Witness Name: Scottish Covid Bereaved
Statement No.: 1
Exhibits:
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF MARGARET WATERTON OF SCOTTISH COVID BEREAVED

I, Margaret Waterton, make this statement on behalf of Scottish Covid Bereaved (SCB). The information and examples contained within this statement have come from my discussions with members of the SCB, statements that members have provided to the legal team, and I have also included some examples from my own personal experiences.

History, Purpose and Aims of Scottish Covid Bereaved

1. The Scottish members of our group originally started out as part of the group Covid Bereaved Families For Justice UK (CBFFJ) which was formed on Facebook in June 2020. Following our meeting with The First Minister, Nicola Sturgeon, in March 2021 it became clear we needed to be an autonomous group/branch within CBFFJ organisation, especially after it became a Limited Company with directors without informing the membership. At that stage we became a sub group of CBFFJ but arranged all of our lobbying and press activity ourselves. Following a clear difference between our group approach on several major topics and that of the main CBFFJ group we formally severed our connection with them in September 2022 and became a completely separate group, namely Scottish Covid Bereaved.

2. Given the very nature of our Group and that we have come about as a consequence of bereavement as a result of the various responses made by both the UK Government and the Scottish Government, we have highlighted issues after the fact rather than prior to the decision making.

3. Since our first press article in July 2020 with the BBC (on Care Homes) we have had a consistent and positive press presence via TV, Radio, Newspapers and Social Media mainly in, but not limited to, Scotland.

4. Our political campaign, ultimately leading to the formation of the Scottish Public Inquiry, began in September 2020 with the then Scottish Labour Leader asking a question on our behalf at FMQs. Since then, various questions have been asked on behalf of members by politicians from all political parties.

5. Whilst our activities have been mainly in Scotland, in the absence of anyone else doing it, we have participated in actions with the original CBFFJ Group in its efforts to secure a UK Inquiry. We are very conscious of the overlap in both Pandemic Planning and the actual handling of the pandemic between the UK Government and the devolved Nations. We feel it is especially important to be knowledgeable about the whole process to assist the Inquiry in identifying areas where the original Pandemic Planning fell short not only in Scotland but in the UK as a whole and we believe we cannot do one without the other.

Membership of the Scottish Covid Bereaved

6. We are a group of bereaved individuals united in a common goal. We do not want our loved ones' deaths to have been in vain. We want lessons to be learnt to stop others having to go through what we have been through. We also believe that by sharing our experiences, both good and bad, we will assist both Inquiries in their establishing what really happened, and therefore further assist both Inquiries in arriving at their conclusions, recommendations and lessons to be learned for future pandemic planning.

7. Although our group came about due to bereavement, there are members of our group dealing with other consequences of the pandemic. Our membership includes a number of healthcare and other frontline and key workers, many of whom may be suffering from post-traumatic stress disorder and other impacts of the trauma that they experienced, and they are finding that there is little, or no support afforded to them.

8. We have members of the group who are either from an ethnic minority group or have a loved one who died who was from an ethnic minority group. They are able to describe firsthand the healthcare inequalities experienced within those groups.

9. We also have members suffering from Long Covid who can demonstrate that there is a lack of medical knowledge and treatment in dealing with this condition. We understand that this is a significantly developing field of medical research in relation to Long Covid, however, we understand that there are limited specialist services treating Long Covid in Scotland. Furthermore, any treatments our members receive is based on where they reside, i.e a 'postcode lottery'.

10. Additionally, our membership includes relatives of an individual who contracted covid whilst in custody and died in custody. The individual had asthma and after becoming unwell with Covid and displaying significant Covid symptoms he was denied fundamental health care.

11. Given the diversity of our group, we are able to demonstrate many issues including delays in treatments for serious chronic illnesses, difficulties experienced with access to appointments with hospital specialists and GPs and other health services. For example, one member's story is of the catastrophic consequences of her loved one not having access to an optician due to a receptionist missing a key symptom at triage.

Overview of the concerns which the SCB has identified in relation to the response of the Scottish Healthcare System to the Covid 19

NHS 111 and 999 Services

12. With regards to NHS 111 and 999 services, a significant number of our members can speak to issues they experienced in their dealings with these services, and in many cases these failings ultimately contributed to the death of their loved one.

13. We are aware that there were occasions when the SAS ambulance service failed to take patients who were seriously ill with covid into hospital, instead, advising patients to stay at home and have their relatives look after them. There is a member of the group whose young adult son, who had an underlying health condition, became very ill with covid. An ambulance was called however, paramedics explained that this man 'didn't fit the criteria' to be admitted to hospital. His GP was then contacted who called an ambulance immediately. An ambulance attended and then advised against taking him to hospital as 'they would probably just send him back home.' When he was finally admitted to hospital, his condition had deteriorated to such an extent that treatment was unsuccessful, and he died.

14. During the pandemic, NHS Scotland set up Covid Hubs which were part of the NHS 111 service. On calling NHS 111, individuals would be asked if they had had a positive 'PCR' test and/or, symptoms of Covid 19 infection. If the individual answered in the affirmative to either or both questions, their call was transferred to the Covid Hub, a 'remote', telephone based 'Out of Hours' service which was intended to offer primary care advice and to provide triage for individuals who may need further assessment at a Covid Assessment Centre or a home visit from a GP or Advanced Nurse Practitioner or admission to hospital.

Covid Assessment Centres were located in existing NHS Primary Care Centres, whose usual purpose would be for non-acute out-patient care and treatment. The primary purpose of both the Covid Hubs and the Covid Assessment Centres was to provide a triage service where people could be given advice about self-management or cared for in the community, thus ensuring that hospital capacity was used for those individuals with the most serious illness.

The Covid Assessment Centres had the ability to engage in basic diagnostics, for example, check an individual's basic observations of temperature, pulse, heart rate, respiratory rate, blood pressure and oxygen saturation levels. There were no facilities for ongoing monitoring or treatment. They provided an assessment at 'a moment in time' and, based on that assessment, supported staff to decide if, for example, the individual required further assessment and admission to hospital. The Assessment Centres only had the ability to prescribe and administer, for example, oral antibiotics, oral steroids, and oral pain relief etc. They did not have the facilities to administer more complex medication which may have necessitated ongoing monitoring of the individual.

For example, one of our members who has usually well controlled asthma, contracted Covid 19 in December 2020. They experienced a deterioration in their asthma condition and contacted NHS 111 around 1am. Having established that they had Covid, the call handler who had taken the initial call, transferred them to a Covid Hub where the Doctor offered clinical advice over the phone and further to calling our member back to determine the effect of the treatment they had suggested, made an appointment for them to attend their local Covid Assessment Centre later that morning. At the Covid Assessment Centre, they were assessed by an Advanced Nurse Practitioner, including having their basic observations checked. They were given additional inhalers and a 'spacer' and advice about next steps if they continued to have further difficulties.

