
12　children who they're concerned about who aren't meeting
13　their milestones. So they have a very important role.
14　Q. You also explain —— well, perhaps you can explain how
15　important it is —— early identification is of issues in
16　relation to speech and language, and how important that
17　is for long—term outcomes or successful outcomes?
18　A. Yes, the identification early is critical. It's
19　different from —— for a child to develop, you get the
20　most development in the early years. The first 1,000
21　days, the first three years of a child's life are
22　particularly important for that language development.
23　If you get in early, it's far more effective, there's
24　more development, it saves money in the long—term, and
25　the children, you know, in terms of long—term outcomes,

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1   communication needs are critical.
2   So if you don't get that development and
3   improvement, then they will find it very difficult to
4   interact with others, to engage in nursery or school,
5   and be able to —— ultimately, I think there's sometimes
6   a thinking that if we close the gap at a certain point,
7   that gap will stay closed. However, the research does
8   demonstrate that you need to keep engaging with those
9   children to maintain improved communication throughout
10   their school career in order to achieve positive
11   outcomes.
12 Q. So you have identified the importance of health
13   workers —— health visitors, but what if any role are you
14   learning that childcare practitioners and teachers play
15   in identifying and referring issues in relation to older
16   children?
17 A. Yes, I think we get a lot of requests for assistance,
18   and they see these children very often, and will refer
19   them to speech and language therapy. They get to see
20   them in context, they get to see how they're functioning
21   with their peers, and whether they're able to interact
22   with adults otherwise, and they are therefore also very
23   important in identifying need early.
24 Q. Thank you. Mr Carter, I would like to move on now to
25   discuss the impact of pandemic restriction measures,

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1   including the closure of early learning and childcare
2   settings and schools on the provision of SALT services.
3   We've just touched on health visitors, but could you
4   please, if you can, give an indication of to what extent
5   disruptions to health visitor assessments and newborn
6   hearing screening impacted on early identification of
7   speech and language difficulties during the pandemic?
8   A. We know the health visitors struggled to access families
9   during the pandemic. They will have had fewer
10   appointments. They had to move to remote offers,
11   telehealth offers, which led to fewer appointments and
12   incomplete data. Therefore, as the first port of call,
13   the fact that they didn't have access to families meant
14   that we weren't identifying children early, and there
15   was a significant dip in requests for assistance at one
16   point during the pandemic because of that.
17 Q. In relation to health visitors, you note in paragraph 22
18   of your statement that they noted a significant spike in
19   around 27 to 30—month mark that was concerning and that
20   this was also observed in Public Health Scotland data.
21   Could you please explain in a bit more detail what was
22   observed and why it's concerning?
23 A. Public Health Scotland produced a few excellent reports
24   on this. They monitor health visitor data. Health
25   visitors engage with children across their development,

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1   including 13 to 15 months and 27 to 30 months. They
2   noticed a significant peak in concerns about
3   communication. Now, health visitors monitor many areas
4   of child development. It's important to know that
5   pre—pandemic, communications was the highest area of
6   concern anyway, sitting about 10% of that 27 to
7   30 month. From January 2021, Public Health Scotland
8   noticed a significant increase compared to pre—pandemic
9   levels. This peaked in August 2021 and actually has
10   remained above pre—pandemic levels until now.
11   This is particularly concerning because the area ——
12   the time that these children are being assessed, this is
13   a critical time for children's language development, and
14   so Public Health Scotland noticed it, and were flagging
15   it up as a concern, and health visitors were saying they
16   were seeing far more of these children. The area
17   where —— the most concern was communication.
18   Interestingly, you can differentiate between
19   children in the highest areas of deprivation versus the
20   most affluent areas. For those in the highest areas of
21   deprivation it was sitting about 20% plus along that
22   timeline, and for more affluent areas it was sitting
23   about 7 or 8 or 9%. So there's a significant different
24   between the two.
25 Q. And again, what were some of the reasons for the spike

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1   and that differential again?
2   A. So the reasons are complex. I suppose if we go back to
3   the different types of children that we have, we've got
4   the children who were born with risk factors, with
5   communication needs; we've got the other children who
6   have socioeconomic disadvantage. The first children
7   with specific communication difficulties what we've
8   noticed is that having come to services, speech and
9   language therapists and educators, they're noting far
10   more complexity of need, and they are noting that these
11   children have experienced more harm, struggling with
12   their mental health, struggling to engage with
13   education, and that will have been because of the lack
14   of access to the services.
15   The other children with socioeconomic disadvantage,
16   the research seems to be showing that the reasons for
17   that peak was because of seeing fewer —— their world has
18   become much smaller, they were seeing fewer of their
19   family members and friends, and therefore interacting
20   far less. They also weren't experiencing the world.
21   Learning language is a dynamic process where you need to
22   experience different parts of the world. Going out to
23   see stuff, seeing animals etc helps develop vocabulary
24   and also lack of access to education. I think the very
25   significant point here is that stress has had a

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1 significant impact and points to why we saw the spike.
2   For families during the pandemic they were
3 experiencing much higher levels of stress, they were
4 struggling with home schooling, home working. They
5 found it stressful to manage all the demands,
6 particularly around economic demands. We know that more
7 people went into poverty, and when you consider even at
8 a baby level, what you're hoping to see is a mother or
9 father being responsive to the babies. The baby makes a
10 noise, babbles, smiles, and it's called serve and
11 return, where you try and have good quality
12 interactions.
13   We know when families are experiencing stress that
14 that serve and return and the opportunities for those
15 types of interactions is reduced significantly. Those
16 serve and returns at baby levels is really important for
17 activating the baby's brain to ready themselves for more
18 communication and future development.
19   We can scale that up to the peak that we saw around
20 toddlers. Again, it's important about this adult—child
21 interaction where they have high quality interactions at
22 home and wherever they are, and so —— there's good
23 quality research to show that actually at the
24 conversational exchanges, there should be a significant
25 number of them per hour. So there's some research which

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1 suggests that the optimal number is about 40 per hour.
2 Now, it can be more than that, it can be less than that,
3 but around 40 is the optimal range for promoting
4 language development.
5   If that is very, very low, so 5 and below, that is a
6 very serious issue where children are in language
7 deprivation and will find it very difficult to develop
8 the skills that they need in future life.
9   So I think stress is a very important factor in all
10 of this. We're still seeing it. Families are still
11 experiencing very significant levels of stress, but that
12 impacts families' ability to play, talk, read, sing with
13 their children. These are all things that help promote
14 language development.
15 Q. Thank you. We'll go on in a moment to speak about
16 redeployment of speech and language therapists in
17 Scotland, but if we could just pause to discuss some of
18 the other observed increases in speech and language
19 difficulties that were observed. So please could you
20 explain some of the additional increases in speech and
21 language difficulties that were observed? You discuss
22 these at paragraphs 22 to 28 of your statement. You
23 discuss there some of the surveys that the Royal College
24 of Speech and Language Therapists conducted.
25 A. So in addition to the Public Health Scotland evidence,

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1 we provided —— we did a survey with Early Years
2 Scotland, where they support early years practitioners
3 working in nurseries across Scotland. We had 245
4 responses to that survey and 89% of respondents said
5 they had seen an increase or a significant increase in
6 the numbers of children with communication and the
7 complexity in which they presented.
8   They also highlighted the impact that was having on
9 children, so they said: it's impacting their ability to
10 participate, to make friends, to learn. They're seeing
11 more behavioural issues because of it, and more
12 challenges with the children's mental health and
13 wellbeing.
14   So —— and anecdotally, we have heard from our
15 members and teachers that they were seeing a very
16 significant number of children coming to school who have
17 very little language, if any, at the P level, and
18 they're raising high levels of concern about that.
19 Q. Thank you, and just some of the reasons for these
20 increases, I think probably mirrors some of what you
21 have already discussed, but you discuss those at
22 paragraphs 25 to 27. You attribute these changes that
23 have been seen to factors such as reduced opportunities
24 for interaction and exploration, decreased access to
25 critical services like education and speech and language

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1 therapy, and challenges experienced by families,
2 although some of the challenges and issues you have
3 already described in relation to ——
4 A. Yes, I think so. The one thing I would add to that is
5 that the lack of —— we know that education and the
6 opportunities to play and engage and play alongside
7 children are very important for child development within
8 the education context.
9   Now, within the education context, they still need
10 to experience regular interaction with others and that
11 conversational exchange in order to make it —— promote
12 their language development, but if they do experience
13 that, that could be a very good thing for their language
14 development.
15 Q. I think you have already touched on it. Presumably some
16 of these needs would have been experienced regardless of
17 the pandemic in relation to certain children, and I
18 think you've already indicated that the consequences of
19 the impacts of the pandemic are that some of these are
20 more complex that you're seeing, that maybe would not
21 have been as complex but for...
22 A. Yes, I think the pandemic exacerbated an already urgent
23 need around children's communication. Even the data
24 around health visitors at 27/30 month, which will
25 underrepresent those with communication needs that

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1   become more apparent later on, but in areas of
2   deprivation, we are seeing double levels of concern in
3   those areas.
4 Q. And why are they more complex?
5 A. So some of the needs are more complex because ——
6   because —— so for children with —— who were born with
7   some of these risk factors, environmental factors also
8   affect them, so if they haven't had exposure to all of
9   the things we have discussed, they will experience more
10   challenges and more complexity. I think the complexity
11   comes from having not had access or having to wait for a
12   long time to access services. So, if you like, for want
13   of a better word, if they haven't had support that they
14   needed or quality advice, then the level of harm will
15   have increased, and therefore the complexity will have
16   increased in those needs over that time.
17 Q. Thank you. If we could then turn to discuss the issue
18   of the redeployment of speech and language therapists in
19   Scotland, which you discuss at paragraphs 29 to 34 of
20   your witness statement. Could you please describe the
21   extent to which speech and language therapists were
22   redeployed to other healthcare roles during the
23   pandemic, and how this impacted on the provision of
24   services for children and young people?
25 A. Yes, the redeployment of speech and language therapists

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1   was variable across the country. Most services did have
2   an element of redeployment. Some were almost stopped
3   entirely and switched to adult services. They had ——
4   they were redeployed into a range of roles. It could be
5   vaccination clinics, it could be intermediate care, it
6   could be acute settings. Depending on the skills of the
7   speech and language therapists, they could use their
8   eating and drinking skills in an adult setting, an acute
9   setting, although there was obviously anxiety around
10   that.
11   Some were deployed as nurse auxiliaries into adult
12   services to prepare for what we saw coming in with the
13   pandemic, and I think most services maintained some
14   level of offer for the most urgent requests, and by that
15   I mean eating/drinking. So the child —— if there was
16   concern about a child choking, or not managing liquids
17   or solids, then they would be able to go and see those
18   children, so we maintained that level as a core offer.
19   Now, that was challenging, because we know that some
20   of those children tended to have more complex needs or
21   physical and more vulnerable, and therefore were
22   shielding, so therefore parents had anxiety about
23   someone else coming into the home or going to a central
24   hub but, you know, speech and language therapists
25   navigated that. So speech and language therapists,

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1   there's a lot of redeployment out of children services
2   into adult services at that initial time.
3 Q. And what was the reason —— what were the reasons for
4   that redeployment?
5 A. The reason we think is —— well, initially we didn't
6   really understand COVID. We had some level of
7   understanding that it affected adults more than it
8   affected children, and therefore there was decisions
9   made locally to redeploy staff to ready the system. So
10   the system didn't collapse, if you like. So I think the
11   reasons in part are —— in that they deprioritised
12   children's services and didn't foresee perhaps the
13   impact it would have on children.
14 Q. How did the Royal College of Speech and Language
15   Therapists view the decision to redeploy therapists, and
16   did that change over time?
17 A. Initially, given the lack of understanding about this,
18   the Royal College wanted to be supportive and therefore
19   were supporting our members in terms of redeployment and
20   were open to that. I think after time what we were
21   hearing from the members was that their skills weren't
22   being fully utilised. They are highly qualified,
23   they've got lots of skills in which they could be
24   utilised, but —— and also concerns from our members
25   about the harm that would be occurring for the people

