

Tuesday, 16 January 2024

(9.59 am)

Opening remarks by THE CHAIR

LADY HALLETT: Good morning to all those present here in the hearing room in Edinburgh and to those who are following us online.

I've always said that this is an inquiry for all four nations of the United Kingdom, which is why I'm pleased to be here in Scotland to begin our public hearings in the devolved nations.

Today we begin the public hearings for Module 2A, focusing on key decision-making in response to the pandemic in Scotland.

May I emphasise yet again that I have not yet reached any conclusions, and I will only do so once I have heard and considered all the evidence, the oral evidence and the written evidence.

We will start this hearing, as we have started the previous two modules, with an impact film. The impact films remind us all why the Inquiry into the Covid-19 pandemic matters. Like its predecessors, it's extremely moving and there will be those who find it too distressing to watch. I will pause in a moment to allow those who are in the hearing room who wish to do so to leave for a few minutes, the film lasts about 20,

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In these hearings, which, as I say, are taking place in Edinburgh, we will examine the political response to the pandemic in Scotland, in the period between January 2020 and April 2022, when the last restrictions were lifted in Scotland. We will do so with the benefit of being able to assess, at this relatively short, but significant, distance from the events of that period, the decisions which were taken by government in Scotland, predominantly those of the Scottish Government, in the discharge of its most fundamental responsibility, to protect the people of Scotland from harm and ultimately from death.

As you have just heard, my Lady, and as one gentleman said, people think Covid is finished; it's not finished for anybody that's touched it.

Another lady said that every citizen in this country was impacted by Covid. The systems by which decisions were taken within the Scottish Government, including the extent to which these systems enabled advice to inform and improve decision-making, are a key part of this module. Given what we have just watched in our opening video and the themes which emerge, the tragedy, the heartache, the loss and destruction of life, the Inquiry must do what it can to see that in future all that can be done will be done to avoid this happening again.

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21 minutes, and those who are following online to press mute or pause the streaming.

After the film has been played we shall reassemble, and Mr Jamie Dawson KC, Counsel to the Inquiry, will begin his opening submissions. He will explain in some detail what we shall be examining in this module and what the issues are that need resolution.

So would those who would like to leave or press pause please do so now.

(Pause)

Could we play the film, please.

(Video played)

LADY HALLETT: Mr Dawson.

Opening statement by LEAD COUNSEL TO THE INQUIRY for MODULE 2A

MR DAWSON: My Lady, I am Jamie Dawson KC, Lead Counsel to the Inquiry in Module 2A. I appear along with my learned juniors, Mr Usman Tariq and Mr Andrew McWhirter, advocates, along with Mrs Heather Arlidge, Ms Bethany Condron and Ms Stephanie Painter of the English Bar.

May I say on behalf of those who are based north of the border to you and our colleagues who have travelled to Edinburgh for these substantive hearings of Module 2A, welcome to Scotland.

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We will examine in due course with statistical witnesses tomorrow the detail of the various aspects of the pandemic in Scotland, including the peaks of infection and death, the hospitalisation rates, and the effects of the pandemic on various different elements of Scottish society, which will be demonstrated in charts and graphs.

The headline figures lay bare the devastation caused by the virus and the ebb and flow of infection in Scotland. Data relating to reported infections shows that the peak of the first wave was 27 April 2020, with 434 newly confirmed cases. However, under-reporting of cases was particularly severe in the first wave due in particular to limits on testing and tracing capacity.

The Alpha variant first emerged in Kent around September 2020, and by the time of the peak of the second wave of infections, 29 December 2020, there were 3,137 confirmed cases. This variant was at that time responsible for the vast majority of infections nationally.

The next wave, particularly primarily of the Delta variability, peaked on 2 September 2021 with 7,622 confirmed cases. This was followed by the huge Omicron wave, which peaked in Scotland on 29 December 2021 with 23,539 confirmed cases. The ONS Infection Survey shows

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1 that at the peak of the second wave around 1% of the
2 Scottish population was infected and at the peak of
3 early 2020 [sic] Omicron wave it was around 8%.

4 These statistics, my Lady, are mere context. As you
5 have heard in the video which we have seen, this
6 devastation affected real people, real lives, it has
7 caused long-term harm.

8 As far as deaths in Scotland where Covid-19 was
9 mentioned as one of the causes of death on the death
10 certificate are concerned, the peak of the first wave
11 was on 9 April 2020, with 108 deaths occurring that day.
12 The peak of the second wave was 16 January 2021 with
13 77 deaths. Smaller waves occurred from late 2021
14 onwards, the highest peaking on 20 March 2022 with
15 34 deaths.

16 The total number of Covid deaths reported in
17 Scotland from the beginning of the pandemic up to
18 31 March 2022 was 14,130. Compared to the UK as
19 a whole, Scotland had lower levels of excess mortality
20 in the first and second waves in the pandemic. However,
21 in contrast, throughout mid to late 2021, Scotland had
22 higher levels of excess mortality.

23 You will hear, my Lady, that even where infection
24 did not result in death, infections caused significant
25 physical and mental consequences. The direct impact of

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1 and the development of children and young people, and
2 the serious exacerbation of pre-existing social
3 inequalities.

4 Those suffering from pre-existing health conditions
5 were not only more vulnerable to infection but also
6 serious morbidity or death. However, their non-Covid
7 health conditions went undiagnosed, unmonitored and
8 untreated due to the pressured created on the health
9 service by the extent of infection which occurred.

10 Almost every area of public life, including schools,
11 the transport system, the justice system, prisons, the
12 majority of public services, were all adversely
13 affected. Hospitality, retail, travel and tourism, arts
14 and culture, and the sport and leisure sectors,
15 effectively ceased to operate. Even places of worship
16 closed.

17 In economic terms, the pandemic resulted in the
18 deepest and fastest economic contraction on record, with
19 the Scottish economy contracting by 19.4% between April
20 and June 2020 alone, the biggest fall in quarterly gross
21 domestic product on record.

22 The economic downturn was widespread but
23 particularly affected customer-facing sectors.
24 Accommodation and food services saw the biggest decline
25 during the second quarter of 2020, with gross domestic

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1 severe disease and death due to Covid did not fall
2 equally. Older people were at particular risk. Up to
3 the end of 2022 in Scotland more than 70% of those who
4 died from Covid were 75 and over.