Our member attended the Covid Assessment Centre for a second time having had further deterioration in their asthma and their late husband also attended on that occasion. Again, basic observations were undertaken, and they were both sent home with antibiotics and steroids in the case of our member, which was the level of medication that could be provided in the Assessment Centres.

15. We also have a member whose elderly relative contracted covid whilst in hospital and despite being very unwell was sent home without an assessment of her care requirements being made. When at home their condition deteriorated, and NHS 111 was contacted. Having waited for 30 minutes they were finally told that someone would phone them back and that didn't happen. As a result, a further call was made to NHS 111 when after a 45 minute wait the family member was

shocked to be told that 'no one wanted to attend people with coronavirus due to the risks involved for their staff.' When this member's relative was finally admitted to hospital, the window to make any meaningful medical intervention had gone, and she died.

16. Another member of the group had a relative who became very ill with Covid. NHS 111 was contacted, and they advised transport would be sent to take this person to a Covid Assessment Centre. However, while waiting for this transport to arrive, their condition deteriorated, and an ambulance was called. When the ambulance attended this person's home, the Covid Assessment Centre transport also arrived. The paramedics witnessed the relative hanging over a fence in the garden struggling to breathe. The paramedic said that this person should go to the Covid Assessment Centre instead of being put into the ambulance. The Covid Assessment Centre van had no oxygen and the journey lasted 30 minutes during which this person received no medical attention. The ambulance could have taken this person to a hospital within five minutes where they would have received medical attention. As soon as this person arrived at the Covid Assessment Centre he was so seriously ill that he was immediately put into an ambulance that had actually been called for another patient at the centre. By the time this person reached the hospital and received treatment it was too late and they died.

Another member and her late husband had to attend their local Covid Assessment Centre on 2 occasions. On the second occasion they attended together. On our member's first attendance, she was asked if she would be able to drive herself to the Centre. This involved a drive of around 15 minutes. Our member has asthma and was feeling very breathless and unwell as she hadn't eaten for several days and had a particularly high temperature. She said that she would drive herself there as her late husband was unable to drive. She was advised that transport could be provided but that this would be in the form of a taxi, a 'people carrier' type of vehicle, in order that the driver's cabin and the passenger cabin could be separated by a Perspex screen and that the driver would not be able to help her get in or out of the vehicle.

Our member's husband attended the Assessment Centre himself the next day and our member was too unwell to drive him there so transport was arranged. Her

husband was so unwell that she did not know how she would get him into the vehicle as the driver, who was very sympathetic, was instructed to remain socially distanced and not to aid her husband. On the second occasion when they both attended together, transport was arranged, and she was able to help her husband into and out of the vehicle and into the Assessment Centre itself.

As the drivers were volunteers and were in the main, taxi drivers, they had no first aid training and were instructed to remain socially distant and not to help. There were no facilities inside the vehicles such as vomit bowls or tissues. The drivers were brave, key workers who were doing their best to provide a basic transport service. They were not trained to offer first aid or more sophisticated treatment such as administer oxygen and, in any event, no medical assessment had been made at the point of 'pick up'. Our member has said that trying to get in and out of a vehicle when you were very unwell, breathless, and struggling to stand up at times unaided was a challenge and is worthy of consideration should this approach be used in the future.

17. A further example of NHS 111 failing was experienced by our group member whose son, aged 28, became seriously unwell with covid symptoms. His partner phoned NHS 111 and was told if he got worse to 'phone back'. He then significantly deteriorated, and his partner phoned an ambulance. While on the phone to the emergency services at '999', he deteriorated further and by the time he got to hospital it was too late to save him. This member has concerns that the emergency services were less inclined to consider that a younger person may become seriously ill with covid, requiring emergency treatment and admission to hospital.

18. Another member whose brother was seriously ill with Covid, couldn't get through to NHS 111 so decided to attend the A & E department of their local hospital who refused to see him. They stayed outside the hospital and phoned '999' and eventually a doctor came out of the hospital, got a wheelchair and wheeled this man into the hospital. However, it was too late and any window of opportunity for meaningful medical intervention had passed, and he died.

Access to GPs and pharmacists

19. Our members have described their experiences with regards to access to GP services during the pandemic and it is apparent that there were significant difficulties accessing GP appointments and also a lack of face-to-face appointments in circumstances where these were required. We also have members who had delayed diagnosis of illnesses due to not being properly assessed and referred to the appropriate services for further investigations.

20. We have a member whose elderly father became very unwell with covid. The GP was contacted on a number of occasions to provide a home visit as the gentleman was too ill to be able to attend the GP Surgery in person. The GP advised that they could only offer appointments to see patients in person at the surgery and home visits were not possible.

21. Early in the pandemic, another member whose mother, aged 76, became unwell and was experiencing pain, contacted her GP on numerous occasions over a period of 6-7 months. She was prescribed pain medication and on contacting the GP surgery, when this pain continued, she was simply given a re-prescription rather than being properly assessed with a view to finding out what was causing this pain. Further investigations only took place when this lady had a fall at home and required to be admitted to hospital. Whilst in hospital, the lady had diagnostic tests including x-ray and a scan and was diagnosed with cancer.

Accessibility of Health Guidance

22. Information has been shared by our members about problems they witnessed regarding healthcare guidance in relation to testing, infection control and visiting relatives being applied inconsistently across health boards and at times across different wards within the same hospital. Our members have explained instances where they were advised of inaccurate guidance which had significant consequences for them. A number of examples of this include the following:

23. One of our members was wrongly advised that they could either choose to be at their mother's bedside as she was dying, or they could opt to not attend to be with their mother when she died, but then would be able to attend at her funeral. This

led to this member having to make an impossible decision that has exacerbated the trauma of losing their relative. Indeed, we have heard a number of our members were told the same thing, mostly earlier in the pandemic. This was clearly a devastating choice to make, and it seemed that there was no consistency of guidance on this issue across Scotland.

24. We have a member whose relative had become very unwell, displaying covid symptoms. He attended his GP and was assessed by a locum doctor who confirmed that his oxygen saturation levels were low. The Locum GP however, said that this couldn't be due to covid as the gentleman hadn't been abroad. Even at this early stage in the pandemic (March 2020), there was already a clear understanding of both asymptomatic transmission, and that Covid was prevalent in the community, the first death from Covid 19 in Scotland having occurred. Thus guidance suggesting 'no foreign travel, do not consider Covid' was misleading and potentially dangerous. his led to a delay in this patient's treatment for Covid which then resulted in his death shortly after admission to hospital.