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1   that they normally serve.
2   And so at that point, once the initial phase is over
3   and we were hearing feedback from the members, that was
4   when we were encouraging government to bring those
5   speech and language therapists back to their core roles
6   to be able to serve the children and young people's
7   communication and swallowing needs.
8 Q. We'll touch on a bit later about the long waiting times
9   that we're seeing now, but to what extent did this
10   redeployment contribute to the increased waiting times
11   that you described later in your statement?
12 A. Given that it was variable across Scotland, but
13   typically I would say it had a very big impact on having
14   to pause the majority of services, and therefore we
15   weren't able to reach families, had a very significant
16   impact on waiting times. There's other aspects of that
17   that would have impacted waiting times, but the
18   redeployment will absolutely have caused a pause and
19   therefore a back—up of need.
20 Q. Thank you. I think you have already touched on this,
21   but what types of speech and language services for
22   children and young people continued to be delivered in
23   person, and how were they delivered? I think you
24   mentioned highest priority was given to people with
25   complex needs, and you mentioned going into homes. What

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1   was the full sort of range of face—to—face?
2 A. So the face—to—face offer, depending on where we were in
3   the pandemic, the key thing that we tried to maintain
4   was that offer of eating and drinking, because whilst we
5   could do some telehealth on that, it's important to get
6   close to the child and to hear and observe and to touch
7   to check on their swallowing, because that is such a
8   critical area and high risk. Other offers were
9   telehealth. Now, it depended on how well set up
10   services were, whether they had access to IT, ipads.
11 Q. Was that face—to—face or was that ——
12 A. Sorry, so, no, so most of the face—to—face stopped,
13   depending on where we were in the pandemic, as it opened
14   up, we would prioritise some face—to—face that needed to
15   happen. That could be around speech and sound
16   difficulties, so the highest need of kids who were
17   really struggling that needed therapy as soon as
18   possible, but the lack of face—to—face will have
19   affected how effective the interventions were and
20   therefore how quickly we were able to promote
21   improvement.
22 Q. And then you mentioned telehealth; could you please
23   describe that and some of the other remote offerings
24   that were provided?
25 A. So telehealth obviously is reliant on both sides having

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1   access to IT equipment. Now, some areas in Scotland for
2   speech and language therapy services, they didn't have
3   access for a very, very long time, which obviously
4   impacted their ability to provide telehealth, which
5   basically is the family on one side, you on the other
6   side, and you can do a bit of assessment with the child
7   if they're of an age. You can observe the child, you
8   can promote, you can coach and model —— well, you can
9   coach the parent.
10   So the therapists were —— very quickly adapted to
11   that, provided lots of high quality —— as high quality
12   as they could approaches and interventions remotely, if
13   they had the IT equipment. The challenge would be on
14   the other side as well, whether the families had access
15   to wi—fi or the adequate IT equipment to facilitate
16   that, and that wasn't always the case.
17   So telehealth was an offer which we rapidly moved
18   on. We also relied on phoning all staff —— all the
19   people on the case loads to talk to the parents and give
20   advice and strategies and reassurance, but also we
21   had —— typically a lot of the services had good social
22   media presence, and the demand for that increased
23   significantly during the pandemic with the parents keen
24   to access high quality advice and strategies for their
25   child, to be signposted to good resources online, and

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1   speech and language therapists spent a lot of time
2   developing videos and signposting to the best
3   information online that they could offer at that point.
4 Q. Thank you. You mentioned sort of the issue of whether
5   or not parents were able to access because of digital
6   inclusion issues. Was there any evidence of literacy
7   levels and language skills of parents impacting on their
8   ability to access services, specifically speech and
9   language services, for or on behalf of their children?
10 A. Well, I only have anecdotal evidence about that. We
11   know, however, that parents with literacy difficulties,
12   but also parents with communication difficulties,
13   because quite often it's an intergenerational cycle of
14   parents with communication needs and their children with
15   communication needs so the —— sorry, I have lost my
16   train of thought, what was that?
17 Q. It was about whether there was any evidence for literacy
18   levels and language skills of parents impacting on their
19   ability to access support, and you were mentioning the
20   intergenerational issues?
21 A. Yes. So literacy difficulties absolutely impact
22   people's ability to engage with services, as does
23   communication needs as well as poverty as I have
24   mentioned before. But I only have anecdotal evidence
25   that that could be a challenge, but also families with

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1   additional language who —— we did have access to
2   interpreters during that time, and utilise them and try
3   to facilitate three—way conversations. It's additional
4   organisation, but it is possible, but made it a bit more
5   complex to ensure that those families' needs were being
6   met.
7 Q. And again, just in terms of, when you were describing
8   the in—person continuing and that being for the highest
9   priority being given to ones with complex needs, what
10   sort of priority level were these other offerings, these
11   remote offerings being delivered to? Was this available
12   to everyone, or was there an order of priority?
13 A. So for services who were able to maintain a certain
14   level of resource and who weren't redeployed and had to
15   pause significant aspects, it was an offer to all those
16   parents and families. For those who had less of an
17   offer or resource, then they did need to prioritise
18   which families they reached out to. Some weren't able
19   to prioritise very many children at all, because they
20   didn't have the resource available, but typically, there
21   were —— interestingly I think sometimes in the initial
22   stages, the parents felt that there wasn't a service ——
23   just assumed that there wasn't a service available, so
24   they weren't reaching out, and therefore it was
25   imperative that the speech and language therapy services

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1   reached out to them and made it —— aware on social media
2   if there was an offer, and what that offer was.
3 Q. Thank you. If we could turn now to discuss briefly the
4   impacts on mental health and wellbeing. In paragraphs
5   37 to 39, you discuss a number of surveys that were
6   carried out during the pandemic that asked specifically
7   about impacts on children and young people in relation
8   to mental health and wellbeing. That was as a result of
9   a reduction in speech and language therapy. I think
10   these were ones that were conducted by the Royal College
11   of Speech and Language Therapists. What are the ——
12   could you please outline the concerns that were
13   identified by or on behalf of children and young people
14   in relation to these impacts on mental health and
15   wellbeing, and also explain what the connection is with
16   the reduction in speech and language therapy services?
17 A. I think —— we've got very high quality research to show
18   the connection between children's vocabulary, for
19   instance, or communication, and mental health and future
20   life, but also the mental health at the time. These
21   were snapshots, so they're small surveys, but we did
22   survey parents just to ask about the impact.
23   We know from some of those surveys that 1% had
24   experienced telehealth prior to the pandemic; 87% said
25   they received less speech and language therapy during

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1   the lockdown, during the pandemic; and 63% said they
2   didn't receive any specialist level speech and language
3   therapy or any speech and language therapy at all.
4   Now, it depends on your interpretation of what
5   speech and language therapy is, because some elements
6   were continuing within educational placements that were
7   reopening. However, in terms of the mental health, when
8   we asked parents the impact of not receiving speech and
9   language therapy, there was a few things they
10   identified. They identified there was an impact on
11   children's ability to make friends, their ability to
12   access education when they were there and on their
13   mental health. We also had surveys for our members who
14   were identifying high levels of concerns of children not
15   accessing speech and language therapy on the children's
16   mental health and their behaviour which is all
17   connected.
18   So in terms of the connection, it's multifactual. I
19   suppose what we see is that there's an element of what
20   speech and language therapy do to reassure parents (a)
21   that they're doing the right thing, or to provide real
22   solutions to adapt the environment, the home
23   environment, and to promote spoken language, so parents
24   can see improvement.
25   When the parent is anxious and has poor mental

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1   health, that obviously influences the child as well, but
2   if the child doesn't have the right strategies and
3   advice, whether that's at home or in school, and they
4   experience those barriers and the disconnect in terms of
5   relationships, then what you see on the surface quite
6   often is behavioural difficulties, and some children
7   will give up, if you like, in terms of learning and then
8   find other ways to engage and get attention.
9   So that's the sort of connection, and so speech and
10   language therapists were there to unlock some of the
11   challenge, to understand the communication and to know
12   what works to facilitate that need. Sometimes that
13   involves improving the communication, sometimes that's a
14   strategy which can support the child to flourish in the
15   environment that they're in.
16 Q. Thank you, and I think you say at paragraph 37:
17   "One of the surveys carried out by the RCSLT asked
18   questions about this issue. The key pieces of
19   information that respondents shared with us were around
20   the impact that the loss of speech and language therapy
21   had on social life and friendships for children and
22   young people, followed by access to education, then
23   impact on home and domestic life, and finally, their
24   mental health."
25   Again, all tied presumably to the loss of speech and

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1   language therapy?
2 A. That's right.
3 Q. Then you go on in paragraph 38 to say:
4   "In the same survey, we also asked a question about
5   the impact on the family more broadly..."
6   So was this not just specifically on the children
7   and young people?
8 A. I think this points to the issue that when there's ——
9   one of your children is struggling and one —— in a
10   significant area of their life, parents instinctively
11   know how important communication is, and they worry
12   about their child's communication. It's the one area
13   they seem to worry about most, and that's because of
14   what I've talked about, how important it is in terms of
15   connection, expressing love and their hope for the
16   future.
17   And so more broadly, when we're asking questions
18   about this, parents will quite often mention about: this
19   is having a big impact on our family, on how we
20   function, how we access —— what we decide to do and what
21   we decide not to do; and the stress of a child accessing
22   education.
23 Q. Then in the next paragraph at 39, you talk about a
24   survey done in 2020 where you surveyed your membership
25   to ask them about the impact of the pandemic and

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1   lockdown on children and young people with communication
2   needs. So was this asking similar questions but of your
3   membership of the practitioners?
4   A. That's right.
5   Q. You say:
6   "The respondents to this survey noted deteriorating
7   mental health and an increase in challenging
8   behaviours."
9   So again, similar to what were being reported by the
10   parents and children and young people themselves?
11 A. That's right, yes.
12 Q. You also mention:
13   "The respondents also raised concerns about barriers
14   to accessing services; about the deterioration of
15   communication skills and swallowing needs; and an
16   increase in safeguarding concerns."
17   What were those specific concerns in relation to
18   safeguarding, if you can remember?
19 A. Yes, I think this —— I am assuming this relates to
20   isolation of families, where there's safeguarding
21   concerns. It's a general reflection on the concern of
22   what would be happening with children who were not able
23   to get access to public services or schools or
24   education, but I don't know specifically about the
25   detail of that.