5 Of course, age was not the only factor that led to
6 stark inequalities and deaths from Covid, although no
7 other individual factor has a stronger effect.
8 Mortality was 2.5 times higher in the most deprived than
9 in the least deprived areas of Scotland.

10 People from some ethnic minority groups had
11 a significantly higher risk of being affected by
12 Covid-19 and dying from it. Risk of Covid-19 mortality
13 in Scotland during the pandemic has been the highest in
14 people from Pakistani communities. Mortality rates were
15 higher among people with disabilities, including, in
16 particular, those with a learning disability.

17 The consequences for the people of Scotland
18 resulting from the countermeasures taken by government
19 to combat the virus were also considerable. Though
20 I will return to evidence available to the Inquiry in
21 relation to these harms specific to Scotland, as in the
22 rest of the UK these included the effects of social
23 isolation, including significant impacts on mental
24 health, a rise in domestic violence, in particular
25 against women and children, serious impacts on education

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1 product dropping by more than 80%. The number of
2 Scotland's businesses fell by over 5% in the first year
3 of the pandemic, between March 2020 and March 2021,
4 meaning that Scotland lost almost 20,000 small
5 businesses.

6 Whilst the number of deaths rose, the NHS, the
7 police and emergency services and other key workers in
8 Scotland continued in their place of work. Many
9 frontline workers lost their lives because of Covid-19.
10 Almost everyone else was forced to work or be educated
11 from home, was furloughed or lost their jobs. At the
12 peak, around 780,000 jobs in Scotland were furloughed
13 under the UK Government's Coronavirus Job Retention
14 Scheme, equating to 32% of the workforce.

15 The details of this impact on every corner of
16 Scottish life will be examined in greater detail in
17 later modules, but these headlines are an important
18 backdrop to the key decisions which were made to fight
19 the virus, to manage the devastation, and lessen the
20 loss by those in government, which we shall examine
21 here.

22 In this module we intend to build on the evidence
23 which has been heard by the Inquiry in Modules 1 and 2,
24 which related to the preparedness of the UK, including
25 Scotland, for an emergency of the nature of the Covid-19

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1 pandemic and the high level response of the
 2 UK Government to it in the period from January 2020.
 3 At this point, the focus turns to Scotland, and the
 4 key decisions taken by those with the responsibility for
 5 managing the pandemic response in this nation. The main
 6 thrust of the module relates to the decisions taken by
 7 the government in Scotland, in particular the questions
 8 of the reasonableness of what the public health experts
 9 would call non-pharmaceutical interventions, or NPIs,
 10 introduced by them to seek to combat the virus.

11 These NPIs were the measures taken by way of
 12 restrictions on our normal lives, to seek to protect us
 13 from the onslaught of viral infection and ranged from
 14 the use of face masks and coverings and social
 15 distancing to lockdowns. They were taken throughout the
 16 temporal scope of the module, from January 2020 to
 17 April 2022, by government decision-makers. They varied
 18 in their nature and extent, as well as their perceived
 19 objective. They were taken in different contexts and at
 20 times in the face of uncertainty or rapidly changing
 21 facts or advice. They varied in their effectiveness.
 22 In many instances the requirement to strike a balance
 23 between competing potential harms which underpinned them
 24 resulted in aspects of our lives receiving benefit while
 25 detriments were caused elsewhere. Benefits and harms

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1 presented to you at the preliminary hearing in October.
 2 I will summarise then evidence which the Inquiry has
 3 already heard, or has available to it so far. This is
 4 not intended as mere repetition but as an important
 5 summary in this module for context but also substance.

6 One important advantage of this UK-wide Inquiry is
 7 its ability to compel evidence from across the UK to
 8 enable comparison and context. What has gone before is
 9 thus of relevance to your assessment of the evidence you
 10 will hear in Scotland. Further, some core participants
 11 and members of our wider public audience in Scotland
 12 will be tuning in to this module and may not have had
 13 the benefit of hearing the evidence in previous modules
 14 which you have heard. The UK context which you have
 15 heard in Module 2 is important here given Scotland's
 16 devolution settlement, which means that UK ministers and
 17 decision-makers are decision-makers in Scotland too,
 18 directly in certain areas and indirectly in others.

19 I will then move on, my Lady, to set out
 20 a chronology of key events. Its intention is to provide
 21 factual context to the issues with which we will be
 22 concerned in the module. It intends to set out the key
 23 NPIs imposed on Scotland, their apparent significance,
 24 and the way that the pandemic progressed in its
 25 devastation across the country.

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1 fell unevenly across Scotland.

2 However, what we seek to do in this module is to
 3 understand the decisions which were taken, why they were
 4 taken, in order ultimately to assess whether they were
 5 reasonable, evidence-based and in the best interests of
 6 the people of Scotland. Where they appear not to have
 7 been, we seek to explore what might have been done
 8 better to achieve these aims. We do so, as we have been
 9 charged under our terms of reference and the scope of
 10 our module, in order that the people of Scotland can
 11 ultimately gain an understanding of why the pandemic was
 12 managed in Scotland as it was, but also to try to form
 13 the basis of possible recommendations to government as
 14 to how any such future disaster might be handled better.
 15 Those who suffered infection, hardship and bereavement
 16 in the pandemic in Scotland deserve no less.

17 I am delivering this opening statement on behalf of
 18 the Inquiry team to provide you and the public who are
 19 listening with a summary of the relevant evidence which
 20 has been gathered by the Inquiry to date and outline
 21 evidence you will hear over the next few weeks.

22 In doing so, I intend to deal with the following
 23 broad matters:

24 Firstly, my Lady, I intend to look at some of the
 25 practical steps taken by the Inquiry since I last

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1 I will then highlight some other areas that we will
 2 cover at the hearing, and set out in some more detail
 3 our plans insofar as we can reveal them at this point
 4 for how we will go about our business before concluding.