25. One of our members has highlighted the varied implementation of infection prevention and control guidance between different wards within the same hospital. Including the use of PPE by staff and visitors. When this member's wife was moved between different wards within the same hospital, differing implementation of policies in relation to the wearing of PPE for staff members and visitors were noted. This member's wife subsequently contracted covid while in hospital and died.

Use of Technology by Healthcare Systems

26. A number of issues were experienced by our members when their family members were in hospital and visiting was not permitted. One of these was the use of technology to enable our members and their loved ones to communicate. Our members had no idea what to expect as no information was provided by Health Boards. For example, members were watching TV coverage of hospital wards where 'tablets' were being used by ward staff to help patients keep in touch with their families. The reality was that there was an expectation that patients would have their own mobile telephones and their own 'tablets' or other such devices to

enable them to communicate with their families. The other reality was that if someone did need help to use a mobile phone or other device, this was very much dependent on the ward staff and the time they had available to do so. Little regard appeared to be paid to those people who did not have access to a mobile phone or other device, or who had visual or hearing impairment or who were unable to access and use their devices due to their treatment and because they were too unwell to do so.

We understand from our members' experiences that the use of technology varied greatly across health boards. A major issue for our members was that they were unable to assess the condition of their loved ones in hospital as they were unable to visit them but then also unable to see them on a video call. This left them feeling helpless as they were unable to advocate for their needs. This caused great distress for relatives in hospital and their families who could not see them.

27. We have a member whose elderly mum who did have a mobile phone and could use it to send text messages. When this lady was re-admitted to hospital with nosocomial covid, she was significantly unwell and was unable to operate her mobile phone and this meant communication was through hospital staff and not directly with her mother. This lady was visually impaired and wore glasses. As she was receiving high flow oxygen via a full face mask, she could not wear her glasses and therefore could not see to use the phone. A nurse used her own phone to make a video call to the member from her mother and this was the only time they saw each other for 7 days. This was an act of great kindness and compassion which our member will always be grateful for. This lack of visual contact caused this member and other members in similar situations difficulty being able to see and assess their loved ones physical and mental health and affected their ability to advocate for their needs and care. This also denied the patient direct communication with their relatives to the detriment of their wellbeing.

28. We also have members who experienced difficulties with contacting their relatives while they were in hospital due to the treatment they were receiving, causing issues with this. One of our members' husband was seriously ill with covid and was being treated using CPAP and being placed in the prone position in an attempt to increase his oxygen saturation levels. This meant that he was unable to

communicate by mobile phone as he could not access his mobile phone to make or receive calls and he was unable to use it to send text messages. This was very difficult because the family were relying on the nursing staff to tell them how he was and to then communicate messages to him from the family. Our member says that her husband used his 'ipad' to listen to music and that he found this comforting but again, he was unable to use this technology and the ward staff did not assist him with this. This man was very frightened and would have benefitted from contact with his family. Our member has told us that she continued to send messages and 'voice notes' to her husband to try to comfort and reassure him but she does not know if he ever heard or saw them. Going forward, the reliance on technology must be reviewed and cognisance given to both the nature of the care and treatment being received and its impact on an individual's ability to use it.

Treatment (not including vaccines) Received by Patients suffering with Covid-19 and how this changed during the relevant period.

29. We have a significant number of members who have explained that the treatment their loved one received for Covid 19 was either non-existent or inadequate. Many were denied the option of being admitted to hospital for treatment due to poor medical assessments at Covid Assessment Centres, by paramedics or conducted over the phone by GPs or on NHS 111 where some members had concerns that there were staff who were not adequately trained. Indeed, our members have explained that they also had relatives who were poorly assessed in clinical settings.

30. Our members understand that people in prisons are more vulnerable to covid. The SCB want to know what the policies were for infection prevention and control. Also what the policies were in relation to testing of other prisoners when others tested positive. Members also want to know what the policies were for treatment when prisoners tested positive. We have a member who had a young adult son, who suffered from asthma, and contracted covid whilst in prison. He received no treatment for his symptoms and even when he was seriously ill, he wasn't admitted to hospital. He subsequently died in prison. This raises questions about healthcare

provision within prison settings during a pandemic and what training staff were given to help them deal with this.

31. We also have a member whose husband was extremely ill with Covid and had been admitted to 'ICU'. He was a candidate for 'ECMO' (extracorporeal membrane oxygenation). However, due to miscommunication with hospital staff and this group member about this form of treatment, he subsequently did not receive this treatment and died at the age of 51.

32. Furthermore, we have a member whose husband was complaining of Covid symptoms and was very unwell. An ambulance was called, and paramedics assessed him but left him at home advising that he did not require treatment in hospital. The ambulance then had to be called again the next day and by the time this man was admitted to hospital it was too late for him to have successful treatment.

Availability, Level and Appropriateness of Covid-19 Testing in Healthcare Settings

33. Our members have explained that there was inadequate testing taking place within Healthcare Settings. They believe that proper testing and strictly applied guidelines on this could have prevented the significant rates of nosocomial infection. There were a number of members who had highly vulnerable relatives in hospital, for example, receiving treatment for cancer, where you would have expected that there would have been great care taken. However, this was not the experience of a number of our members.

34. We have a member who was taking part in an Organ Exchange Programme with his wife. They were both due to go into hospital to have this procedure undertaken. Both were tested for Covid two weeks prior to being admitted to hospital. However, neither were tested on arrival at the hospital despite the NHS policy that they both should be tested 24hrs before surgery. After surgery, although this member's wife was immunocompromised, she was not tested before she left the hospital. She became unwell with covid symptoms when she returned home and required to be readmitted to hospital where she subsequently died.

35. We also have a member who's relative was admitted to a specialist cancer hospital to receive chemotherapy. On admission, this member was told that her relative would not survive if she contracted covid. However, she then discovered that this hospital was not doing routine covid testing on admission, which our member found shocking given the extreme vulnerability of the patients in this hospital. Four weeks after this member's relative had been admitted to this hospital, she started to show symptoms of Covid and was then tested and found to be positive for Covid. The family were advised that there had been an outbreak of Covid in her ward and this member's relative did not survive this.

Decisions relating to the discharge of patients from hospital

36. Our Members have described a number of failings relating to decisions to discharge patients from hospital. They have described situations of early discharge when they consider their relatives would have benefitted from further treatment within hospital. Additionally, some were discharged home where there was inadequate provision of care for their relative at home.

37. We have a member whose vulnerable wife, due to previously having cancer, losing a kidney and suffering from asthma, contracted covid and was admitted to hospital. However, she was discharged two days after admission while still very unwell. She subsequently deteriorated at home and had to be readmitted and then died. This member has raised concerns that his wife was discharged from hospital on day 2, when Doctors should have been aware that Covid symptoms frequently deteriorate during days 5-10. This member believes that if his wife had remained in hospital, she may have had a better chance of surviving.