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1   Q. If we could then move on to discuss the issues around
2   schools reopening and operating with restrictions. When
3   education settings reopened with restrictions, what
4   access did speech and language therapists have to
5   children, and —— probably thinking more about the ones
6   where the services were embedded in schools and then
7   separately ones where they weren't.
8   A. So again this was variable across Scotland. Different
9   local authorities interpreted the guidance differently
10   and interestingly it would seem that those services who
11   were more embedded pre—pandemic and had a close
12   relationship and were viewed as a core member of the
13   team got access to education far quicker than those who
14   were seen as an external agency who were kept away from
15   education settings. So for services where there's
16   established relationships they got on very, very fast,
17   or reasonably fast, and then for those who weren't or
18   didn't have as close a relationship, then it could be
19   many, many months before they got anywhere near an
20   educational placement and that was a concern for us.
21 Q. And just in terms of the concern, was that in relation
22   to impacts of children not being able to access those
23   services?
24 A. Yes, that was in relation to knowing how important
25   partnership working is in a multidisciplinary approach

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1   to meet the needs of children and to ensure that
2   children are accessing the highest quality services and
3   overcoming barriers and so it's about the connection and
4   how important communication is for children to access
5   educational establishments and deliver on the outcomes
6   that you would hope them to achieve in the education
7   setting.
8   Q. In terms of some of the practical challenges, you
9   discuss at paragraph 42 challenges that the use of
10   personal protective equipment had for speech and
11   language therapists and their ability to do their job
12   and you also outlined some of the difficulties or
13   tensions that arose in relation to guidance and
14   different guidance for health practitioners and
15   educators, if you could please just elaborate a little
16   bit more on some of those concerns and challenges?
17 A. Yes, obviously there was different guidance for health
18   professionals versus education and so what our members
19   found was that as a health professional you had to
20   follow guidance which is far stricter, which you might
21   expect, but that given that they were working in an
22   education context, that meant that they were going in
23   with full uniform, sometimes full PPE, apron, mask,
24   gloves, compared with their education colleagues who may
25   be wearing a mask, for instance. So this actually

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1   caused some tension and anxiety on both sides where
2   educators were wondering why the health staff were
3   wearing so much PPE and they weren't and also from the
4   health staff feeling, this felt like a barrier to the
5   job they were trying to do. In part it was reassuring
6   to educators that our members were supporting education,
7   to explain that we were being careful, we weren't
8   visiting too many places or one if at all before coming
9   to their educational placement but the fact that there
10   was different guidance and speech and language therapy
11   in this position where they straddle health and
12   education, it became a barrier and got in the way of our
13   partnership working when we did manage to get back into
14   education.
15 Q. And were there any discussions around that at the time?
16 A. Locally there was, as far as I can tell, and having
17   engaged with lots of speech and language therapy leads,
18   they had local negotiations. Some of the local
19   authorities took a harder stance and others negotiated,
20   so it was about trying to come up with a pragmatic
21   solution. But also you're trying to manage the anxiety
22   of staff on both sides so that was a tricky situation to
23   be in but, yes, I would say there was quite a lot of
24   local negotiations on that.
25 Q. Thank you. I think if we could then turn to look at

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1   some of the ongoing impacts and you mentioned
2   specifically at paragraphs 43 to 47 increased waiting
3   times for speech and language therapy post pandemic.
4   Could you please explain a little bit more about that
5   and in particular what the current waiting times are for
6   speech and language therapy for children in Scotland?
7   A. We started to hear anecdotally that the waiting times
8   for speech and language therapists were very high and so
9   therefore in May 2023 we sent a comprehensive freedom of
10   information request to all services in Scotland. At
11   that point the information came back demonstrating that
12   there were 6,503 children waiting for speech and
13   language therapy. The average wait at that point —— the
14   average longest wait for the initial contact with a
15   therapist if they needed it was one year, one month; the
16   average longest wait at that point if they needed
17   therapy was one year, five months. Now, that —— we also
18   asked for data across the last five years which allowed
19   us to demonstrate the increased wait during that period
20   so we were able to show that the wait over the last five
21   years for initial contact for speech and language
22   therapy had deteriorated significantly and had decreased
23   by eight months in those last five years. For wait for
24   therapy it increased significantly and the average
25   longest wait had increased by ten months over those last

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1   five years. So the wait was very significant and we
2   refreshed some of that, that data in May 2024. There
3   are more children waiting for speech and language
4   therapy now, 6,727, and —— the waits are variable though
5   so in some areas they could wait for 12 weeks, in some
6   areas it's more than 3 years, but for the data we have
7   most recently, the longest wait was over six months for
8   50% of the health boards in Scotland. And the reason
9   that is very significant, which I alluded to earlier, is
10   that for children's development that level of wait it's
11   like a lifetime because they're doing so much
12   development during that period compared with an adult
13   waiting for something similar so that is a particular
14   concern because they're not getting the support they
15   need and they're developing or should be developing
16   rapidly during that period.
17   Q. Thank you. And just you've touched on it, or some of
18   the reasons, but what is contributed to this increase in
19   waiting time?
20   A. I think what's contributed to the wait is that services
21   were paused, for some services that was a significant
22   wait, speech and language therapists were deployed, it
23   was harder to get to children face—to—face so actually
24   progress for children and therefore throughput, if you
25   like, was delayed and restricted. In addition to that,

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1   we have got recent freedom of information requests to
2   show —— to give us insight into the capacity in the
3   system for Scotland to deal with this number of
4   children, so we know that the increase in speech and
5   language therapist headcount in the last five years has
6   increased by 2% in Scotland, but compared with the rest
7   of the UK, the rest of the UK have increased the
8   headcount of speech and language therapists on average
9   by 15%, so the capacity in Scotland is a concern and
10   shows, we're able to highlight, that also will be
11   affecting how quickly we can get to children and meet
12   their needs.
13   Q. And again you've touched on this already but given what
14   you have already told us about the impact of the
15   pandemic on restrictions on children's communication and
16   language skills that have already been observed and how
17   important early intervention is, how concerning are
18   these waiting times for the profession in terms of
19   outcomes for the children and more generally?
20   A. I think our members speech and language therapists know
21   this better than most, they don't want children to have
22   to wait a long time because they know how urgent it is
23   to see some of these children and trying to express to
24   those people in the system why this wait is far too long
25   and they are trying to do that, as are we. I think it's

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1   been described as a Public Health crisis. I think, as I
2   have expressed before, there was a concern pre—pandemic,
3   the pandemic has worsened this and we're concerned that
4   we don't have the resources in Scotland. We do need to
5   do the transformation in Scotland to support new ways of
6   working but you need a threshold resource to deliver
7   that. And these are real children we are talking about,
8   real children who are experiencing harm, and therefore
9   there is an urgency about supporting the children who
10   have experienced this and supporting the improved needs
11   but also other children who are coming through so the
12   outcomes are clear, research is demonstrating how
13   important it is and we need to take it seriously and
14   address it as soon as possible.
15   Q. Thank you, Mr Carter, I'm going to come on just finally
16   to some of the lessons to be learned but one moment,
17   please. Mr Carter, then finally you have from
18   paragraphs 51 onwards to the end of your statement, you
19   identify some potential lessons to be learned. If I
20   could just ask you to go through those and just
21   elaborate where appropriate on any particular ones that
22   you would like to draw to the Inquiry's attention.
23   A. There's the general one about the eating and drinking
24   and swallowing about protective equipment for members.
25   I think for a while for a period during the pandemic we

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1 were making the case that coughing is an
2 aerosol—generating procedure and therefore our members
3 needed to be protected against that because when they're
4 dealing with people with eating and drinking needs,
5 they're getting very close. When you choke or cough, if
6 you have a problem with your swallowing, you're more
7 likely to cough and we were seeking the highest level of
8 protection FP3 masks, so that's a key lesson, I would
9 say.
10 Q. Just pausing on that, you spoke about difficulties of
11   wearing PPE when trying to do the job of providing
12   therapy. Were these special masks the transparent
13   masks, face coverings?
14 A. Well, for speech and language therapists working with
15   children or adults with dysphagia, ie the eating and
16   drinking difficulties , the transparent mask was less
17   important because they just needed to be able to get
18   close to them to be able to touch their neck, to feel
19   the swallow and to assess that adequately. For children
20   with communication needs and indeed particularly speech
21   sound difficulties , transparent masks are critical so
22   the child can actually see what you're doing with your
23   lips , your tongue, and so therapists did get access to
24   transparent masks, it was quite a long way into the
25   pandemic before we got that but that is a key —— a key

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1 learning for if this was to happen again.
2 Q. And then I think the next one you have relates to the
3   redeployment issue. You say that.
4   " ... after that initial lockdown period, it would
5   have been useful to have had a period of reflection .
6   The best use of the workforce should have been
7   reconsidered and staff should have been returned to
8   services where their skills should have been of most
9   value."
10   Do you care to elaborate on that? I assume that
11   relates to the redeployment issue?
12 A. Yes, I think that once the pandemic was understood and
13   it became obvious what was happening, we would want to
14   avoid deprioritisation of children's services to ensure
15   the harm didn't occur and so our strong recommendation
16   is that children's services are protected and that
17   speech and language therapists stay in their core role
18   to be able to meet the needs of these children.
19 Q. And then you have got at paragraph 54, you again refer
20   to maintaining children's services and more importantly,
21   maintaining a level of integrated teams around children.
22   Do you care to elaborate on that potential lesson?
23 A. I think the interesting thing about the pandemic is it
24   shone a light on how important it is to be fully
25   integrated , to be close to each other, and so a rigid

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1 view as a health—only service got in the way of that in
2 terms of guidance and our ability to engage in an
3 integrated manner and services who recovered more
4 quickly and who saw improved access were those who are
5 more integrated prior to the pandemic so this is a key
6 lesson about the importance of speech and language
7 therapists being embedded within educational placements.
8 Q. And then at 55, I'm not sure how related this is to the
9   previous one, but you talk about therapy services that
10   remained most effective had adopted a preventative
11   approach pre—pandemic. Could you please elaborate a
12   little bit on that?
13 A. Yes, so services who had delivered transformation
14   pre—pandemic and who were working that whole system
15   approach which I described around universal targeted and
16   individualised observed that even when they weren't able
17   to get into an educational context that some of that
18   work could continue even if they weren't there and that
19   was the whole point of being able to prevent harm and
20   continue work and support and provide a sustainable
21   approach to some of these needs so that was the point
22   that we were trying to make there.
23 Q. And was that work ongoing being delivered by educators,
24   by teachers and ...
25 A. That's right, educators, early years practitioners , and

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1 because they had the skills and the approaches and the
2 knowledge of particular interventions , then that would
3 have continued even as a whole class offer or a small
4 group or even individual .
5 Q. You've made the point very clearly in your evidence
6   about how critical children's spoken language skills are
7   in respect of their outcomes. Is there anything you
8   would want to add to that lesson that you have got in
9   paragraph 56?
10 A. I think it's been the awareness in the general public
11   and in the system of how important communication is, is
12   relatively low. The pandemic clearly showed the
13   exacerbated need. It highlighted how urgent it is to
14   address children's spoken language and that this is a
15   public health crisis and we need adequate levels of
16   speech and language therapy to serve these children in
17   an integrated manner and I would hope the lessons
18   learned are how critical communication is for children's
19   learning and how it can be promoted and also what gets
20   in the way of it .
21 Q. Thank you, and then just finally , you say it 's
22   important:
23   "We need to learn the lessons and develop a
24   nationwide approach to meet the needs of children with
25   communication needs."