5 In accordance with their right to do so, you will
 6 later today hear opening statements delivered on behalf
 7 of eight core participants in this module as follows:
 8 Ms Claire Mitchell KC will speak on behalf of Scottish
 9 Covid Bereaved; Mr Danny Friedman KC will speak on
 10 behalf of Disability Rights UK and Inclusion Scotland;
 11 Sam Jacobs will speak on behalf of the Trades Union
 12 Congress and the Scottish Trades Union Congress;
 13 Rory Phillips KC will speak on behalf of the National
 14 Police Chiefs' Council; Simon Bowie KC will speak on
 15 behalf of Public Health Scotland; Una Doherty KC will
 16 speak on behalf of NHS National Services Scotland; and
 17 Geoffrey Mitchell KC will speak on behalf of the
 18 Scottish Ministers.

19 The other core participant in this module,
 20 Scottish Care, has opted not to deliver an opening
 21 statement, although you will hear, from a representative
 22 of that organisation, evidence later this week, my Lady.

23 So to turn, then, to a number of practical matters
 24 of significance as to where we have reached in the
 25 module. You will recall, my Lady, that a third

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1 preliminary hearing in the module took place in October
 2 of last year and I intend to provide a broad update as
 3 to where we have reached. At the last hearing
 4 I provided an update of documentary recovery received by
 5 the module. Both discovery and disclosure of documents
 6 to core participants has continued to occur since that
 7 date. The up-to-date position is that 54,331 documents
 8 have been recovered by the module in response to its
 9 Rule 9 requests, a little over 36,500 documents have
 10 been disclosed to core participants after an assessment
 11 of relevance.

12 I set out at the last preliminary hearing a history
 13 of the documentary discovery in accordance with our
 14 numerous requests to Scottish Government and its various
 15 directorates. We remain grateful for the documents
 16 which have been produced in helping to resolve the
 17 issues in the module from Scottish Government and they
 18 have continued to be so since I last addressed you.

19 We intend to address various issues in the module,
 20 more detail of which I will narrate in this opening
 21 statement. When seeking documents on various occasions
 22 from the Scottish Government we have sought to be clear
 23 as to what we need to see, focusing our detailed
 24 requests on both the scope of the module and the list of
 25 issues with which they are provided. This effort,

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1 preliminary hearing, the issue of the recovery of
 2 informal communications. You will recall that this was
 3 included amongst the list of issues in the module, in
 4 particular issues relating to structures which were in
 5 place to enable effective communication amongst key
 6 decision-makers, how effectively they function, and how
 7 they developed. These included informal systems of
 8 messaging such as texts and WhatsApps in any aspect of
 9 core decision-making.

10 We made it clear to the Scottish Government that we
 11 expected documents either held by them or in the hands
 12 of individuals on whose behalf they were acting that we
 13 would expect to see these documents as part of our
 14 assessment. You will recall, my Lady, at the last
 15 preliminary hearing that we had had some difficulty with
 16 accessing these documents and that few, if any, had been
 17 made available to us. I am pleased to say, my Lady,
 18 that after a certain degree of political controversy
 19 over the issue, a large number of documents have now
 20 been made available to us. These have been analysed and
 21 relevant messages will be put to witnesses during the
 22 course of these hearings. These comprise messages from
 23 around 85 messaging groups which came directly from the
 24 Scottish Government and a total across both types of
 25 messages, ie those within groups and between

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1 my Lady, as I set out at the last preliminary hearing,
 2 has involved a number of requests and at times some
 3 difficulties getting hold of the documents which we
 4 wished to have.

5 In order to assist the process, we set out for the
 6 Scottish Government a number of key documents which, in
 7 our view, were essential to our assessment of matters
 8 within the module. These included Cabinet minutes and
 9 associated papers, situation reports provided to
 10 a Scottish Government decision-making body, the minutes
 11 and associated papers of the Scottish Government
 12 Covid-19 Advisory Group, and a residual category of
 13 documents containing documents provided to ministers
 14 setting out advice, commentary, recommendations and
 15 submissions concerning key decisions.

16 It is our understanding, my Lady, that the
 17 Scottish Government has provided to us all of the
 18 documents that it considers falls within these important
 19 categories. We therefore approach these hearings on the
 20 basis that we have everything that we need, which we
 21 have been able to analyse. If that transpires not to be
 22 the case, as I said in the preliminary hearing in
 23 October, we will want to know why.

24 My Lady, you will remember, and perhaps have seen
 25 some significant press attention since the last

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1 individuals, of around 28,000 messages. These include
 2 messages from prominent ministerial decision-makers and
 3 others in key advisory roles within the
 4 Scottish Government.

5 On one further practical matter, my Lady, which
 6 I would like to touch upon, which I touched upon at the
 7 last hearing, is that of legal professional privilege.

8 You will recall, my Lady, that I raised the issue at
 9 the last preliminary hearing and have an update to set
 10 out in that regard. At that hearing I explained that,
 11 after prior discussions on 3 August 2023 our module
 12 formally requested that the Scottish Government waive
 13 privilege in the documents being provided to
 14 the Inquiry. That was to enable the Inquiry to be sure
 15 that it was able to probe all corners of the relevant
 16 documentation to deal with the varied and important
 17 issues which are raised in the module.

18 Various proposals were made by the Scottish
 19 Government in the period around and after that hearing,
 20 and there was a significant amount of engagement about
 21 it. My Lady, the position which we have reached now is
 22 that the Scottish Government has effectively waived LPP
 23 in the documents which have been provided to us, other
 24 than in respect of something called the Law Officers'
 25 Convention, and even in that regard only in relation to

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1 law officers' opinions. Our current assessment of the
2 documentation is that that slight reservation on the
3 waiver will result in very few documents having
4 redactions applied to them.

5 One thing I would say, my Lady, which is of
6 relevance to core participants in particular, that
7 though this is a welcome development, the lateness of
8 this decision on the part of the Scottish Government has
9 had a practical effect. The number of documents which
10 had had redactions applied for either of these reasons
11 amounted to around 3,282 documents.

12 These have now been provided to the Inquiry in
13 accordance with the Scottish Government's waiver with
14 the redactions removed. Many of these had already been
15 disclosed to core participants and reviewed by
16 the Inquiry. The unredacted documents require to be
17 reprocessed, disclosed and reviewed. This takes time.
18 A certain amount of priority documents for the purposes
19 of these hearings have gone through that process
20 already. These comprise Cabinet minutes and associated
21 papers totalling just under 400 documents, but there is
22 an ongoing process for the other documents to be
23 disclosed.