38. Also, we have a member whose husband was a key worker and was admitted to hospital having tested positive for Covid and was then very unwell. Again, after two days he was discharged home, while still unwell and still testing positive. His wife at home was immunosuppressed and therefore extremely high risk, and was concerned she would also catch Covid. This member's husband deteriorated further while at home and had to be readmitted to hospital where he died.

39. Furthermore, we have a member whose father was admitted to hospital for a non – covid issue. He was then discharged too soon and so had to be readmitted one day later to a different ward. The new ward had a covid positive patient in the bed opposite to this member's father, but this was not disclosed by nursing staff at the time. He was discharged again a few days later while very ill. This member explained that her father had been tested by nursing staff but discharged before they received results. A further issue with this is that he was being discharged home where he resided with his vulnerable and shielding wife. He was displaying covid symptoms when he returned home and became so ill that he required to be readmitted to hospital. His wife also became unwell with covid symptoms. Her condition deteriorated rapidly and she was then also admitted to hospital. They both were admitted to the same ward and died within five days of each other.

DNACPRs

40. A significant number of our members have told us of their serious concerns in relation to DNACPR. The issues they have raised focus, in the main, on communication and ensuring that relatives clearly understand what DNACPR means and that ultimately, this can be a medical decision; ensuring that relatives are certain that their loved one has understood DNACPR and that they agree that they have the capacity to make their own decisions; the clinical decision making, who has been involved in making the decisions and what information is the decision based upon; the means by which the individual signs the DNACPR form and how the decisions are recorded in the medical notes and communicated to the wider healthcare team.

41. Going into the pandemic, Doctors had a wealth of clinical guidance relating to good practice and ethical decision making in relation to DNACPR at their disposal. In addition, guidance was developed to further support medical practitioners during the pandemic in making DNACPR decisions, when it was recognised that the likelihood was that many people would become seriously ill because of Covid.

Many of our members experienced a significant difference between the rhetoric of ethical clinical practice and the reality.

42. During the first national lockdown, almost no-one was allowed to visit their loved ones in hospital. Communication with clinical staff was mostly by telephone. Our members had little opportunity to be with their loved ones when these conversations were taking place and had little to no opportunity to contribute to the decision-making process.

43. Communication, care, and compassion was at best inconsistent across NHS Scotland. Even in different hospitals in the same Health Boards, our members had very different experiences when the expectation would be that every Health Board would be working within the same set of national principles and clinical guidelines.

44. One member whose mother died from nosocomial SARS Cov2, and whose husband died from Covid Pneumonia 6 months later, in 2 different hospitals within the same Health Board, had 2 very different experiences of how the conversation with the medical staff in relation to DNACPR was handled.

45. In the case of her mother, our member had to have a conversation with a doctor in a Covid Hub and having found a DNACPR form in her mother's belongings on her discharge from hospital, expressed concern about how the consent had been acquired in the first place and if the decision then would still stand as her mother was to be readmitted to hospital, this time with suspected Covid. In her response to our member, the Covid Hub Doctor reassured our client that DNACPR and treatment options would be discussed afresh but that 'this was not the first time' that the Doctor had heard about DNACPR consent being obtained inappropriately.

46. We have a group member who was advised by the hospital that DNACPR was discussed with his elderly mother. This member accessed his late mother's medical notes and subsequently discovered that on the two occasions when DNACPR was discussed with his mother, medical staff were unsure whether she understood what this meant. The family were never informed about this and only became aware of this following her death when they accessed the medical notes.

47. Another member has described feeling pressured into signing a DNACPR in relation to their mother who died from Covid. She has advised that she felt that a particular Junior Doctor had been tasked with getting her to sign a DNACPR in relation to her mother and had pestered her for days about this. As soon as the DNACPR was signed, this member never saw this particular Junior Doctor again.

48. We have a member whose 39 year old sister died from covid. This member found out following her sister's death that a DNACPR had been put in place when her sister was in the hospital with covid. She has explained that her sister did know about this but wanted it removed. She further explained that her sister had learning difficulties and so this member has serious concerns that DNACPR was discussed with her sister without a family member present to help her understand. Her sister had been discharged from hospital but then shortly after was readmitted. When readmitted she had had a heart attack and as the DNACPR was still in place the medical team could therefore not actively resuscitate her and she died.

Ante-natal, Postnatal and Maternity Care/ Services

49. We have a number of members who have shared information about their experiences with Maternity Care during the pandemic. These services were seriously disrupted which led to pregnant women having to attend largely unsupported by their partner or other family members during this vulnerable time.

50. We have a member who was pregnant with her second child during the pandemic. Her second child was born in May 2020. This member had a history of postpartum psychosis following on from her first pregnancy and had received treatment and support from a CPN in relation to this and was satisfied with the care she received at this time (2018). She has explained that while pregnant with her second child she had to attend hospital appointments on her own. These appointments were frequent as she had gestational diabetes. She had to go in for her induction by herself, as her partner wasn't allowed to accompany with her. She explained she

had to labour in her room by herself before she was moved to the labour ward. This was obviously a difficult experience for her.

51. This member has also explained that while in hospital she witnessed mothers in the same room as her who were struggling but explained that she was discouraged from talking to the other mothers in the room. She found this hard, as she knew from her past experience with having her first baby, that it was helpful to have the support of others around at this time and she felt she wanted to offer support to the other mothers but couldn't due to the restrictions that were place upon her.

52. She has explained what her care was like after she had had her baby, where she says that if she had felt the same way she did after having her first baby, she thinks that she wouldn't 'be here', as she wouldn't have been able to cope with not having all the support she had had before the pandemic. She has explained that the support vanished after lockdown. There were no face-to-face appointments, she only got calls from her CPN. She was required to make zoom calls with her psychiatrist, but this didn't work well as she was at home with a newborn and a toddler without her partner there to help with childcare, while she had her appointment. She felt she couldn't have a proper conversation with her psychiatrist.

Discriminatory Practices within Healthcare Settings

53. Our members have been affected by discriminatory practices in a number of ways within healthcare settings.

54. We have a member whose mother and father both moved into a care home during the pandemic. This member's father, aged 83, had only moved into the care home in order to be with his wife. He did not require to be in a care home himself. Subsequently, having contracted Covid, he was admitted to hospital. This member became frustrated on having a call with the hospital following her father's admission, where she was asked how long had the care home staff been feeding her father. She advised the nurse that her father was completely self-sufficient and

only went into the care home to be with his wife. This member was upset by this as she considered that from the beginning, the hospital had treated her father as 'dispensable'. She believes that all they saw was an 83-year-old man who came from a nursing home and not what was a previously independent gentleman.