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1   Why is a nationwide approach important?
2   A. I think there's learning across Scotland. We're
3   actually working with a collaborative at the moment to
4   identify the principles for transformation across
5   Scotland so that collaborative includes the association
6   and directors of education, COSLA, Scottish directors of
7   allied health professions, children speech and language
8   needs, and we've identified clear principles for what
9   needs to happen which includes prevention, it also ties
10   up together with adequate resource and we're speaking to
11   the Scottish Government about that, so there is an
12   opportunity to take a nationwide approach to this. You
13   also need though to identify the local needs, so the
14   needs of those in Orkney might be different from inner
15   city Glasgow so, yes, the one for Scotland approach but
16   actually need the ability to adapt the approaches and
17   resource for the needs of that local community.
18 Q. Thank you, Mr Carter, and then finally is there anything
19   else you would want to add to your evidence in relation
20   to either lessons learned or otherwise?
21 A. No, thank you.
22 Q. Thank you, my Lord. I have no further questions unless
23   your Lordship has any?
24 THE CHAIR: Thank you very much indeed and thank you
25   Mr Carter, that's all. We'll now take a break until, a

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1   little bit longer than we had planned, until 1.45, very
2   good.
3   (12.32 pm)
4   (Luncheon adjournment)
5   (1.45 pm)
6   THE CHAIR: Good afternoon, Ms Stewart.
7   MS STEWART: Good afternoon, my Lord. Giving evidence this
8   afternoon is a panel of two, Dr Shannan and Mrs McCann,
9   both representing the Scottish Sensory Centre.
10 THE CHAIR: Very good. Good afternoon, Dr Shannan and
11   Mrs McCann. Very good. When you're ready, Ms Stewart.
12   DR BRIAN SHANNAN (called)
13   MRS ELIZABETH MCCANN (called)
14   Questions by MS STEWART
15 MS STEWART: Thank you. Dr Shannan, can you please confirm
16   your full name for us?
17 DR BRIAN SHANNAN: Yes. Dr Brian Shannan.
18 Q. And Mrs McCann?
19 ELIZABETH McCANN: Mrs Elizabeth Jane McCann.
20 Q. Now, the Scottish Sensory Centre has provided a response
21   to the Inquiry's Rule 8 request. My Lord, this can be
22   found at SCI—SSC—000001. This document was signed by
23   Professor John Ravenscroft who is the head of the
24   Scottish Sensory Centre. But I understand that you both
25   had input to this response, Dr Shannan, in respect of

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1   the impacts on the deaf and Mrs McCann in relation to
2   those who are visually impaired; is that right?
3   DR BRIAN SHANNAN: Yes.
4   ELIZABETH McCANN: That's correct.
5   Q. In terms of your professional experience, I want to come
6   to you first, Dr Shannan. You are a qualified teacher
7   of the deaf, a qualified educational audiologist, and
8   since January of this year, you have been the
9   co—ordinator for deaf education at the Scottish Sensory
10   Centre?
11 DR BRIAN SHANNAN: That is correct.
12 MS STEWART: Thank you. During the pandemic can you explain
13   to us a bit about what your role was?
14 DR BRIAN SHANNAN: Yes, during the pandemic, I was the
15   manager of the service for deaf children in Fife, and I
16   was also employed at the university as a placement tutor
17   within deaf education, and I also was the course
18   organiser and lecturer in audiology at the university.
19 MS STEWART: Thank you. Can I just say, my Lord, the
20   Scottish Sensory Centre is based within Moray House,
21   which is Edinburgh University, School of Education and
22   Sport.
23   What did your role within the university or within
24   the Scottish Sensory Centre entail?
25 DR BRIAN SHANNAN: At the Scottish Sensory Centre, I'm

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1   involved in a variety of groups that are there to
2   support deaf education. I also help organise courses
3   for teachers of the deaf and other professionals working
4   in deaf education.
5   Q. Thank you, and I understand you were commissioned by the
6   National Deaf Children's Society to undertake some
7   research into the views and experiences of deaf children
8   and their families using assistive devices at home
9   before and during the pandemic. And, my Lord, this
10   research was published in 2022 and it has been disclosed
11   to core participants and can be found at SCI—SSC—000006.
12   If I can turn to you now, Mrs McCann, you're a
13   qualified teacher of visual impairment, and you are the
14   professional learning co—ordinator at the Scottish
15   Sensory Centre again for visual impairment; is that
16   right?
17 ELIZABETH McCANN: That is correct.
18 Q. And during the pandemic, can you tell us what role you
19   had?
20 ELIZABETH McCANN: So I had multiple roles at that time, so
21   I was working as a qualified teacher of visual
22   impairment within a local authority, and I had a
23   caseload spanning a range of ages from children in
24   primary school, secondary and in special schools. So I
25   did that for two days a week, I also worked at the

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1　　Scottish Sensory Centre, and again, I had a dual role
2　　there, so very similar to Dr Shannan, I was organising
3　　courses for teachers of visual impairment, so
4　　professional learning, and not just for teachers but
5　　also for a range of other professionals as well and
6　　third sector.
7　　　　I also teach on the postgraduate diploma in visual
8　　impairment. This is a mandatory qualification for
9　　teachers to gain the qualification to become qualified
10　　teachers of visual impairment.
11　Q. Thank you, and that was something I wanted to come on to
12　　ask you about, was the qualifications for teachers of
13　　the visually impaired; what additional skills and
14　　qualifications do they have? Do they do the
15　　postgraduate diploma in education in the usual way and
16　　then additional training?
17　ELIZABETH McCANN: Yes. So they do their teacher training
18　　as per normal. They would go and work in a mainstream
19　　school, and then they would generally be appointed in
20　　the role of teacher of visual impairment, and they would
21　　come to Edinburgh University. We are the only provider
22　　of the qualification in Scotland, and they come on on
23　　blocks and undertake the postgraduate diploma which is
24　　at Masters level 11. It generally takes around
25　　two—and—a—half to three years to complete.

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1　Q. Thank you, and do these teachers, specialist teachers
2　　tend to be employed by a local authority or a charity
3　　or ...
4　ELIZABETH McCANN: They are —— in the main they are employed
5　　by a local authority, the only exception being if the
6　　teacher was working in a grant—aided school, but that's
7　　the only real exception. I should also add, just for
8　　context as well, that while I mostly teach teachers who
9　　are gaining the qualification, I also have some students
10　　who are there on a full—time basis who may undertake a
11　　course in visual impairment as part of the MSc on
12　　inclusive education.
13　Q. Following qualification, are these teachers based
14　　typically within a single school, or are they
15　　peripatetic?
16　ELIZABETH McCANN: So it can vary. They will either be in a
17　　service, so they would be peripatetic in nature,
18　　covering really from birth up until the age of 18, and
19　　working —— going into schools, visiting these learners
20　　in school and at home, and again across all types of
21　　schools and early years provision, or they may be based
22　　in one school if they are employed by a grant—aided
23　　school.
24　Q. Thank you. In relation to the qualifications for the
25　　teachers of the deaf, Dr Shannan, can you explain a

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1　　little bit to us about their additional qualifications
2　　and skills?
3　DR BRIAN SHANNAN: So in many ways it follows a similar
4　　format to the one that's just been described. The
5　　primary difference is that the teachers also require to
6　　have a specific training level in British Sign Language,
7　　but it's exactly the same. They're employed by the
8　　local authority. The course is delivered at the
9　　university. I just should have added one additional
10　　point to my role during the pandemic that just came to
11　　mind, I was also working, as well as managing the
12　　service in Fife, I ran weekly clinics at the audiology
13　　department with my colleagues from NHS Fife. So we ran
14　　joint audiology education clinics throughout the
15　　pandemic.
16　Q. Thank you, that's helpful. That's something I will come
17　　on to, to speak about the link between education and
18　　health in a short while. Dr Shannan, can you explain
19　　for us just in high level terms a bit about the Scottish
20　　Sensory Centre's work, its aims and objectives?
21　DR BRIAN SHANNAN: Sure. So the Scottish Sensory Centre is
22　　there to try to promote and provide skills and training
23　　for —— for professionals working within the field,
24　　specifically deaf education, and visual impairment.
25　　The —— as I said, it will engage with different

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1　　government organisations and bodies such as third sector
2　　organisations to try to work and promote work that will
3　　enhance the profession as well as providing training,
4　　specific courses for professionals.
5　Q. Thank you. We're interested to learn from you today
6　　about the impacts on —— on learners who are blind and
7　　deaf as they go through their various stages of
8　　education, principally in early years and school
9　　education. Staying with you, just now, Dr Shannan, in
10　　terms of how those identified as being deaf are referred
11　　to the correct organisations prior to entering formal
12　　education, can you tell us a bit about how that
13　　operates?
14　DR BRIAN SHANNAN: Yes, so it's important probably to try
15　　and look at the origins of deafness for a child, so for
16　　a percentage of the children, they are born, have
17　　congenital deafness, and that deafness is permanent.
18　　It's primarily identified through the newborn hearing
19　　screening programme. For another percentage of deaf
20　　children, they will acquire permanent deafness later in
21　　life at some point during their childhood. Those two
22　　groups of children will generally be referred by an
23　　audiology department, or in some areas by an ear, nose
24　　and throat department to a central education system.
25　　　　However, there are another group of children that

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1   primarily have a temporary or transient form of
2   deafness. It normally affects the middle ear, and it's
3   quite commonly been referred to as "glue ear". So this
4   condition, there's a high percentage of children, around
5   80% of the population will at some point suffer that
6   glue ear, especially in the very early years, and so
7   that is usually managed by the ear, nose and throat
8   department and that will generally have either a
9   surgical procedure to remove the blockage in the ear or
10   have hearing aids, because it's important to put
11   deafness as not being an inability to, say, to hear, but
12   deafness is a challenge accessing communication.
13   For some children, they will have a form of deafness
14   which means that accessing speech, even in a quiet
15   environment, can be challenging; but for children that
16   have got a permanent form of deafness, they find it ——
17   listening in noise accessing communication a challenge.
18   But we also have deaf children that, you know, require
19   British Sign Language because it's important to see
20   deafness not as a medical condition, but as a sense of
21   identity about who you are.
22   Therefore parents, when they find out their child is
23   deaf, need to make decisions about communication because
24   all children require language and communication, and
25   it's important to state that children develop their

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1   language and communication within really the first four
2   years of life, so it's not —— it's not as if, you know,
3   for a few years as happened potentially in the pandemic
4   where, you know, things were put on hold, the children
5   only have a very narrow window to develop those
6   communication skills, and families have a time to make
7   decisions and informed choices about the communication,
8   whether that be BSL or spoken communication.
9 Q. Thank you. That provides us with a helpful context when
10   we come on to look at the impacts. Can you tell us how
11   it is that these children are made known to education
12   services?
13 DR BRIAN SHANNAN: So for the permanent form of deaf
14   children, they will be referred generally by an
15   audiology department to a central education service.
16   For the children that have got a temporary form of
17   deafness, unfortunately, there is —— currently within
18   Scotland, there is no national referral pathway for
19   those children, and therefore some children will go to
20   audiology services, and they might, depending, be
21   referred on a central service, but for some, they might
22   just be referred back to the local school. And for some
23   children with glue ear, they might be managed on a "wait
24   and see" basis by a GP, so they're unknown to a whole
25   group of people that need to have an intervention, and

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1   their language and communication will be compromised
2   without it.
3 Q. Thank you. Staying with teaching of the deaf,
4   Dr Shannan, it will be helpful if you could ——
5   I understand there's those who use BSL and there are
6   those who use spoken communication. Could you provide a
7   bit of context for us in terms of telling us how and
8   where these two groups of children are educated by and
9   large, those who use BSL and those who are deaf but able
10   to speak?
11 DR BRIAN SHANNAN: So for deaf children, the vast majority
12   of deaf children are now educated in a mainstream
13   school. That would be true whether children are using
14   spoken communication or British Sign Language. For a
15   percentage of children, they will go to an enhanced
16   provision which would generally be a resource base for
17   the deaf, or sometimes are called schools for the deaf.
18   They are places within —— normally within a mainstream
19   school that have specific staff and acoustic conditions
20   that will be —— enhance their ability to access
21   communication.
22   So for BSL children, they would require access to a
23   communication support worker or a support staff member
24   that ideally should have a high level of British Sign
25   Language skills, to be able to allow them to access the

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1   communication, and for children, whether it be in a
2   resource base or in a mainstream provision, they would
3   require additional devices and support to make the
4   curriculum accessible. A hearing aid has a range of
5   about 1 to 1.5 metres, some of them maybe more ——
6   2 metres. After that you're relying on the sounds
7   reflecting in the room.
8   So if the acoustics in the room are not good for
9   speech, therefore they can make speech more difficult to
10   hear, and therefore you require a device where the
11   teacher or the person speaking would wear a transmitter
12   that would communicate directly to a receiver that
13   attaches either to a hearing aid; or for some children,
14   they have an implantable hearing aid called a cochlear
15   implant, and it would communicate and therefore by
16   increasing what's called the ability to have direct
17   speech being communicated to the device and therefore to
18   the hearing mechanism, you could try to mitigate to some
19   extent the challenges of poor acoustics or distance.
20 Q. Thank you, I want to ask you in a short while about the
21   assistive devices that are used, but before I do, just
22   staying just now with the individual professionals who
23   work alongside these children to provide their
24   education, what is the role of other professionals
25   beyond the teacher or the teacher for the deaf?