24 As a result, there will be a practical impediment to
25 the amount of documentation that we will have seen,

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1 related to the ambit of Module 2A.

2 We anticipate, I hope reasonably and certainly
3 consistently with the way in which we have approached
4 preliminary hearings in this module, that the audience
5 will be likely to comprise those who are interested
6 predominantly in the Scottish experience of the pandemic
7 and thus that many may have little or no experience of
8 the evidence which the Inquiry has already heard which
9 constitutes important context.

10 The context is, in our view, important both for
11 understanding what this module is, but also what it is
12 not. The module is not an analysis of Scotland's
13 preparedness for an emergency such as the pandemic.
14 That was looked at in Module 1, a summary of key
15 evidence in -- which I will set out in a moment. Given
16 the role that both the UK Government and the Scottish
17 Government had in planning for an emergency in Scotland
18 such as the pandemic, Module 1 covered both aspects of
19 that.

20 Equally, the module is not a detailed analysis of
21 UK Government decision-making. Much of that ground has
22 been covered in Module 2, with detailed oral testimony
23 having been taken from ministers, senior civil servants
24 and other advisers relating to the management of the
25 pandemic at UK level, many of those decisions taken at

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1 although, as I've set out, the developments in this
2 regard are welcome on the part of the Inquiry.

3 My Lady, since the last preliminary hearing, when
4 I set out a number of steps that we intended to take in
5 advance of this hearing, I'm pleased to be able to say
6 that we have managed to complete, I think, all of them.
7 We have sent out to core participants for their
8 assistance two key documents, one which sets out
9 a chronology of key events, key decisions and details of
10 the ebb and flow of the pandemic in Scotland, which is
11 in far more detail than I intend to cover today, I'm
12 sure you're pleased to hear.

13 We have also sent out another document which intends
14 to encapsulate what we consider to be uncontroversial
15 evidence relating to a number of key individuals and the
16 roles they played in the Scottish pandemic response, and
17 also the way in which key bodies within the
18 Scottish Government and its advisory systems were
19 structured. We trust that these documents are of
20 assistance and we will give consideration in due course
21 to the possibility of publishing either both or one of
22 them.

23 My Lady, at that juncture, if I may turn to the next
24 section of my opening statement, which relates to the
25 evidence available to the Inquiry already, which is

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1 that level of course having a direct or indirect effect
2 in Scotland as well.

3 The module seeks to focus instead on the
4 decision-making of the Scottish Government, which was
5 the predominant means by which the pandemic was managed
6 in Scotland. It would be artificial, however, for the
7 evidence of the Scottish ministers and their advisers to
8 be heard in complete isolation. The reality of
9 a combination of the devolution settlement, which
10 allocated responsibility for reserved matters to the
11 Westminster Parliament and hence the UK Government, and
12 devolved matters to the Scottish Parliament and hence
13 the Scottish Government, coupled with the all
14 encompassing nature of the pandemic, which affected in
15 some way all aspects of society, resulted in both
16 governments having control over the management of the
17 pandemic in Scotland to some extent.

18 Though our focus will be on the evidence of the
19 Scottish ministers and their advisers, an examination of
20 the management of the pandemic in Scotland will entail
21 an examination of the Scottish Government perspective on
22 key decisions and structures and working between the two
23 governments. To an extent this has been examined with
24 UK Government ministers and advisers in Module 2, but we
25 also will need to look at specific aspects of

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1 intergovernmental working which we will do with both
 2 Scottish Government and UK Government ministers.
 3 This will not be a re-run of the evidence heard by
 4 you already, my Lady, in Module 2, but it will draw upon
 5 that evidence and seek to look at key aspects of the
 6 role the Scottish Government and the UK Government in
 7 their interrelation, insofar as significant in the way
 8 that the pandemic was managed in Scotland.

9 Equally, the module is not a detailed examination of
 10 the impact of the pandemic or the way in which it
 11 manifested itself in certain key sectors of society in
 12 Scotland. An analysis of impact will come later.
 13 A more detailed investigation into the way the pandemic
 14 manifested itself in sectors such as the NHS and care in
 15 Scotland, the roll-out of testing and vaccination
 16 programmes, the procurement of PPE, will come later.

17 However, the general epidemiological flow of the
 18 pandemic, the spread of infection, death and morbidity
 19 caused by it in its wake and the key high-level
 20 political decisions which were taken to try to combat
 21 the virus do form part of our investigation.

22 Thus, the understanding of and the key decisions
 23 taken or not taken by government in Scotland in the
 24 field of care, concerning vaccination strategy,
 25 regarding testing for the virus and other protections

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1 place on 14 April 2010. As far as operational response
 2 was concerned, agencies relevant to the response, such
 3 as police, fire service or health boards in any given
 4 emergency, would form something called a resilience
 5 partnership, within which structure they could
 6 co-ordinate, collaborate and share information.

7 There were three regional resilience partnerships
 8 within which local resilience partnerships comprising
 9 multiple local agencies sat. Alongside that was the
 10 Scottish Resilience Partnership, a core group of the
 11 most senior statutory responders and key resilience
 12 partners. The group acted as a strategic policy forum
 13 for resilience issues, providing advice to ministers.

14 Work to prepare for the pandemic or such other
 15 emergency was done on a UK four nations basis.
 16 Preparation focused on planning for a flu pandemic, on
 17 the basis of expert scientific advice. Infectious
 18 disease was, however, also identified and considered in
 19 the Scottish Risk Assessment, which you looked at in
 20 Module 1. It was considered that the reasonable
 21 worst-case scenarios for flu would apply to other risks
 22 if they occurred and preparations could be adapted.

23 This was on the basis that in planning for an emergency
 24 focus was not -- on the consequences, ie the impact of
 25 a pandemic, and not on the cause.

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1 from it, like PPE, will be considered to the extent
 2 necessary to get to the bottom of the government's
 3 strategy, its reasonableness, its proportionality, and
 4 its efficacy.

5 As I have made clear at previous hearings relating
 6 to the module, the reason for approaching matters in
 7 this way is to try to get to an understanding of the key
 8 issues which affected the largest number of people in
 9 Scotland and to provide an assessment of those issues in
 10 a report at a time when those issues are still live in
 11 the memory.