55. This member didn't feel that her father was given a chance at fighting covid by hospital staff and also wasn't made comfortable at end of life. She has explained that when she was able to visit her father in hospital, she saw that he was really suffering. She begged hospital staff to give her father medication to settle him and this was refused. She was then asked by a nurse to stop asking them to help her father.

56. This member has explained that by the time the staff got round to considering medication, it was too late. This member has explained that her father fought, struggled, and thrashed around for 13 hours before he died.

57. Our members have expressed concern about the clinical decision making that was used to inform decisions regarding the level of care and treatment to be afforded to their loved ones, particularly with regard to ITU level care and ventilation. It was often unclear how the decision not to progress to that level of treatment was arrived at, and it appeared that the decision-making processes were inconsistently applied. Our members were often not involved in any of the decision-making processes. They were not advised what clinical criteria were being used to inform the assessment and decision making including for example, the use of 'Early Warning Scoring Systems', Treatment Escalation Plans, critical care decision making scoring systems etc. Decisions were made and not communicated effectively to our members causing them significant distress. Our members were also concerned that they were hearing constantly in the media about clinical decision making that was coming under extreme pressure due to the lack of availability of ITU beds and staff, ventilators, 'piped' oxygen, PPE and so on. This was extremely distressing and traumatic for our members.

58. One of our members has explained that when her husband was admitted to hospital with Covid Pneumonia, she had daily telephone conversations with the

doctor. She had made it clear to the doctor that she wanted her husband to be afforded every effort and every level of care and treatment including ITU and ventilation. She became aware that the nature of the conversation and the questions the doctor was asking had changed. The doctor became focused on the general health and level of fitness of her husband. She was asked how far her husband could walk and how long it took him to do so. She felt pressured by this point specifically. She felt anxious about how her response would be used in decision-making for his care and treatment as she was aware that how far her husband could walk was not in and of itself, a central element to this level of clinical decision making. This member's husband had recently been diagnosed with chronic fatigue syndrome. However, she explained that he was otherwise quite healthy with no previous chest or cardiac issues. Her husband had arthritis which was a restrictive factor in his mobility. His knee replacement surgery had been cancelled due to the pandemic.

This member felt that the Doctor really pressed her on this when she finally told him that her husband could walk for about half a mile before he had to stop due to the pain in his knees. The Doctor then said, 'that's what I mean' and intimated that this member's husband was in a state of health that would mean he may not be considered for ventilation and ITU care. This member has explained that her husband still had lots of his life yet to live. He eventually was assessed for his suitability for ventilation and this member was shocked to find out that he was assessed as not a candidate for ventilation and would not be moved to ITU. He subsequently died.

The impact on people identified as on the shielded list/ Highest Risk List and those with vulnerabilities who were not on this list

59. We have members whose relatives had to continue attending their places of employment during lockdown as they were key workers and had not received a shielding letter from the government, despite having particular underlying health conditions that would make them vulnerable if they contracted covid.

60. The husband of one of our members was a keyworker and suffered from asthma and pernicious anemia. He was not considered to be in the shielding category, therefore did not receive a shielding letter and had to continue to attend work. Subsequently, there was an outbreak of covid at his workplace and he contracted Covid and became very unwell and died.

61. Furthermore, we have an example of a member who received a shielding letter in April 2020 due to having asthma, previously having cancer where she lost her kidney and had also recently been diagnosed with fibromyalgia. However, in July 2020 she received a letter confirming that she could return to work in August 2020. She then returned to her employment as a domestic assistant with the Scottish Fire and Rescue Service and subsequently contracted covid, became very ill and died.

62. We also have a member whose parents both had serious underlying medical conditions. Her father had a tumour removed from his left lung in October 2019. He was receiving chemotherapy and being treated palliatively. Her mother had COPD. This member has explained that her parents didn't start shielding until they received their shielding letter and that she considers her parents received their shielding letter too late. We understand that this was received at the end of March 2020. They both contracted covid and passed away one day apart on 8th and 9th April 2020.

Changes to inspections and monitoring of healthcare settings

63. Our members are concerned as to what Infection Prevention and Control (IPC) monitoring, supervision and inspection was being undertaken in hospitals and healthcare settings during the pandemic. We understand from one of our members who previously held a Senior Role in a Health Board area, that both pre-pandemic and currently, Healthcare Improvement Scotland had responsibility for the 'Safe delivery of care in acute hospitals' and that this included 'infection prevention and control (including respiratory pathways)' and the 'systems and processes in place to mitigate risks in relation to the delivery of safe care'. Pre-pandemic, the Inspection process was compromised of both announced and unannounced

inspections. Thereafter, a report and recommendations with an agreed action plan would be developed and the Health Board would be required to report on its progress on the action plan both to the Health Board itself, and to Healthcare Improvement Scotland.

In addition, Health Boards were required to report on key performance indicators regarding IPC and to report on patient safety measures for improvement in relation to IPC. Also, we understand that pre-pandemic, should there be an outbreak of an infection, Outbreak Management Teams would be put in place and manage the outbreak through until safe conclusion and that this included reporting to the Health Board, Healthcare Improvement Scotland, and the relevant Directorates at Scottish Government. Hospital based IPC teams would offer training, support and supervision on IPC practice and ensure that current policy and guidance was being correctly implemented.

Our members have advised us of a number of examples they have witnessed, where fundamental IPC guidance was being breached by healthcare staff. Our members are concerned as to what level of inspection, support and supervision was deployed, both at local and national level, to support healthcare staff understand and apply the current IPC guidance including the use of PPE, particularly when we have been given to understand that the guidance was changing very frequently.

Our members are also concerned as to how 'covid outbreaks' or 'covid clusters' were being managed in hospitals and the impact of both of this and the level of compliance with IPC policy and guidance on the rates of nosocomial infection and deaths.

Scottish Covid Bereaved Further Concerns

64. Our members have raised a multitude of concerns relating to the healthcare system.

65. We have a member who has explained that, having travelled to the hospital where her father was being admitted, she noticed there was no separation of covid and

non-covid patients on admission. She also witnessed patients standing outside the hospital smoking and meeting with friends, without social distancing, and then going back into the hospital. Her father was in hospital for a hip replacement. When a family member handed in items to the hospital for her father, it was noted that the staff in the ward weren't wearing PPE.

66. Another member has explained that while the hospital where her relative was being treated had strict visiting protocols, she witnessed people getting round the restrictions on visiting by meeting family and friends in the car parks and just outside the hospital where they would mix with no social distancing or being required to wear face masks. This is an issue that was not addressed in hospital infection control protocol/plans.