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1   DR BRIAN SHANNAN: So for a deaf child to be, you know, have
2   a successful outcome, a range of professionals need to
3   be involved, so at the point of finding out a child is
4   deaf, it's unusual for somebody to be identified as
5   deaf, and therefore the first person to become involved
6   would be a paediatrician. So a paediatrician would be
7   there to do what's called aetiological investigations,
8   so an investigation into why the child is deaf.
9   So for some families, they wish to find that out, so
10   they would —— a paediatrician would be involved,
11   audiology would be involved, because they are the ones
12   that obviously do the initial assessment and continue to
13   check that hearing levels have stayed the same and to
14   issue any hearing aid. There would be ear, nose and
15   throat, if the child had some middle ear issue, because
16   as I said before, it's quite common.
17   In addition to that, there would be the need for a
18   speech and language therapist to be involved, to ensure
19   that the language and communication is developing as it
20   should. There would also be, for families being able to
21   make an informed choice, have access to a BSL tutor or
22   the ability to learn BSL. In addition to that, there
23   would be —— a teacher of the deaf would be assigned in
24   one shape or form. For some children, they require a
25   weekly visit. For some it can be once every month or it

1   could be once every year. It depends on the child's
2   needs. There would be a support staff member for when
3   they're in school or in nursery.
4   Then obviously there's the third sector
5   organisations that are there to provide support to the
6   families such as the National Deaf Children's Society,
7   there's the Deaf Action, British Deaf Association. So
8   there's a wide range of people involved.
9   Q. Thank you, and pre—pandemic, were those interactions
10   done all in person within a school or early learning
11   centre and also within the home?
12   DR BRIAN SHANNAN: Yes.
13   Q. Thank you. I want to turn now to you, Mrs McCann, and
14   your area of expertise. Again, can I ask you, in
15   connection with those children who are visually
16   impaired, how is it that they are, first of all,
17   identified and made known to education services?
18   ELIZABETH McCANN: So the majority of children are
19   identified in the clinical setting, so this would be by
20   an ophthalmologist. We also have an organisation called
21   VINCYP, which stands for Visual Impairment Network for
22   Children & Young People. VINCYP have a pathway, and so
23   once a child is identified as having a visual
24   impairment, and they have a set of criteria which is
25   actually quite broad, the referral would be made to

1   education services, and also to habilitation, who deal
2   with orientation and mobility, so that is the ability to
3   move around safely both in the home, the school and the
4   wider environment as well. And there can also be
5   referral to third sector, so to charities as well.
6   So generally it's through health but schools can
7   also make referrals for children if they have a concern
8   about their vision, but the child in the first instance
9   or the parents would be expected to take their child to
10   a high street ophthalmologist to make sure there's not
11   just some simple refractive error.
12   Q. Thank you. In terms of the education of these children
13   and young people, I understand there are those who use
14   braille and those who require other adjustments. Can
15   you tell us a bit about how and where these two groups
16   of children and young people are educated?
17   ELIZABETH McCANN: So very much like children who are deaf,
18   children who have a visual impairment are educated in a
19   mainstream setting, so they would attend their local
20   nursery, primary or secondary school. There are a small
21   number of children who may attend a grant—aided school,
22   for example, for visual impairment, but the vast
23   majority are in a mainstream setting.
24   Now, we do have in Scotland some additional resource
25   spaces. They tend to be scattered through the central

1   belt of Scotland, so these are a resource base within a
2   school where children who are likely to have the most
3   significant visual impairment, so they would require
4   large print, or would be braille users, and if they
5   lived within a local authority, that may be a choice
6   that is made for that young person to attend a base.
7   Q. In connection with the other professionals who are
8   integral to this child's education, in addition to the
9   teacher or the specially qualified teacher, can you tell
10   us a bit about the other professionals. You mentioned
11   habilitation, for example; are there others?
12   ELIZABETH McCANN: Yes. So a lot of children or many
13   children would also have access to support for learning
14   assistant. They may be either employed centrally by the
15   local authority and only work with children who have got
16   a visual impairment, and they would have additional
17   skills. So, for example, they may be very good —— or
18   they may be trained in the use of braille. We also have
19   other people who are employed again, maybe centrally, by
20   the local authority, as transcription, for working in
21   transcription. This means that they would prepare
22   curricula materials in alternative formats. It might be
23   braille, it could be large print, they would make
24   pictorial materials. They would adapt that into raised
25   diagrams for learners who are blind or need braille.

1   They may convert texts into electronic documents so that
2   it could go to a young person's iPad that they could
3   access it that way. So we have these transcription
4   people as well.
5   We have also habilitation specialists who, as I
6   mentioned previously, support with safe movement and
7   access, and also do aspects of daily living, which can
8   involve basic things such as dressing, using cutlery,
9   learning how to make a hot drink safely and so on. And
10   also all of the health professionals that go round that
11   as well, so ophthalmologist, orthoptist, paediatricians
12   as well.
13   Q. Thank you very much. In terms of the impacts of
14   lockdown and other restrictions, I'm going to take
15   visual impairment and deafness separately, and also
16   blind deafness to which you have dedicated a section in
17   the Rule 8 response. Before I move on to that, I was
18   struck, Mrs McCann, at something you said at section 7
19   on page 5 of your Rule 8 response. You said that:
20   "As a result of online learning/use of video games
21   during Covid, more children have been diagnosed with ...
22   difficulties due to the much—increased ... screen time."
23   Can you explain to us how and to what extent
24   increased screen time can impact a child's eyesight?
25   ELIZABETH McCANN: So the longer that you spend looking at a

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1   screen, then your eyes have to converge or turn inwards
2   in order to be able to focus, and as adults who may have
3   a job working on screens generally, there's quite clear
4   health and safety advice about having a break away from
5   screens, but this didn't happen during COVID, and as a
6   result that continued and repeated convergence over a
7   long period of time has led to more children having
8   issues with alignment, issues of the eyes, and not ——
9   and therefore squints and so on and also myopia as well,
10   so shortsightedness. So these things have been
11   exacerbated by that additional screen time. Because of
12   lockdown and so on, things have not been picked up, not
13   been addressed again by clinics in the way that they
14   would have done.
15   Q. Thank you. Is this something that has impacted
16   children's eyesight, or is it something that applies to
17   the population at large?
18   ELIZABETH McCANN: So these would be children who would not
19   have been known previously to services, so this is a new
20   group of children, if you like, that are being
21   identified as a result of COVID, and whether they are
22   known to teachers of visual impairment now would depend
23   on how —— the significance of that visual impairment has
24   become, and whether it can be corrected with glasses.
25   Q. Thank you. Staying with the impact on those who are

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1   visually impaired, I want to ask you some questions
2   about the use of assistive devices and the impact of
3   school closures and the move to online learning. At
4   section —— perhaps, first of all, before we move on to
5   that we can look at the impact on the learners who use
6   braille. Can you set out for us how their learning was
7   impacted by learning from home, and doing so online?
8   ELIZABETH McCANN: So when we think about children who are
9   blind learning in school, we have a model called
10   "Learning to access and access to learning". When
11   children are young, perhaps in nursery and primary
12   school, it's very much about access to learning, so
13   their work is prepared for them in an alternative
14   format, and as that learner progresses through school
15   and as their skills develop, it changes from access to
16   learning and learning to access, so that they learn to
17   access independently, and that can be through braille
18   and through assistive technology, so over time that
19   changes.
20   The move to online learning had a significant impact
21   on that, because in order to be able to access learning,
22   your learning has to be created in a format that you can
23   access. In school, on a day—to—day basis, for a learner
24   who has got a significant visual impairment and is a
25   braille user, there's not a single piece of work that is

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1   presented to that learner that hasn't gone through some
2   kind of process before it goes to that learner. So
3   there will be multiple adaptations and modifications and
4   preparation of that work in a different format.
5   That didn't always happen during lockdown, and
6   didn't happen for multiple reasons. In order to make
7   that learning accessible, there has got to be close
8   communication between the teacher of visual impairment,
9   the class teacher and then also the person who's going
10   to do the transcription. Sometimes that can be someone
11   who has a dedicated role for transcription, and
12   sometimes it can be a support for learning assistant.
13   In some cases, the support for learning assistants
14   who may have been working with children with visual
15   impairment were diverted to do another job. So that,
16   for example, could have been to work in a hub school, so
17   the person who was doing that transcription support was
18   taken away to do another task. For some learners, they
19   didn't have the skills of access to learning or may have
20   been at the point of access to learning, and it's very
21   difficult and challenging to teach braille, for example,
22   when you're doing it online.
23   We had additional difficulties in terms of the
24   platform that we were being asked to use. During the
25   initial lockdown, I was actually —— or just before the

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1   lockdown, I was teaching a young person braille in
2   school, and when lockdown came, we were all asked to use
3   Teams, but again, while Teams was a function, many of
4   the aspects of that functionality were closed off, so,
5   for example, the use of the camera. So it was difficult
6   if that young person was sitting perhaps with a parent
7   or a sibling in the house to model things such as hand
8   technique for moving across the line of braille, because
9   there were no cameras, so all of those things were a
10   barrier.
11   Again, for other learners who are perhaps large
12   print users, they would access their work in school
13   using video magnifiers, and a video magnifier is a
14   fairly large piece of equipment, particularly if you're
15   in a primary school, because you're used to sitting in
16   one room in one seat for quite a lot of the time. So
17   these are fairly large pieces of equipment, expensive
18   pieces of equipment. When the first lockdown happened,
19   not all children got their equipment home with them, and
20   that could have been for a variety of reasons; first ——
21   and one particular reason may be the need to transport
22   that piece of equipment home, and not having transport
23   to take it to the home as well, or, indeed, room to have
24   it at home as well. So that put learners at a
25   disadvantage, because they didn't have essential pieces

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1   of equipment that would allow them to access their work.
2   Q. Thank you. I want to just go back to something you
3   mentioned a short while ago, which is the redeployment
4   of specialist teachers, and I notice from your Rule 8
5   response, you talk also about the furlough of certain
6   specialists. What was the incidence of that
7   redeployment or furloughing, and what was the impact of
8   that?
9   ELIZABETH McCANN: So if I can take furloughing first of
10   all, furloughing, generally speaking, happened to those
11   who were working in the third sector, and those are
12   people who deliver habilitation so that orientation and
13   mobility and daily living, so these workers were
14   furloughed, and so there was no support for
15   habilitation.
16   So I can speak about a student who came from China
17   to do her full—time Masters at the University of
18   Edinburgh, and she arrived at the height of the
19   pandemic, and she decided to take one of my courses, and
20   I met her. So it became quite clear to me when we met
21   at the university that her mobility skills were not as
22   good as they might have been for someone of her age, so
23   there was nobody around to help her on how to navigate
24   independently and safely from her residence to, say, the
25   supermarket down the road.