12 To turn, then, my Lady, to the evidence heard in
 13 previous modules about Scotland's preparedness for
 14 a pandemic, which was largely looked at in Module 1, the
 15 evidence you heard, my Lady, was to the effect that,
 16 prior to the arrival of Covid-19, the
 17 Scottish Government operated a hub and spoke resilience
 18 model with the Deputy First Minister, then John Swinney,
 19 at the head of its Resilience Division. In the event of
 20 an emergency of any kind arising, the
 21 Scottish Government Resilience Room, or SGoRR, could be
 22 activated to co-ordinate and direct actions designed to
 23 respond to the incident.

24 In his evidence, John Swinney recorded that the last
 25 recorded meeting of SGoRR before the pandemic had taken

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1 There was an antiviral stockpile, FFP3 respirator
 2 masks, masks were part of the PPE stockpile in
 3 preparation for the pandemic. In addition to having
 4 adequate supplies of PPE, the four nations did also have
 5 a just-in-time contract for FFP3 respirators as
 6 a contingency, though the foreign supplier was actually
 7 prevented from fulfilling the contract by their
 8 government at the early stages of the Covid-19 response.

9 PPE for Scotland and the other devolved
 10 administrations was procured through the Public Health
 11 England. This was on the basis of economies of scale.
 12 The Barnett formula, about which we will hear more in
 13 this module, was used, and so Scotland took about 8.2%
 14 of the total required for the UK. It was then sent to
 15 Scotland and safely stored in a warehouse. It was
 16 procured by the Scottish Government for the NHS and
 17 social care staff. Agencies such as, for example, the
 18 police would have been aware they required to have their
 19 own stockpiles of PPE for use in an emergency.

20 Scottish planning for a pandemic was largely based
 21 on the UK model, which as you have heard was based on
 22 a possible influenza pandemic. Scotland conducted its
 23 own pandemic influenza preparedness exercises, including
 24 Exercise Silver Swan, in 2015, and Exercise Iris in
 25 2018, relating to a possible outbreak of MERS. Scotland

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1 had a role in the national Exercise Cygnus in
2 October 2016, which also concerned preparedness for
3 an influenza pandemic.

4 Workshops set up in January 2018 on local
5 authorities' flu pandemic preparations occurred in
6 Scotland. A report was produced from that exercise
7 which Scotland was not involved in producing but access
8 to it was given by their colleagues in England. The
9 report contained a number of recommendations for people
10 to consider.

11 A number of tabletop exercises were spoken about in
12 the evidence which you heard. In her evidence to
13 Module 1, the former Chief Medical Officer for Scotland,
14 Catherine Calderwood, reviewed the utility of these
15 tabletop exercises. She noted that some of the
16 recommendations from previous exercises were still
17 outstanding by January 2020 and that, of course, had the
18 timing, nature and extent of this pandemic been fully
19 understood, the full implementation of all of the
20 recommendations and in particular those following
21 Exercise Iris would have been expedited, but this was
22 not the case.

23 My Lady, Module 1 testimony also suggested, perhaps
24 relevant to evidence that you will hear here, that the
25 relationships between the UK Government and the

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1 with various aspects of the evidence in Module 1.
2 I would also like to touch to an extent on some of the
3 evidence which you've heard, which emanated from the
4 Module 1 section, relating to the position in particular
5 for those vulnerable and at risk before and during the
6 Covid pandemic.

7 In Module 1, which also looked at Scotland,
8 your Ladyship heard evidence relating to the underlying
9 fragility of the NHS in Scotland before the pandemic.
10 For example, in a statement taken from the Royal Medical
11 College's Professor Stephen Turner, he stated that:

12 "Before the pandemic was declared, in March 2020,
13 capacity to provide healthcare in Scotland (and the UK)
14 was already limited. Waiting lists for clinic
15 appointments and operations, and waiting time to be seen
16 in the Emergency Department were all rising."

17 You heard evidence, my Lady, from
18 Professor Clare Bambra and Sir Michael Marmot on health
19 inequalities, which provided an important backdrop to
20 the evidence which you will hear about the reaction to
21 the emergency health crisis in Scotland from January
22 2020. Their evidence was to the effect that there is
23 a clear socio-spatial gradient in health in the UK: the
24 more deprived local authorities have worse health
25 outcomes than in others.

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1 Scottish Government, in particular at ministerial level,
2 were unusually poor in the lead-up to the Covid-19
3 pandemic. This was also stressed in an expert report
4 which you heard about from Professor Ailsa Henderson in
5 Module 2.

6 In his evidence in Module 1, John Swinney stated
7 that:

8 "... generally relationships between the
9 administrations were pretty poor by that point. Poor in
10 the aftermath of Brexit, because obviously constituent
11 parts of the United Kingdom -- well, we were -- in
12 Scotland we were not happy with Brexit at all, or not
13 happy with the -- and you obviously had to spend a lot
14 of time on the no-deal Brexit, as the Inquiry heard this
15 morning from Nicola Sturgeon. But generally relations
16 were pretty poor."

17 The UK influenza preparedness strategy of 2011
18 considered interventions such as those which might be
19 used in a pandemic such as the one caused by Covid, but
20 it did not consider lockdowns. Instead, it encouraged
21 carrying on with normal lives for as long and as far as
22 that is possible, whilst taking basic precautions to
23 protect themselves and lessen the risk of spreading
24 influenza to others.

25 My Lady, that's a broad summary of where we reached

26

1 Scotland featured at the lowest end, with data from
2 the Office of National Statistics from 2020 showing that
3 for 2017 to 2019, both male and female life expectancy
4 was lowest in the UK in Glasgow city, at 73.6 and
5 78.5 years, 11.3 years less than the most affluent part
6 of the UK. Even in Glasgow, they opined that there are
7 very large inequalities in life expectancy between the
8 least and most deprived areas: 11.6 years for women and
9 15.4 years for men.

10 In Scotland healthy life expectancy at birth amongst
11 men living in the 10% most deprived areas was 47 years
12 in 2017 to 2019, compared to 72.1 years amongst those
13 living in the 10% least deprived areas. Women in the
14 most deprived areas could expect to live to 50.1 years
15 in good health, compared with 71.6 years in the least
16 deprived areas.