67. We have a member whose elderly father was admitted to hospital from his care home. He was in the shielding category and was therefore, very vulnerable. He was placed into a four bed room in hospital. This member considers that he should have been put into a single room given that he was in the shielding category. While visiting the hospital, it was noted that nurses were not changing their PPE when going between different patients. This member thinks that staff may have become complacent during the second covid wave. This man caught covid as one of the other patients in his room had contracted it and he subsequently died.

68. We have a member who observed an Advanced Nurse Practitioner moving from red zones to green zones to treat patients, contrary to infection control protocols. Additionally, she has explained that she witnessed her father sharing a zimmer frame with another patient who was in the bay next to him.

69. A member whose mother had leukemia explains that she was admitted to hospital for treatment during March 2020 and was put in a shared room and also noted that staff were not wearing PPE in a situation where patients were all extremely vulnerable as they were being treated for cancer.

SCB Formal Engagement with the Scottish Government re the impact of the Covid-19 pandemic on the healthcare system and patients receiving healthcare.

70. Our group began a political campaign ultimately leading to the formation of the Scottish Public Inquiry. This began in September 2020 with the then Scottish Labour Leader asking a question on our behalf at FMQs. Since then, various questions have been asked on behalf of members by politicians from all political parties.

71. Within our group of bereaved individuals, we identified consistent areas of concern amongst our Members which we have shared with the First Minister, Deputy First Minister and the Health Secretary when we met with them.

72. Our first meeting took place in March 2021, where we had a virtual meeting with the First Minister, Nicola Sturgeon. We put a number of questions relating to the concerns of our members, to the First Minister (a full list of these questions can be made available on request).

73. For example, we flagged up the fact that Nosocomial deaths were in the region of 25% compared with Care Home deaths at 9% - this figure has subsequently been confirmed by various research including the BMJ Report as at June 2021 which actually put the figure at 27%.

74. We also raised issues about covid symptoms consistently being restricted to the three cardinal ones, namely high temperature, persistent cough, and loss of sense of taste or smell whether you were speaking with NHS 111 or using on-line testing criteria. The Scottish Cabinet Secretary for Health confirmed to us in December 2021 that the UKHSA were responsible for the symptom profile and would not, at that stage, change it. A clear example of the Devolved Nations having to follow the UK lead.

75. We also had various meetings with Deputy First Minister, John Swinney and the Cabinet Secretary For Health, Humza Yousaf between 17th August 2021 and 24th November 2021.

76. At these meetings we again raised issues relating to covid symptoms and testing criteria and we received a formal reply on this on 23rd December 2021. We also raised a lack of bereavement counselling especially for those bereaved when strict social distancing measures were in place.

77. The Chair of the then Scotland branch of CBFFJ met with the then Chancellor of the Exchequer, now the Prime Minister, Rishi Sunak, in November 2021. Mr Sunak was the Chair's constituency MP. At that time, the Scottish Inquiry had been confirmed but Prime Minister Johnson continued to prevaricate about whether to instruct a Covid Public Inquiry and if so, announce who might lead it. The purpose in meeting Mr Sunak was to ask him to press the Prime Minister in Cabinet, to instruct a Covid Public Inquiry at UK level and to declare it and name a Chair. The Chair of the Scotland Branch of the then CBFFJ implored him to press the Prime Minister to do the right thing. Within a month or so, Prime Minister Johnston had announced a UK public inquiry. In addition, over a period of 6 months, the Chair of the Scotland Branch of CBFFJ continued to have email correspondence with Mr Sunak in matters related not only to the UK Covid Inquiry and its Terms of Reference, but other more general matters, including, for example, that he support in Parliament a call for a 'Hillsborough Law now', and that the Covid Memorial Wall in London be recognised as the UK's primary Covid Memorial. This included the Chair having correspondence from not only the Chancellor of the Exchequer, but also the Paymaster General, Michael Ellis.

Lessons Scottish Covid Bereaved considers can be learned or recommendations Scottish Covid Bereaved would wish the Inquiry to consider in relation to the way the healthcare system operates in the event of a future pandemic.

Workforce

78. The NHS Scotland workforce was already under pressure pre-pandemic with significant vacancies across medicine, nursing, midwifery, Allied Healthcare Professionals and other support and key worker roles.

79. Vacancies in specialist areas which were particularly relevant in the pandemic, including ITU and Specialist Respiratory services created significant additional pressures.

80. NHS Scotland has developed a Workforce Plan. In terms of lessons learned and planning for future pandemics, it is imperative that this Workforce Plan addresses retention and recruitment, specialist skills deficit and underpins future pandemic preparedness plans. These plans should set out how the healthcare workforce could be 'flexed' in a future pandemic in a more planned and co-ordinated way that takes cognisance of the likely level of staff absence due to sickness or in the case of Covid, isolation.

81. Contractual terms and conditions which specifically relate to both statutory and contractual sick pay must be addressed so that staff are not concerned that their attendance record will be adversely affected by for example, periods of self-isolation, such that staff continue to work when symptomatic or returning to work before they are fully recovered or are continuing to test positive.

PPE

82. The current NHS Scotland systems for procurement, quality, storage, stockpiling and management and distribution of PPE must be the subject of a root and branch review. It is clear from the actual lived experience of healthcare staff and SCB members, that the 'just in time' approach to procurement, stock management and distribution were totally ineffective in the pandemic. Sufficient attention was not paid to the quality of the PPE provided to healthcare staff.

83. This placed healthcare staff at very significant risk and had a catastrophic impact on those healthcare workers who lost their lives and on those who now have Long Covid.

84. 'Fit testing' of PPE, particularly FFP3 masks, was inadequate at best. The masks and the 'fit testing' were based around the model of a white, beardless male face and took no account of the female workforce or workforce from ethnic minority backgrounds.

85. The guidance provided for NHS healthcare staff changed frequently and it became almost impossible for healthcare staff to 'keep up' and ensure that they were complying fully with current guidance. Staff may have ended up 'doing nothing' for fear of not being compliant with current guidance. Those developing the guidance should take cognisance of the constantly changing workforce who are 'patient facing' in a pandemic when staff themselves may be going off sick in large numbers. Guidance should be simple, straightforward, pragmatic and most of all, offer the staff and therefore the patients, the highest level of protection.

86. Fundamental understanding of how to wear, use and remove PPE must be an essential element of practice for every member of healthcare staff relevant to their place of work. 'Fit testing' processes must be reviewed and be able to be 'scaled up' as part of pandemic preparedness.

87. SCB members believe that the lack of the correct and appropriate level and quality of PPE for each clinical area contributed directly to the incidence of nosocomial Sars Cov2 infection and therefore to the number of deaths.

88. SCB members believe that the availability of PPE contributed directly to whether members were enabled to be with their loved ones when they died in hospital.