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1   Prior to her arrival, we would have previously
2   alerted those services, and they would have come in to
3   the halls of residence and they would have done simple
4   things like marking up the washing machines, the cooker,
5   to allow her to cook independently, know when things are
6   turned on, you know, what programme to use on the
7   washing machine and so on, for washing her clothes. We
8   were not able to do that, so as a result, although I'm
9   not qualified in habilitation, I was —— I was able to go
10   in, but I was able to do that because the University of
11   Edinburgh has the Scottish Sensory Centre there, and I
12   would hate to think of the impact that would have had on
13   other students across Scotland, who perhaps didn't have
14   that, at least some kind of service. But there was no
15   service across Scotland for anybody delivering
16   habilitation.
17   Unless in a very slim —— and there are very few of
18   them, habilitation officers who are employed by the
19   local authority. I can probably think of two in the
20   whole of Scotland, so that was a huge issue. And again,
21   there was no habilitation for children and young people.
22   In terms of teachers, then, and also classroom
23   assistants, they were also being asked, or the potential
24   to be asked to go into hub schools, so, again, this made
25   planning and teaching very difficult. Even when we were

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1   doing our best to do online teaching, the difficulty was
2   that you could be called away at a moment's notice to
3   support in a hub school if that was needed, which then
4   left the teachers of visual impairment and the staff
5   also feeling that those children with visual impairment
6   were less important because hub schools were taking
7   priority.
8   Q. You mentioned a short while ago about the use of video
9   magnifiers. Are there other assistive devices that are
10   used by those who are visually impaired?
11   ELIZABETH McCANN: Yes. So video magnifiers are in the main
12   used by learners who are large print users. For our
13   learners who are braille users, they have a Perkins
14   brailler, which is a bit like an old—fashioned
15   typewriter. That is what most young people start to
16   learn with. As learners get older, they may have
17   braille notetaker devices which are small. It's like a
18   very mini computer which will speak, and also has pins
19   at the bottom which pop up and are your braille cells.
20   Also, young people have laptops with specialist
21   programmes such as speech output, and some may also have
22   braille displays as well. So as well as the computer
23   talking, what's on the screen, you have the text in
24   braille as well on the braille display.
25   Q. And were these devices available to the children who

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1   were learning online at home?
2   ELIZABETH McCANN: Some children may have had those, but
3   again, it becomes very challenging to teach those
4   devices when you aren't there in person, because you
5   cannot see what is on the screen in front of that young
6   person. Not all children had the —— were kind of far
7   enough long in that access to learning, and to be able
8   to be confident. Parents weren't confident either on
9   how those devices worked, so it made learning of screen
10   readers and also notetakers much more challenging.
11 Q. You set out in your Rule 8 response that some pupils had
12   IT devices provided by the local authority, and you
13   referred to the difficulty or the inability to install
14   software or update apps. Can you explain a bit about
15   the software and apps necessary for the learning of a
16   visually impaired young person?
17 ELIZABETH McCANN: So many of our young people will have
18   tablet devices as well, which sometimes can replace what
19   a video magnifier does, so —— and will access things,
20   but these devices are owned by the local authority, and
21   so they are quite, for security reasons, locked down, so
22   when it comes to updating those devices, you can't do it
23   unless you are actually on council premises, so
24   therefore your device becomes out of date quite quickly,
25   or you can't log in as well because your password has

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1   expired. So all of those things are challenges as well
2   that prevents access.
3 Q. I want to just ask you a little bit about hub schools
4   just as my final, final question on this section. Were
5   pupils who use braille given access to hub schools in
6   the first lockdown?
7 ELIZABETH McCANN: No. As far as I'm aware, children who
8   are braille users did not. During the second lockdown,
9   in some local authorities, young people who are braille
10   users had access, but this was not universal across
11   Scotland.
12 Q. What about those with visual impairments who don't use
13   braille, were they also given access in the second
14   lockdown?
15 ELIZABETH McCANN: As far as I am aware, most children who
16   are large print users, unless there was some other
17   reason, didn't have access to hub schools.
18 Q. Thank you. I just wanted to ask you to describe to us,
19   insofar as you're able to, what the hub schooling of
20   these pupils who did attend the hubs looked like, for
21   example, did they have the benefit of a qualified
22   teacher of visual impairment, and the other necessary
23   support you've outlined already?
24 ELIZABETH McCANN: From what I have been told, because
25   I wasn't actually in a hub school at that point during

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1   the second lockdown, and I wasn't working for a local
2   authority, but my understanding is that teachers of
3   visual impairment did go in to local —— into the hub
4   schools if there was a child, a young person there, who
5   was a braille user, yes.
6 Q. Thank you. I want to turn now to you, Dr Shannan, to
7   ask you very similar questions in relation to deaf
8   learners. You set out in the Rule 8 response that at
9   the first lockdown, not all pupils had the devices they
10   needed to learn from home. Can you tell us a bit about
11   the devices that deaf students, first of all, the BSL
12   users might require to have?
13 DR BRIAN SHANNAN: So it's important to put in context that
14   90% plus of children that are deaf are born into hearing
15   families, so for the BSL users, in a sense fall into two
16   groups. There are BSL users whose first language in the
17   home are deaf parents that are using BSL, so —— and in
18   those cases, the children will be exposed to BSL and
19   they will develop language in a similar way to a hearing
20   child through exposure to a language.
21   However, for deaf children that were born into a
22   hearing family, they were at a significant advantage,
23   because to develop —— basically you need to develop a
24   language and you develop a language through exposure.
25   The old saying is: language is caught, not taught. So

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1   you need to be able to have exposure to people that are
2   proficient with that language. That was not happening
3   across Scotland. So (inaudible) there's a limited
4   number of skilled staff pre—pandemic, but within the
5   pandemic situation, not all those —— the cameras, as
6   we've already heard, on Teams were switched off, so you
7   need to physically see somebody, you need somebody ——
8   for family members who have a deaf child, they need to
9   be able to access sight tutors to develop their skills
10   so that they can communicate with their child.
11   It's quite an emotional wrench to be able to have a
12   deaf child that you cannot communicate with, and all the
13   support networks that you require have been removed.
14   So, you know, deaf children, the parents were at home
15   trying to support their deaf children as best that they
16   could but without access physically to a BSL user. So
17   in some areas they would try to access alternative video
18   communication systems, but the blanket switch—off of the
19   screen system basically, you know, denied deaf children
20   their education, because you couldn't access
21   communication. For —— I interrupted myself so I'll stop
22   there.
23 Q. That's fine, and I understand from those who perhaps
24   rely on lip reading, also, that would have been an
25   impact?

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1   DR BRIAN SHANNAN: Correct, because communication, every ——
2   although we talk about BSL and spoken language, we call
3   that multimodal communication, namely every language,
4   spoken language involves looking at people's body
5   language, looks at lip reading, all of those different
6   things. So we all use different —— we all use visual
7   and auditory parts to communication, so a BSL user or a
8   deaf user that's using spoken language, the switching
9   off of a screen basically switched off education.
10   Q. You've set out in your Rule 8 that learners struggled to
11   access laptops or computers where two—way communication
12   was available. Is that what you mean, that there was a
13   screen and cameras in both directions?
14   DR BRIAN SHANNAN: Correct, so in some situations for some
15   families where they had maybe multiple children in the
16   family, there might have only been a single laptop. So
17   some children were accessing their education through
18   online learning that might have been on a phone or a
19   tablet or a laptop or a shared device. So you —— not
20   only did the technology —— the technology had full
21   capacity but significant restrictions were imposed on
22   that functionality. That disadvantaged children
23   especially with an additional support need, and deaf
24   children —— as I said, deafness is not a learning
25   disability. Deaf children can achieve the same as

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1   hearing children if they have access to communication.
2   What we did by removing that is we took away
3   communication.
4   Q. You say in your Rule 8 that there was limited input from
5   teachers of the deaf, and this is something that
6   Mrs McCann has touched on in relation to those who are
7   visually impaired. Can you tell us a bit about why that
8   was the case?
9   DR BRIAN SHANNAN: So again, there was a variety of reasons.
10   Some of those were, as Mrs McCann has said, that, you
11   know, decision—makers within the local authorities were
12   prioritising, you know, potentially support into hub
13   schools because maybe staff members were absent, and
14   they were looking to source staffing for those —— the
15   hubs, but in some cases there was just a lack of
16   priority given to deaf children. In some cases, we had
17   unions telling staff members not to support children
18   online, because they felt there were safety concerns,
19   but again, all of these competing interests were
20   happening, but at the heart of this was a deaf child;
21   and as I said you can't —— if what is happening is
22   occurring during the time when your window of
23   opportunity to develop a language is happening, to
24   remove that, you're taking away somebody's right to a
25   language, to communication, to participation, and it has

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1   a lifelong effect. You can't come back after a year or
2   two and say: we'll pick up your language. A human being
3   has that window of opportunity.
4   Q. Thank you. You mention your Rule 8 response, and,
5   indeed, the parents you surveyed say that there was
6   ineffective classroom management, and this was a
7   barrier, and this brings us back to the helpful
8   explanation you gave us before about the impact of
9   noise, or noise coming from more than one source. Can
10   you explain a bit to us about how the classroom
11   management was ineffective?
12   DR BRIAN SHANNAN: So in an ideal situation, a deaf student
13   would have their assistive device, which they would be
14   able to attach to a laptop, which would then mean that
15   what was being was transmitted from the laptop would go
16   straight into the receiver of the hearing aid, and
17   therefore into the hearing mechanism. As I have
18   described, those systems were not routinely available.
19   You then had an online learning platform. As I
20   said, in many cases there was no access to a visual
21   reinforcement. So you were then having somebody, the
22   class teacher, on an online list having, not muting all
23   the microphones, for instance on the computer, and so ——
24   it's understandable, people were in busy households, so
25   sometimes you have televisions on, or other things going

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1   on with the family, which was then polluting the
2   learning environment.
3   You then also had —— in a classroom, you would
4   generally not expect to see everyone just shouting out
5   the answers, but, you know, there wasn't —— there's a
6   hand up option on Teams. That wasn't always being
7   utilised. So really, for a lot of, you know, parents
8   and certainly in the research we carried out, parents
9   were saying, you know: basically, the kids were just
10   becoming deflated and disengaged, because this was not a
11   learning environment that was accessible to them, and so
12   the pandemic in a sense amplified already issues around
13   how deaf children access mainstream provision.
14   I think it's important that policymakers have a
15   greater understanding of the needs of deaf children so
16   that —— those were not firmly established because if
17   they were, then the online learning would have been
18   more —— managed more organised, but, you know,
19   mainstream teachers were thrown into suddenly learning
20   online. So they were learning technology, technology
21   that had been restricted, and there was no real
22   communication with professionals in the field to say:
23   we're doing this, you know, is there a way that we can
24   make this better, or we can mitigate the effects.
25   Q. In terms of the assistive devices, you have explained

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1 very powerfully for us that the absence of the
2 face—to—face with the speaker or the speakers is
3 important, but had that not been the case, did the child
4 have access to the device needed to amplify the sound,
5 for example?
6 DR BRIAN SHANNAN: No, so in a sense if we think about
7   hearing devices for deaf children that use them, there's
8   either a hearing aid or a cochlear implant. Then, like
9   I said, there's an assistive device that attaches a
10   receiver to that, and a microphone. So for the hearing
11   device, the hearing aid to work, you need to have ear
12   moulds that are properly fitted. Because of the
13   pandemic, there was a delay for some children being able
14   to get access to new ear moulds. A lot of the health
15   boards were going to scanned moulds that had been taken
16   previously, and the manufacturers were adding on a
17   millimetre here across the board to try to get a mould
18   that fitted.
19   So in some cases, the children's hearing devices
20   were not working at an optimal level. Then on top of
21   that, lots of services, the equipment is expensive,
22   there is no doubt about that. However, that was not
23   routinely made available to families. Equally, when
24   there were problems, because you were a family being
25   given a device, how do you connect this up, how does it

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1 all work, the support network around that was not always
2 available.
3   So, you know, it was a lack of access to universal
4 devices, a lack of access to the hardware laptops, and
5 also, you know, making sure that the equipment that the
6 deaf children required to access the curriculum —— that
7 was suitably maintained.
8 Q. In terms of access to hub schools, were those who are
9   users of BSL given access to hub schools in the first
10   lockdown, or indeed the second?
11 DR BRIAN SHANNAN: So in the first lockdown, there was no
12   deaf children that I was aware of that were accessing
13   the hub schools. In the second lockdown, some deaf
14   children did access those schools, but again it was not
15   universal across the country. Certainly for BSL users,
16   there would be a strong case to be made that they
17   required that physical person to be there to communicate
18   with them.
19 Q. In connection with those who communicate with the spoken
20   word, were they given access in the second lockdown?
21 DR BRIAN SHANNAN: Again, this was not always universal, and
22   again, it comes back to this lack of understanding.
23   There's a conceptual understanding that a deaf child, if
24   you provide them with a hearing aid, that suddenly they
25   become an honorary hearing person, that they can hear

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1 and participate in society. That is not the case. A
2 device is only as effective as the environment that it's
3 in and the other equipment that is attached to it, and
4 therefore making the case that deaf children required
5 communication, they needed to learn and develop their
6 language, and therefore were valid candidates for a hub,
7 was not universally applied across the country.
8 Q. Thank you, and if you're able, can you tell us a bit
9   about what the hub schooling of these children looked
10   like when they did attend the hubs?
11 DR BRIAN SHANNAN: So I can only speak for the area that I
12   worked in at the time, that we would send teachers of
13   the deaf or support staff to the hub to support the
14   young people. The hubs generally had a group of
15   priority candidates, so children of parents that were
16   working in the emergency services, or core services.
17   There were children that had —— whose needs were
18   identified as being specific, but they were always
19   trying to maintain a manageable number within the hubs,
20   so again, it comes down to that case being made on a
21   case—by—case basis, and it depended on, you know,
22   different education managers. Within authorities
23   generally, education managers will oversee an area of a
24   region, and so it depended upon, were those educational
25   managers mindful to accept the case being made.