17 You also heard, my Lady, plans which the
18 Scottish Government had put in place to deal with this
19 desperate health situation. It was established that
20 a paper entitled *Public Health Priorities for Scotland*,
21 from 2018, set out national and local government
22 priorities for health over the next decade. These were
23 underpinned by a focus on reducing health inequalities,
24 and had tackling health inequalities as its primary
25 objective. A new national body, Public Health Scotland,

28

1 was established as a result in 2020 as a national
2 special health board within NHS Scotland. It has
3 responsibility for providing evidence, analysis and
4 intelligence to support public health and health
5 inequalities, policy development nationally, and to
6 support local activity.

7 It was concluded, however, by Messrs Bamba and
8 Marmot that:

9 "... with some exceptions, the specialist structures
10 concerned with risk management and civil emergency
11 planning did not properly consider societal, economic
12 and health impacts in light of pre-existing
13 inequalities. The UK Government and the devolved
14 administrations and relevant public health bodies did
15 not systematically or comprehensively assess
16 pre-existing social and economic inequalities and the
17 vulnerabilities of different groups during a pandemic in
18 their planning or risk assessment processes."

19 There was also, my Lady, heard in previous sections
20 of the Inquiry, in particular in Module 2, a good deal
21 of evidence which related to structural discrimination.
22 You will recall, my Lady, that at an earlier stage in
23 the Inquiry's processes in response to submissions made
24 by a number of core participant groups, you acceded to
25 a request for what turned out to be multiple reports

29

1 evidence to suggest that they operate differently in the
2 different nations.

3 The evidence which they provided described
4 inequalities in certain communities in various areas,
5 inequalities in health, inequalities in accessing
6 healthcare. They describe that -- social and economic
7 inequalities that face ethnic minority people, which
8 they faced as we entered the pandemic such that they had
9 strong potential to lead to different outcomes or
10 exacerbate vulnerabilities.

11 They expressed the view that ethnic minority people
12 should have been identified as a vulnerable group, but
13 that they generally were not. They identified numerous
14 missed opportunities to do this in decision-making in
15 the UK, and stressed the failure to engage properly with
16 the ethnic minority community to tailor lockdown
17 provisions to their needs, address digital exclusion,
18 build existing racism into strategies about clinical
19 interventions and provide enhanced employment safety
20 nets.

21 Professor James Nazroo also provided a helpful
22 report in relation to pre-pandemic structural
23 discrimination against elderly people. He was of the
24 view that the evidence produced in his report about
25 later life and ageism and the conclusions drawn were

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1 being written by a number of experts in various
2 different important areas to the work of the Inquiry.

3 These reports came from a number of individuals and
4 were originally intended to deal with the broad question
5 of structural discrimination, not only within the UK as
6 a whole, but also within Scotland. In the end, the
7 reports and evidence presented by numerous expert
8 witnesses, from whom you heard in Module 2, not only
9 addressed those points but also touched upon a number of
10 what they perceived to be failings under sections
11 entitled "missed opportunities" and "lessons learned" in
12 their respective areas, and I intend to provide some
13 information about the evidence which was provided by
14 these witnesses which is also of particular significance
15 in Scotland.

16 Professor James Nazroo and Professor Laia Bécarea
17 provided evidence in relation to pre-pandemic
18 inequalities based on race, including the role of
19 structural racism. They expressed the view that while
20 ethnic minority populations were smaller and more
21 geographically concentrated in Scotland compared to
22 England, and data was generally more limited to England
23 alone, the data which they accessed indicated that
24 processes of radicalisation and racism are equally
25 relevant across all four nations of the UK; there is no

30

1 relevant to each nation of the UK. He pointed out that
2 the increased vulnerability of older people to
3 a pandemic caused by a respiratory virus had been
4 thoroughly documented in the past, which is why elderly
5 groups were recommended to have an influenza
6 vaccination. He pointed out that the elderly were more
7 likely to suffer adversely from NPIs as a result of
8 their likelihood to suffer from exclusion, social
9 isolation and reliance on the NHS in relation to other
10 non-Covid health needs.

11 As had been the case in his report on racism,
12 Professor Nazroo identified a number of missed
13 opportunities in the UK-wide response as regards the
14 needs of elderly people. He noted that in the early
15 stages of the pandemic, the SAGE committee had asked for
16 evidence on which groups of people were most at risk.
17 He stated that this evidence does not seem to have
18 produced and the request did not seem to have been
19 followed up.

20 As far as social care was concerned, he stated that
21 prior to the pandemic the fragile state of social care
22 had been clearly documented. The failure to build
23 resilience and equality into the social care sector,
24 including adequate rewards and security for the
25 workforce, was inevitably going to lead to crisis during

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1 a pandemic, thus robust infection control measures, in
2 his view, in care homes were necessary.

3 Professor Thomas Shakespeare and Professor Watson,
4 Nicholas Watson, provided a similar report in relation
5 to people with disabilities. Their report drew on
6 significant evidence from Scotland. They offered the
7 view based on that evidence that disabled people were
8 particularly vulnerable and that disability entails
9 a strong age gradient. In total, approximately half of
10 people significantly affected by disability were
11 over 60. In particular it was known that people with
12 intellectual disabilities were more susceptible to
13 severe outcomes from viral infections and other
14 respiratory infections or disorders more broadly. In
15 particular, Scottish research from 2018 had shown that
16 people with intellectual disabilities have as many
17 health conditions at 20 and over as the rest of the
18 population aged 50 and over and live 20 years less than
19 their non-disabled peers.

20 Like others, they presented an analysis of missed
21 opportunities and impacts of the pandemic, in their case
22 on the disabled community. This analysis shows that the
23 increased vulnerabilities to Covid faced by disabled
24 people led to disproportionate impact particularly on
25 people with intellectual disabilities, including data

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1 pointed out that prior to the pandemic Scotland had been
2 a leader in mainstreaming across government departments.
3 Again, she pointed out a number of missed opportunities
4 during the course of the pandemic which
5 disproportionately affected women, in particular in the
6 areas of mental health, domestic violence, and in
7 particular health areas with which women tended to be
8 more connected.