Testing

89. SCB believe that the testing capacity across Scotland was woefully inadequate and could not be 'scaled up' quickly and effectively. SCB believe that this significantly contributed to the rate and scale of community transmission of Sars COV2, and that this in turn led to the high rate of nosocomial infection and number of deaths including those healthcare workers who died.

90. The testing protocols and guidance in the early part of the pandemic were focused on those individuals arriving in or returning to the UK from other countries. No cognisance was taken of the risks of asymptomatic transmission although this was understood from at least January 2020. Tests were not available for asymptomatic individuals even when they had been in close contact with for example, a family

member with overt symptoms and when they were advised to secure a test by medical practitioners.

91. Once tests were made available to members of the public, the early systems resulted in it taking 48 hours for a test to arrive at its destination and then a further 24 hours before it was returned and a further 48 -72 hours before the results were known and communicated to the individual.

92. Staff testing in hospitals and healthcare settings was plagued by wholly insufficient testing capacity. SCB believe that in the early stages of the pandemic, the time delay in getting the test results back which could be as much as 5 days, significantly contributed to the rapid, extensive, and catastrophic transmission of Covid in hospital and healthcare settings and within the healthcare workforce.

93. Patients being admitted to hospital had a Covid test on admission. Thereafter, each hospital appeared to have its own testing regime. Future pandemic planning and management must clarify the in-patient testing regime and apply this consistently across NHS hospitals.

94. Contact tracing capacity was completely overwhelmed in the early stages of the pandemic. As the pandemic progressed, SCB believe that 'gaps' in this important aspect of pandemic management were exposed.

95. SCB believe that going forward in terms of pandemic planning and preparedness, Testing and Contact Tracing capabilities must be in a position where they can be scaled up quickly and effectively and that as part of workforce planning, there is provision made to redeploy and 'upskill' staff to support this aspect of pandemic

management. SCB would suggest that future workforce and pandemic preparedness plans consider this going forward.

Infection Prevention and Control

96. SCB members have directly experienced and observed significantly variable infection prevention and control practices.

97. Members are aware that the 'IPC' guidance for hospitals, healthcare settings and healthcare staff was changing at pace and often several times per day.

98. SCB would urge recommendations that ensure that in future pandemic situations, IPC guidance is developed that is based on the best available evidence; is consistent across NHS Scotland; is simple, clear, and concise and can be readily and consistently implemented by NHS Scotland staff. In addition, IPC and PPE guidance for members of the public attending hospital and healthcare settings is also clear, simple and consistently applied across NHS Scotland.

99. 'IPC' guidance includes not only PPE but also the fundamental aspects of 'IPC' of hand hygiene, and cleaning regimes in wards and clinical areas with particular emphasis on 'high traffic' & communal areas such as toilets. We understand that ventilation, and in particular the role of HEPA air filtration and its use in the removal of airborne contaminants, is an essential element of IPC practice.

100. It also includes the management of patients in wards and the wider hospital. This includes 'boarding' of patients from one clinical area to another, and cohorting, isolating and shielding patients within a single ward or clinical area.

101. The SCB understand that high bed occupancy, the ineffective management of patient movement in hospitals, including excessive boarding of patients to 'free' beds, and ineffective use of cohorting, isolating and shielding patients, significantly contributed to the incidence of nosocomial SARS Cov2 infections and to the number of deaths from nosocomial SARS Cov2.

102. In addition, the movement of staff from one clinical area to another to manage and support patient care needs including the use of temporary staff such as 'bank' or 'agency' staff, has an impact on IPC and transmission of infection and therefore the rate of nosocomial SARS Cov2 infection and number of deaths.

103. SCB would urge that recommendations result in pandemic preparedness plans related to hospital settings taking cognisance of the potential/actual surge in demand for hospital care, and to make plans which increase capacity of ITU, HDU, Respiratory HDU beds and which make clear how patients can be effectively managed to maximise patient safety and minimise the risks associated with moving patients to, from and through clinical areas. Plans should also mitigate for increased staff movement.

104. SCB would also suggest that the use of HEPA air filtration in hospitals is an absolute priority which needs urgent action.

Care, compassion, consistency

105. SCB members have no doubt as to the bravery and nothing short of heroic efforts of our country's healthcare staff and key workers.

106. Communication is central to person centred, compassionate care. Whilst our members have many examples of exemplary communication between healthcare staff and our members, we also have many examples of where there was no communication about issues that were crucial to our members to have understood about the care and treatment of their loved ones; where communication was poor and led to misunderstanding and confusion; or where communication was inconsistent between healthcare staff, and our members were uncertain about the accuracy of the information that they were being given. This created additional anxiety and distress for our members who were unable to see their loved ones and reliant on healthcare staff for information.

107. The experiences of SCB members of their loved ones care in hospital, particularly at end of life, was variable and inconsistent. Some members were enabled to be with their loved ones when they died; some were able to spend for example, a few hours for a few days until their loved ones died; others a few minutes on the day that their loved ones died; others told that they could not come in at all; others told that they would need to choose between being with their loved ones when they died and not being able to attend their funeral as they would be self-isolating. Some members, whose loved ones were on life support, were not allowed to be with their loved ones when the life support was turned off. Some were told by telephone that the life support would be turned off during the call; others given the opportunity to come to their loved one's bedside but told that they could stay only for a limited time which varied. For example some were only given 5 minutes and some were only given an hour.

108. Our members experiences demonstrate that within the same hospitals, even in the same ward, there was inconsistency in how these decisions were made. Across Health Boards, different decisions were being made in their various hospitals. No apparent rationale or consistent guidance appeared to be in place.

109. SCB consider that their experiences at the end of life of their loved ones, when our members may not have seen or spoken to their loved ones for days or weeks, was lacking in compassion; did not appear to be based on scientific evidence and has played a significant part in the ongoing traumatic grief that our members are experiencing.

110. Future pandemic planning must be based on the foundation of care and compassion and there must be consistency across the NHS in how family members are enabled to be with their loved ones at the end of life.

111. The burden placed on NHS healthcare staff by excluding family from supporting their loved ones at end of life was unnecessary and has undoubtedly added to the mental health and emotional well-being traumas experienced by many healthcare staff.

112. SCB members experiences of how their loved ones and their belongings were managed after death was also inconsistent with some being told that their loved ones belongings would be incinerated and that they could not have anything to take away; others being handed clear plastic bags with the belongings carelessly 'stuffed' inside; others asking for items with irreplaceable emotional value to be given to them, only to find that the items could not be found; some being told that their loved ones would be placed in a body bag, treated as 'toxic waste' and that our members would not be able to see their loved ones again.

113. Again, SCB would urge future pandemic planning to take account of our members experiences regarding the management of loved ones after death.