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1 Q. And was the case made by the teaching staff or by the
2   parent to the local authority?
3 DR BRIAN SHANNAN: Our authority was generally made by
4   either the staff, the teachers of the deaf approaching
5   myself, or myself approaching the different education
6   managers and making that case.
7 Q. Thank you very much. I want to look now at another
8   cohort and that is those who are deafblind. If I can
9   bring you in on this, Mrs McCann. It's set out at
10   page 6 at section 7(b) that online learning does not
11   meet the needs of these children and young people, and
12   you speak about a multisensory approach being required.
13   Can you explain to us what's meant, first of all, by a
14   multisensory approach?
15 ELIZABETH McCANN: So I think if I talk just very briefly,
16   first of all, about deafblind.
17 Q. Of course.
18 ELIZABETH McCANN: So these are children who have got a dual
19   sensory impairment, but most of those learners that we
20   find in Scotland, but perhaps not exclusively, do have
21   additional support needs above and beyond having a
22   hearing loss and a visual loss. So many of those young
23   people would be found in special schools, but —— so
24   those young people had more access to learning during
25   that time, but obviously if there were significant

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1   health concerns, then some parents may have taken the
2   option not to send them to school because of the
3   fragility of their health.
4   Nonetheless, they are still entitled to education,
5   but a multisensory approach to learning is exactly that:
6   they need to have literacy, for example, through sensory
7   storytelling that use simple language, but also have
8   props and real objects, which will have a variety of
9   touch and smell and perhaps taste as well that will
10   enhance learning and be able to help them to understand
11   concepts more readily.
12 Q. Is a multisensory approach to learning about the
13   environment in which the child is, or is it more about
14   the pedagogy deployed by the teacher?
15 ELIZABETH McCANN: Well, it's both, because as I have just
16   really described the pedagogy, for those learners, they
17   need to have an environment where there are few other
18   distractions, because that can interfere with learning,
19   so they want a low arousal environment where it is
20   quiet, that allows them to focus on the language that is
21   being used, and where there are a few distractions; for
22   example, people moving around will be a distraction away
23   from the learning, which will take the attention away,
24   because they —— sometimes they're hearing if they're ——
25   perhaps if their vision is quite low, then they may have

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1   a hearing loss, but actually their hearing is a better
2   sense, so they will tune into that and they will use
3   that very well.
4   But for those children, anybody moving around will
5   be a distraction. Also, you know, very bright rooms,
6   light is also —— positioning of that young person within
7   the room is really important, because often again they
8   can stare at light and not actually take their visual
9   attention on to the thing that they are being presented
10   with.
11 Q. Is it, in your view, Mrs McCann, possible to have this
12   multisensory education within a domestic setting?
13 ELIZABETH McCANN: It's very, very challenging. In a home
14   setting where everybody was at home, everybody —— for
15   some families, you know, their accommodation wasn't
16   always ideal. So everybody was in the same room or in a
17   couple of rooms. Again, as Dr Shannan has explained,
18   about competing background information, and also
19   something that I haven't mentioned, and I probably
20   should have mentioned in my last question that you
21   asked, there has been a lot of talk and discussion about
22   the amount of input that parents need to have, or that
23   another person needs to have with that child, whether
24   they have a visual impairment or are deafblind.
25   For some families, if there are a lot of children at

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1   home, trying to divide and split up your attention is
2   really difficult. It's also really difficult in
3   families where both parents worked, because they were
4   juggling two jobs, each having a job, where they were
5   having online meetings, and so it was very, very
6   difficult that —— when did you squeeze in —— education
7   had to be almost fitted around the needs of the parents
8   first, because they had to keep hold of their job in
9   order to have a family and a roof over their head. So
10   that was another huge issue, but there were lots and
11   lots of barriers, particularly for the learners who
12   required that multisensory approach, because education
13   for them, it's very difficult to squeeze in lessons that
14   last an hour, because their attention and their level of
15   fatigue is such that it needs to be short bursts
16   throughout the day, and that's another additional
17   challenge.
18 Q. Thank you. One thing I did want to ask you, but I'm not
19   sure who's best placed to respond to this, is about the
20   assistive devices used by those who are deafblind, and
21   in particular the switches that they use. You've set
22   out that not all students had access to switches when
23   they were at home, that sharing of switches was an
24   issue. I don't know which one of you is best placed to
25   speak to that?

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1 DR BRIAN SHANNAN: I'm happy, yes.
2 Q. Please carry on.
3 ELIZABETH McCANN: Yes, so for many children who are
4   deafblind, they don't have speech, and so they may
5   access switches. They would have been assessed by —— it
6   might have been an occupational therapist or in terms of
7   where is the best position for that switch to be in to
8   allow them to physically move either an arm or a head or
9   a leg in order to access that switch.
10   There are a variety of switches that are on the
11   market, and switches that have —— require minimal
12   movement for a young person that's got quite restricted
13   both gross motor and fine motor skills, so these are the
14   kind of switches that you might just put your hand on,
15   and a slight finger movement would trigger the switch;
16   or other switches which are larger, as I say, that can
17   be accessed by hitting it.
18   So, again, in a classroom situation, those switches
19   may be shared by a number of learners, and, indeed, for
20   example, in a morning routine, for saying good morning
21   to their classmates, that might be something that would
22   be passed around a group of young people. But again,
23   when learning moved to online learning and young people
24   weren't accessing school, they didn't always have access
25   to any switch, never mind one that was the most

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1　appropriate for them.
2　DR BRIAN SHANNAN: Could I make just one point. It would be
3　　important also within the group that are deafblind, for
4　　some, they can be, say, born deaf, but they develop
5　　Usher Syndrome, which is where your sight becomes much
6　　narrower or narrow to the point of not being able to see
7　　at a later point. So they can become visually impaired,
8　　you know, into their early teens.
9　　　　So for that group of children, especially for BSL
10　　users, they move from being able to use BSL
11　　communication to one where their world starts —— and
12　　therefore their communication is removed, and therefore
13　　they need to move to a kind of on—body signing system.
14　　So there needs to be a transition from one type of
15　　communication to another, as well as the impact being,
16　　you know, in your early teens, discovering that you're
17　　going to begin to lose your eyesight and all the
18　　implications there, and the need for all those support
19　　services to be in place.
20　　　　That absolutely has to happen in person, and, you
21　　know, you can't learn these things online. So it's just
22　　to kind of put in context that for some, the ones that
23　　we've been talking about where deafblindness was at
24　　birth, and there's maybe more complex needs, but there
25　　are other deafblind individuals that —— whose

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1　communication and learning has followed a traditional
2　　path, other than, you know, being deaf or visually
3　　impaired, and they happen not in sync, and therefore
4　　it's a process, so within that group, also just needs to
5　　be considered.
6　Q. Thank you. In terms of these children's access to hub
7　　schools, I understand from your Rule 8 that there may
8　　be, for those who are born deafblind, certainly some
9　　additional health needs that perhaps would make hub
10　　schooling not an attractive option, but were these
11　　children offered hub school places in the first lockdown
12　　or the second?
13　ELIZABETH McCANN: So my understanding is that —— that
14　　children who had complex additional support needs,
15　　including deafblindness, were offered —— some of them
16　　were offered hub places in the first lockdown, and
17　　during the second lockdown as well.
18　Q. Thank you, and again, you mention that they typically
19　　attend special schools. Would their schooling replicate
20　　that which they would have had pre—pandemic?
21　ELIZABETH McCANN: For some, there were some issues in terms
22　　of many of these young people are transported to school
23　　by taxi which is paid for by a local authority. Again,
24　　as far as I'm aware, there were some issues around
25　　transport for those young people, and, you know, again,

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1　if they were sharing taxis and the availability of taxis
2　　to take young people to schools, so sometimes that then
3　　fell —— that burden fell on parents as well, so there
4　　were issues; and again, also around issues with staffing
5　　as well, in those schools as well, and staff who
6　　themselves were vulnerable, and therefore couldn't work
7　　in a hub school. So all of those played a —— had an
8　　impact on learning.
9　Q. Thank you. I want to move now on to looking at the
10　　reopening of schools and operating within the
11　　restrictions. If I can come to you first on this,
12　　Dr Shannan, at section 8(e), you say when schools
13　　reopened, family and anxiety issues meant some deaf
14　　learners remained at home.
15　　　　Can you tell us a bit about what it was that led to
16　　these deaf learners not returning to school?
17　DR BRIAN SHANNAN: So this was certainly an experience that
18　　I witnessed in Fife where there were a number of deaf
19　　learners that had been very confident members attending
20　　school, great attendance, good attainment, and they just
21　　could not leave the house, they could not go into
22　　mainstream schools, they —— for some, they would come on
23　　kind of a restricted timetable to try to reintegrate
24　　back into school, and for others, they would maybe stay
25　　within a room within the school and not be able to feel

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1　confident enough to go into the —— into the classroom.
2　　I was shocked by the number of children that I had ——
3　　you know, I had known most of these children since they
4　　were born, to see the impact on them and their families,
5　　and their families were certainly really worried about
6　　that and their children's future.
7　Q. You raised the issue of bubbles as being one aspect of
8　　the restrictions that impacted deaf pupils, insofar as
9　　it impacted the level of professional input that they
10　　might have. Can you expand on that a little for us?
11　DR BRIAN SHANNAN: So within a school, within a primary
12　　school, you know, the nursery could be classed as one
13　　bubble. The early years part of the school, you know,
14　　primary 1, 2 and 3 could be classed as another bubble,
15　　and then the senior school could be another bubble. So
16　　if you had a deaf student in each of those provisions,
17　　you weren't able to go and visit all of those because
18　　you would be crossing bubbles. So, you know, you were
19　　basically only able to go and see —— you were restricted
20　　to a limited number of schools per day, but you were
21　　also limited to the number of bubbles that you could go
22　　and see, and therefore as I said, going back to the
23　　previous point about if you don't have the equipment, if
24　　there's a problem with your piece of equipment, then
25　　you're not able to access the curriculum that there was