9 Professor David Taylor-Robinson gave a similar
10 report in relation to children. Again, he presented
11 evidence of deteriorating child health in the period
12 before the pandemic, and inequalities in child and
13 adolescent mental health in particular. He stated that
14 there were several missed opportunities as regards
15 children, and that policies should have targeted broader
16 factors influencing outcomes, including the material
17 environment, including digital access, in which -- and
18 promoting a rich environment in which children could
19 learn through play, and a number of matters relating to
20 children's mental health not generally addressed during
21 the course of the pandemic.

22 There is, in addition to this evidence, my Lady,
23 a good deal of evidence which is already available to
24 this module. You will recall and will have had
25 summaries and had evidence in Module 2 that the Inquiry

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1 from Scotland which, in their words, shows much higher
2 risk of infection, severe infection and mortality
3 amongst those with intellectual disabilities. The
4 pandemic in their view placed extra burden on already
5 overburdened services. There was also a failure to take
6 account of the impact of poverty on disabled people and
7 to foresee the issues this would cause, particularly
8 digital exclusion.

9 Professor Laia Bécáres also provided evidence in
10 relation to the members of the LGBTQ+ community. She
11 gave oral evidence and spoke also of stark inequalities
12 across the UK in that community. She reported
13 significant missed opportunities in the management of
14 the pandemic across the UK. She expressed the view that
15 due to increased prevalence of pre-existing physical and
16 mental health conditions, LGBTQ+ people, particularly
17 those who are disabled, from minority ethnic groups or
18 younger and older LGBTQ+ people, should have been
19 identified as a particularly vulnerable group and
20 measures should have been adapted and adopted to reduce
21 their risk of infection.

22 Similarly, Dr Clare Wenham gave evidence in relation
23 to gender inequalities. Again, she commented that there
24 were similar gender-based inequalities prior to the
25 pandemic, although it is fair to say that she had

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1 has commissioned what is now a large body of evidence
2 from a number of groups across the UK relating, first of
3 all, to the impact on the particular groups in question,
4 but also to the experiences of those groups during the
5 course of the pandemic. Though some of these relate
6 predominantly to other areas of the UK, some of the
7 organisations which have responded are UK-wide and
8 indeed there are a number which have provided specific
9 Rule 9 responses in this regard to Module 2A.

10 There are a number of threads which I think we can
11 bring together from these responses which, in addition
12 to the moving impact film, give us a useful insight into
13 the impact of the pandemic on these various sectors, but
14 also on the particular problems experienced.

15 I will summarise some of these for your benefit this
16 morning, my Lady. The evidence suggests that there was
17 a lack of effective consultation with representatives of
18 impact groups by the Scottish Government, in particular
19 in the initial stages of the pandemic, but also after
20 the Scottish Government's four harms strategy, to which
21 I will return, was devised, which ostensibly sought to
22 consider and mitigate the effect of countermeasures,
23 despite the fact that there was a membership of many
24 campaign or impact organisations on Scottish Government
25 advisory or expert committees.

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1 One of the witnesses from whom you heard this
 2 morning, you will remember, who had suffered from
 3 pre-existing mental health difficulties, explained that
 4 nobody took stock and said "Who have we missed?" That,
 5 my Lady, will be a significant theme of the evidence
 6 which we will explore in this module, in particular
 7 looking not only at the area which has been covered in
 8 considerable detail in the early months of the pandemic,
 9 but the extent to which as the pandemic went on --
 10 during the course of our scope -- the extent to which
 11 the Scottish Government in particular learned lessons
 12 from what it had experienced before and applied those
 13 lessons effectively.

14 Furthermore, my Lady, the evidence suggests that
 15 there was a lack of account being taken by the
 16 Scottish Government of the needs of and effects of the
 17 pandemic on particular groups regarding the particular
 18 and disproportionate effects of the virus on them, the
 19 particular and disproportionate effects of
 20 countermeasures, the NPIs, on certain groups, and the
 21 support or care which would normally have been provided
 22 to that group which could not be due to the pandemic,
 23 such as medical care, social services or social work
 24 report.

25 Furthermore, my Lady, the evidence suggests there
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1 The extent to which reliance was placed on voluntary
 2 or charitable organisations by government to inform
 3 their understanding of the needs of these communities is
 4 also significant and suggests that perhaps those were
 5 not well understood at the beginning of the pandemic.

6 Further, evidence suggests there was in certain
 7 places a lack of data for certain groups, given that
 8 there appeared to be no pre-existing system for
 9 collecting data on those groups. Some have reported
 10 that this meant it was difficult to prove particular
 11 impacts and losses to government and meant that there
 12 was a requirement to make cases for additional help, for
 13 additional effort, for additional attention, based on
 14 more anecdotal reporting, which proved difficult.

15 Overall, a number of organisations suggested that
 16 there was inadequate access to social care and
 17 understanding about the particular rules in that regard.

18 My Lady, I intend now to turn to providing something
 19 of a summary of the relevant expert evidence which you
 20 heard in Module 2.

21 We will, I think, be having a short break. That
 22 will be an appropriate moment for me to break, if that's
 23 a convenient moment for you.

24 **LADY HALLETT:** Thank you very much, Mr Dawson.

25 Yes, for those who haven't been following our
 39

1 was a lack of funding for particular needs based on the
 2 increased needs created by the virus, for example a lack
 3 of funding for social care.

4 Generally a number of organisations suggest that
 5 there may have been a lack of ability to get action on
 6 certain required initiatives due to the devolution
 7 settlement and the need for funding for certain things
 8 to come from the UK Treasury.

9 The extent to which the Scottish Government's
 10 advisory subgroups which sought to provide
 11 an opportunity for engagement with impact organisations
 12 actually provided information or advice which was taken
 13 into account in decision-making at all is something we
 14 will look at. In particular the Black and Ethnic
 15 Minorities Infrastructure Scotland group, BEMIS, found
 16 that the Scottish Government's expert advisory group in
 17 which they were concerned on ethnicity even struggled to
 18 reach an adequate definition of "ethnic minority" and
 19 was overly dominated by academic views.