114. SCB members would be happy to support any such further work using our lived experiences to inform future planning, policy, and guidance.

DNACPR

115. One of the most significant and most distressing areas of concern raised by SCB members is that of DNACPR.

116. SCB members are aware that medical staff in every healthcare setting, have an abundance of professional guidance regarding DNACPR at their disposal.

117. SCB members are aware of guidance based around an ethical framework which was developed in NHS Scotland at the outset of the pandemic to support medical staff with their clinical decision making during the pandemic.

118. The issues raised by our members focus, in the main, on communication and decision making, capacity, securing a signature on the DNACPR form and recording the decision in the medical notes.

119. During the pandemic, SCB members have recalled their experiences of listening to constant media coverage which was indicating that the NHS was running out of ventilators, running out of ITU bed capacity, had insufficient ITU skilled staff, was running out of 'piped' oxygen in hospitals and that the NHS was overwhelmed. Members also recall their experiences of media coverage from other countries, including Italy, where doctors were confirming that they were having to 'ration' clinical care, particularly HDU and ITU level care because there were insufficient ventilators, beds, and staff. Clearly, this has raised concerns for our members as to whether the same issues were happening in our NHS hospitals and our loved ones were subject to clinical decision making that was based on criteria other than those ethical frameworks and professional guidance.

120. Our members were most often unable to be with their loved ones when these decisions were being made as no-one was allowed to visit their loved ones in hospital. They were reliant on medical staff having these very difficult conversations over the telephone. Consultation and communication were inconsistent, even within the same hospital or hospitals within the same Health Board.

121. The way some medical staff gained consent, recorded this in the medical notes and communicated this with our members has left many with significant concerns.

122. Going forward, it is crucially important that the Inquiry seeks to understand the exact nature of the clinical decision making that was taking place during the pandemic, specifically with regard to DNACPR decision making and ensure that the ethical frameworks and guidance which underpins this are subject to a root and branch review and that the pillars of capacity, consent, communication, consistency of decision making and record keeping are central to future guidance. Future such guidance should also be able to be adapted in real time to support clinicians in future pandemics. Our members would be happy to assist in the future development of such guidance.

Treatment of vulnerable patients

123. One of our members has raised the question of whether a 'Hospital at Home' Service might be worth considering for the future to treat all vulnerable/ shielding patients, in circumstances where, for example, they require 'IV' antibiotics to treat a chest infection. 'IV' antibiotics could then be administered within the home, potentially avoiding admission to hospital. Had this approach been utilised, it may have reduced a significant number of hospital admissions and deaths from nosocomial covid infection.

Symptomology/Testing

124. There was undue and detrimental focus on the 'cardinal' symptoms of cough, fever and later, loss of taste and smell by, amongst others, NHS111, paramedics and health care professionals, both in general practice and in the hospital setting, despite emerging knowledge of the possibility of infected individuals being asymptomatic; asymptomatic transmission, and case reports of, for example, skin rash, neurological symptoms, and an increased clotting tendency as presenting features of Sars COV2.

125. Moreover, in the elderly, who were recognised at being more likely to have a poor outcome, insufficient prominence was given to the knowledge that the presentation of Covid 19 might differ from that seen in younger age groups. For example, in the elderly, the 'cardinal symptoms might be absent; the threshold for diagnosis of

fever should be lower; atypical symptoms such as delirium, falls, generalised weakness, and functional decline, might be the presenting feature/s and the patient might present with mild symptoms disproportionate to the severity of their illness. This guidance was available early in the pandemic (Covid -19 in Older Adults, University of Toronto- Guidance from the Regional Geriatric Programme of Toronto, cited by T Salanki in a blog on the British Geriatrics Society site 14 April 2020). Also the 'ZOE' study provides a comprehensive list of symptoms across all age groups.

126. In any future pandemic, once available, testing should be mandated for, not only those suspected clinically of being affected, but also on a routine basis, patients and staff in any healthcare setting, residential settings (care & nursing homes, prisons), those visiting any of these settings,and those with an underlying increased risk of severe disease and their family members. Such tests should be free of charge to the user.

127. In any future pandemic, unwell patients should be considered infected by the pathogen until proven otherwise; in other words, guidance issued to health care professionals should be less rigid.

Discharge of patients from hospital to care homes

128. The discharge of patients from the hospital setting to nursing and care homes and in some instances to their own homes (there being individuals living in the home who had underlying health issues making them more susceptible to becoming infected with Covid) without evidence of a negative Covid test led to countless preventable deaths.

129. Planning for a future pandemic should include robust systems for 'step-down' care facilities to relieve the pressure on acute hospitals (e.g. use of Nightingale Hospitals, with provision for staffing from e.g. pool of recently retired staff, staff redeployed due to 'pause' in routine work, those in Army & Navy reserves, final year medical & nursing students under supervision).

130. If such testing is available in a future pandemic, no patient with a positive test or with known exposure to the pathogen and with a test result which could be a false positive (e.g. a situation whereby an individual may test negative on Day 2 post-exposure but positive on Day 3) should be discharged into a nursing or care home, unless that home has facilities for barrier nursing and full PPE.

Expert Advice

131. SCB members are concerned how expert clinical, scientific, epidemiological, public health and microbiology advice was provided to both UK and Scottish Governments and how it informed decision making. Our members are concerned as to how these expert advisory groups had their collective voices heard and their advice taken cognisance of. It is the belief of SCB that decisions were not made timeously, that expert advice was, at times not understood and therefore not heeded, and that it was overridden by political decision making and not acted upon and that this resulted in avoidable deaths from SARS Cov2.

132. SCB urge recommendations that ensure that expert advice is central to future pandemic preparedness planning and that expert groups are co-ordinated across the 4 nations of the UK. SCB also urge that the Devolved Administrations are enabled to deal with situations as they arise in their populations, in line with 'WHO' guidelines which set out that epidemics and pandemics 'are best managed at the lowest practically effective level of Government' and 'not centrally managed'.

133. SCB are also concerned as to what risk management processes informed pre-pandemic planning and the development of the 'Four Harms Framework' used by the Scottish Government to inform their pandemic response. SCB consider that robust risk management processes be used to inform future pandemic planning.

134. SCB believe that the response of PHE was slow and failed to grasp the seriousness of the pandemic. Its advice and guidance were initially slow to

emerge, was subject to frequent change such that healthcare staff could not 'keep up', and their guidance on testing, particularly in the early stages of the pandemic, failed to take cognisance of evidence of asymptomatic transmission and the existence of the virus in communities in the UK before January 2020.

135. SCB supports a review of the role of UKHSA, PHE and PHS in pandemic preparedness and that these organisations have co-ordinated plans in place for the future.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 29-02-2024