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1   no —— that kind of flexibility to move between the
2   bubbles just was not within any of the regulations.
3   Q. Thank you. And Mrs McCann, you raised similar issues in
4   connection with the bubbles. Is that for the same
5   reasons as outlined by Dr Shannan?
6   ELIZABETH McCANN: Yes, and also if you have a child, a
7   young person in a classroom who perhaps already has a
8   support for learning assistant, you know, you weren't
9   able to go in as well as an additional adult into a room
10   and then the opportunity for withdrawal which is perhaps
11   not, you know, would be our normal way of working, we
12   would rather be in the classroom to see what's
13   happening, every available space was taken up, so there
14   was no opportunity for withdrawal either, but yes,
15   exactly as Dr Shannan mentioned, I think there was also
16   another issue as well, particularly between the end of
17   the first lockdown for learners who are transitioning as
18   well. So for transition for a young person who has got
19   a visual impairment requires a lot of thought especially
20   if they're moving between schools, from nursery to
21   primary, primary to secondary, and also secondary out of
22   education, but if we think about in between stages, a
23   lot of work again is done by habilitation specialists in
24   order to familiarise that young person with the new
25   environment that they are going into but obviously these

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1   people had been furloughed and so when schools were
2   going to open up again in the August, at the end of that
3   first lockdown, there was a lot of scrabbling around
4   happening in order to get people back into work and see
5   which children were going to be transitioning and make
6   all of the arrangements to get access to the schools,
7   which, prior to COVID and now as well, a lot of that
8   work would happen during the holidays because
9   habilitation specialists don't have teachers holidays
10   but they're all being furloughed so there was a lot of
11   work that had to be done in a very short space of time
12   when teachers ostensibly were on holiday so that liaison
13   and that was just missing.
14   Q. One thing I wanted to ask you about in addition to what
15   you said there is the functional visual assessments and
16   you say it was difficult to undertake many aspects of
17   such assessments. Can you tell us what these
18   assessments are and how and why they're conducted?
19   ELIZABETH McCANN: So, generally speaking, a teacher of
20   visual impairment would carry out functional vision
21   assessment within the school environment to find out how
22   well that young person is using their vision and from
23   the results of that assessment, generally speaking,
24   distance assessment, testing of near vision as well,
25   colour and contrast and so on, we then make

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1   recommendations to the class teacher in terms of where
2   that young person should sit in class to make maximum
3   use of their vision. We would give advice on teaching
4   strategies as well and also on how their work should be
5   prepared for them, for example, font size, font type,
6   line spacing, all those sorts of things. In order to
7   carry out a lot of those assessments, we need to be
8   sitting close to that young person and there's an
9   exchange of material and during a pandemic, of course
10   there was great concern about materials being passed
11   between people as well, touching things, being most ——
12   and services have a limited number of tests because
13   these tests are expensive so, generally speaking, those
14   tests go out, they're used in a school, they come back
15   and they're passed on to the next teacher, so during the
16   pandemic that wasn't allowed to happen and so there was
17   periods of time where tests were unavailable as well so
18   that limited the ability of teachers of visual
19   impairment to actually carry out a functional visual
20   assessment. They were not happening in the clinic
21   setting either and a lot of, you know, more clinical
22   assessments, which are not the same, I have got to
23   stress, as a function of vision assessment carried out
24   by a teacher in a school weren't happening either so we
25   weren't really getting good clinical information or able

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1   to get that information in a functional sense either.
2   Q. What was the impact on the learner of not having that
3   functional assessment?
4   ELIZABETH McCANN: So if you don't have good data to work
5   from, then you are not really able to make —— give good
6   advice to teachers and again you're very much relying on
7   the learner themselves saying "Well, this is ..." —— if
8   they've got their text on an iPad or on a computer,
9   "This is the text that I'm using" or "This is the size
10   that I'm using" but we don't have —— we don't have good
11   data so we're therefore unable to make the best advice
12   and so learning is not optimised for that pupil.
13   Q. Just one final question for you, Mrs McCann, in
14   connection with this aspect. You mention that on the
15   return to school, poor skills both in use of technology
16   and in braille reading technique had to be unpicked and
17   retaught.
18   Why was this, why had pupils picked up these poor
19   techniques?
20   ELIZABETH McCANN: So there are a variety of reasons. Again
21   the challenge of doing braille lessons remotely when
22   there wasn't someone who knew braille sitting beside
23   that young person, that was a difficulty and a challenge
24   and sometimes learners didn't have braille so if they
25   were using hard braille to read rather than using a

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1   braille device, they maybe perhaps didn't have as much
2   hard braille as they normally did because the people who
3   were doing the transcription when lockdown came didn't
4   take home embossers. Very large pieces of equipment, at
5   the first lockdown nobody knew how long this was going
6   to take, thought it might be a week, maybe a fortnight,
7   so they didn't have that equipment at home and again it
8   needs a car or someone's strength to carry it. They're
9   bulky, they're heavy pieces of equipment. And many
10 embossers also have acoustic hoods. If you do
11 transcription and you're at home and you have got
12 family, you do not want to have an embosser running in
13 your house. It's very, very noisy, and an acoustic hood
14 is very large as well. So a lot of people didn't have
15 hard braille and as a result they used the things that
16 were there in front of them and so that would be a
17 mobile phone because they had learned that they could
18 listen and it's often something that's mentioned by
19 people who don't really understand literacy for children
20 and young people and indeed adults who are blind that
21 listening does not replace literacy, because you do not
22 know how to spell a word, you do not understand about
23 layout on a page and so on. So listening alone is
24 second rate, it's not literacy, but many young people
25 had used listening alone as a way of accessing their

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1   learning in order to keep up with their sighted peers.
2   It was the quick fix, if you like, when nothing else was
3   available to them. And then for learners, some learners
4   who did have their devices had learned to do things, if
5   they were further down that road of learning to access,
6   some of them learned by trial and error on what their
7   devices could do for them but this then had subsequent
8   issues. So, for example, I heard of one learner who was
9   using their braille note—taker and was accessing their
10 work quite well because work was either emailed to them
11 or —— and they could open the file and access it, email
12 it back to their teacher and so on, that had become
13 their normal way of working.
14   Now, on a note—taker, you would access a Word
15 document because that's the document or the format
16 that's most readily accessible, you can have speech, you
17 can have braille, you can edit it and so on. When that
18 young person then returned to school and they were still
19 using that way of working, it had become their normal
20 way of working. However, unfortunately due to the
21 security of our exam system, they were not able to
22 access the exam papers in Word format and so there was a
23 lot of negotiation had to take place between the teacher
24 of the local authority and SQA in order to have their
25 paper in a format that they could access that was still

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1   their normal way of working because what they were doing
2   was not something that previously had been allowed due
3   to exam security.
4 Q. Thank you, and you have answered what would have been my
5   next question about SQA. And on attainment, Dr Shannan,
6   you have set out at section 8(h) and I'm not going to go
7   into this in any detail but just to tell you that the
8   Inquiry has the BATOD survey that you refer to about the
9   potentially widening attainment gap due to lack of
10 specialist support and I understand from that that it
11 was a lack of specialist support during the pandemic but
12 I won't ask you further on that because I'm mindful of
13 my time.
14   Just before we close, I wanted to ask both of you,
15 perhaps Dr Shannan first of all, were the impacts you've
16 described both in the Rule 8 and here for us today, did
17 you make representations to the Scottish Government to
18 make them aware of these impacts either at the time or
19 subsequently?
20 DR BRIAN SHANNAN: At the time, there was no direct method
21 that I had to make them aware of these issues for sure
22 and subsequently obviously we have carried out the
23 research that's already been submitted which sets out
24 many of these issues and obviously in the submission
25 here obviously part of that the Inquiry is to highlight

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1   these so the submissions that we've made today and also
2   in the Relate addresses those issues.
3 Q. Yes, thanks very much. And, Mrs McCann, is that a
4   similar situation for you in the role that you had at
5   the time of the pandemic?
6 ELIZABETH McCANN: Yes, although I think it's also fair to
7   say that Scottish Sensory Centre is funded by a Scottish
8   Government and we do provide annual reports for them so
9   they were aware or should have been aware through that
10 report of the work that Scottish Sensory Centre was
11 doing in terms of trying our best to support teachers of
12 visual impairment and indeed teachers of the deaf in
13 order to deliver as good a service as they possibly
14 could.
15 Q. Thank you very much. Just in closing, I wanted to ask
16 you, you both, whether in addition to what you have said
17 today and indeed, Dr Shannan, you have set out in the
18 research paper we referred to recommendations to benefit
19 deaf learners and mitigate some of the negative impacts
20 but further to that, are there any other key lessons
21 that Scottish Sensory Centre thinks should be applied to
22 ensure these impacts are addressed and mitigated?
23 DR BRIAN SHANNAN: I think the pandemic amplified issues
24 that were already there around the inclusion of deaf
25 children and education. There has been a general move

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1 towards a generic approach to provision, so almost
2 thinking that rather than having bespoke support, the
3 move should be towards a kind of generic provision, that
4 the pandemic highlighted the failings of such an
5 approach, you know, switching off cameras, the lack of
6 understanding that deafness is not about an inability to
7 hear, it's about access to communication, it's about
8 making sure that school buildings are accessible by
9 making sure that we have good acoustics, that we have
10 assistive technology within —— integrated into school
11 buildings so, you know, I think in conception, in design
12 and implementation, there needs to be a recalibration of
13 the support that deaf children require, so that whenever
14 another crisis occurs, there is better understanding of
15 the needs of deaf children so that when the policymakers
16 are making difficult decisions, they're being mindful
17 that, you know, as I said, deaf children cannot get
18 those years back if it happens in the first four or five
19 years of life. If you're a parent that's had a newly
20 identified baby, then the ability to attend groups where
21 you can meet other parents of deaf children and interact
22 and allow your children to communicate, we are, you
23 know, from my —— from the clinics that I attended, the
24 number of children that are coming through with
25 communication difficulties, you know, communication

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1 difficulties primarily because like I said language is
2 "caught, not taught", the ability to interact. All of
3 this, the ability to make sure that there's a way in
4 managing what was clearly a crisis that we have realised
5 that we're not creating future crises going forward.
6 Q. Thank you. And, Mrs McCann, do you have anything to add
7 to this from the perspective of those for visually
8 impaired and teachers and learning?
9 ELIZABETH McCANN: Yes, I think we know that visual
10 impairment is a low incidence disability, there are ——
11 the numbers are small, but I think again, and it is
12 similar to what Dr Shannan was saying, because our
13 numbers are small, we almost completely fell off the
14 radar and there wasn't enough consideration given. And
15 a similar point, this move towards, you know, generic
16 support for learning is not good, the move away from
17 having managers who are not qualified in visual
18 impairment. In order for that voice to be amplified,
19 you know, in higher managerial structures within local
20 authorities is really important and we're not seeing
21 that now, that there's not —— the teachers of visual
22 impairment often don't have a manager who's qualified in
23 any form of sensory impairment and being able to take
24 that message and having it heard up the tree is really,
25 really important, and I think as well, it's also

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1 highlighted that need for really specialist pieces of
2 equipment and sadly what I hear now is that because of
3 shortage of money that young people are not getting that
4 equipment. If we were to have a lockdown tomorrow,
5 would we be in a better place or would we actually be
6 worse? And I think that is also something that has to
7 be kept in mind that, you know, access to equipment and
8 technology for learners with visual impairment is really
9 so important because with the right access, whether that
10 be through technology, through support from the right
11 people with the right qualifications, children who have
12 got visual impairment can learn and be successful
13 learners and equally as successfully as their sighted
14 peers.
15 MS STEWART: Thank you very much and thank you also to,
16 Dr Shannan.
17 My Lord, I don't have any further questions for the
18 witness.
19 THE CHAIR: Thank you very much, Ms Stewart. And thank you
20 very much, Dr Shannan, and Mrs McCann, I'm very grateful
21 for your evidence. And that brings proceedings for
22 today to an end. I think we're later tomorrow morning,
23 aren't we? It's 11 o'clock, or something like that, is
24 that right?
25 MS STEWART: I think it's 11.15.

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1 THE CHAIR: 11.15, I do beg your pardon. Very good, that's
2 all, thank you.
3 (The hearing was adjourned to 11.15 am on Wednesday 13
4 November 2024)
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