20 The extent to which there was adequate communication
 21 of the rules, guidance, reasons for those rules to
 22 at-risk and vulnerable people in Scotland via public
 23 communication, via various limitations on their ability
 24 to receive it, is a consistent theme amongst the
 25 evidence that we have.

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1 proceedings so far, we take a break every 90 minutes or
 2 so for the benefit of the stenographer and others. So
 3 I shall return at 11.30.

4 **(11.15 am)**

(A short break)

6 **(11.30 am)**

7 **LADY HALLETT:** Mr Dawson.

8 **MR DAWSON:** Thank you, my Lady.

9 Before the break, I was about to embark upon
 10 a summary of some of the expert evidence which had been
 11 heard in Module 2 which is of relevance to the matters
 12 with which we will concern ourselves in this module.

13 Professor Ailsa Henderson provided a report and gave
 14 evidence to the Inquiry in connection with devolution
 15 and the UK's response to Covid. She provided a detailed
 16 history to you, my Lady, of devolution in Scotland and
 17 also Wales and Northern Ireland, which I do not intend
 18 to rehearse here. But we will in this module, in fact
 19 this week, hear evidence from a further expert in
 20 a similar field, Professor Paul Cairney, professor of
 21 political science at the University of Stirling, who
 22 will build on the evidence the Inquiry has already heard
 23 from Professor Henderson and expand on a number of
 24 Scottish-specific constitutional matters upon which
 25 Professor Henderson has already opined for your
 40

1 assistance.

2 There are a number of aspects of
3 Professor Henderson's evidence which are relevant to
4 matters which will be covered by this module, but
5 particular elements which are of relevance are as
6 follows: she gave evidence to the effect that sitting
7 alongside the underlying devolution settlement there
8 was, at the start of the pandemic, a memorandum of
9 understanding and supplementary agreements, the most
10 relevant version being from 2013, outlining how the UK
11 and devolved governments were to interact with each
12 other, the principles underlying that engagement, the
13 individuals and organisations involved, as well as
14 mechanisms for dispute resolution. The memorandum was
15 not legally binding but operated as a guide to practice.
16 It called for good communication, early notice of
17 developments, consideration of the views of others, and
18 sharing scientific, technical and policy information,
19 including the statistics and research, so long as it was
20 practical, in a "reasonably accessible" format, and that
21 would not involve disproportionate cost. It included no
22 specific mention of managing emergencies or times of
23 crisis, but the general principles of co-operation,
24 clear communication and data sharing would, according to
25 Professor Henderson, "obviously provide a backdrop to

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1 between the four nations on developing a plan for
2 handling the virus, including the first SAGE meeting on
3 22 January 2020, attended by representatives of Health
4 Protection Scotland (a forerunner of Public Health
5 Scotland), early meetings of COBR from 24 January 2020,
6 and the UK *Coronavirus: action plan* of 3 March to which
7 the Scottish Government contributed.

8 She identified that early statements were clear in
9 their call for common messaging, clear communication and
10 collaboration, but also acknowledged the prospect and,
11 indeed, inevitability of territorial variation as
12 a result of different approaches and different
13 circumstances. The plan identified the existing
14 resilience structures in each of the four nations,
15 including those to which I have referred in Scotland,
16 and also outlined the role of various existing
17 co-ordinating bodies, including COBR, and the various
18 subgroups of SAGE, NERVTAG and the JCVI.

19 She went on to provide a commentary on the
20 progression of the management of the pandemic and the
21 extent to which an intergovernmental approach was
22 in fact maintained. By mid-March 2020 COBR meetings
23 were supplemented by four ministerial implementation
24 committees, later referred to as ministerial
25 implementation groups, or MIGs, covering health, public

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1 the interaction of administrations".

2 The memorandum of understanding sets out the
3 institutional architecture by which the governments
4 would come to contact each other, in the form of routine
5 weekly or daily contact between the devolved and UK
6 departments, both officials and ministers. It also
7 provided for there to be a more formal Joint Ministerial
8 Committee, bringing together the First Ministers of the
9 devolved legislatures, and Deputy First Minister in the
10 case of Northern Ireland, and the Prime Minister or
11 delegate, as well as secretaries of state for the
12 devolved territories, to meet in plenary session at
13 least once a year.

14 Before the beginning of the Covid-19 pandemic, the
15 role of the JMC was to discuss the borders between
16 devolved and reserved matters, discussing devolved areas
17 that might impinge upon reserved matters and vice versa,
18 to keep under review arrangements for how the different
19 actors worked together as well as to provide a venue for
20 dispute resolution.

21 In her oral evidence, Professor Henderson confirmed
22 that there had been no JMC meetings after 2019, and that
23 it had only met 11 times in relation to Scotland between
24 2007 and that year.

25 She provided evidence about the early collaboration

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1 services, economic response, and international, each
2 chaired by a different UK Government minister.

3 By June 2020 she explained that the MIGs were
4 replaced by two Cabinet committees, one for operations,
5 Covid-O, and one for strategy, Covid-S. Covid-S gold
6 was chaired by the Prime Minister, Covid-O by
7 Michael Gove. Members of the devolved administrations
8 were not invited to attend these on a standing basis.
9 As we will investigate in this module, by this point the
10 Scottish Government had developed many of its own
11 systems for the management of the pandemic.

12 Her report also explained that COBR ceased to meet
13 after mid-May 2020 for a matter of some months, as these
14 other various bodies had become alternative fora for
15 communication. By late September, early October, Welsh
16 First Minister Mark Drakeford complained he had not
17 spoken to the Prime Minister in months. Both he and the
18 Scottish First Minister issued a letter to the
19 Prime Minister calling for COBR to meet again. Four
20 COBR meetings took place in autumn 2020. In the Lords,
21 Baroness Andrews complained that the PM had delegated
22 contact with the First Ministers to Michael Gove rather
23 than taking responsibility for this himself.

24 The Scottish Affairs Committee review of
25 intergovernmental working highlighted that divergence in

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1 lockdown timing coincided with COBR meetings and MIGs
2 falling into abeyance, although stopped short of
3 attributing it to this factor alone.

4 They also note the fact that existing mechanisms for
5 intergovernmental relations were not employed as lines
6 of communication.

7 As regards UK level decision-making,
8 Professor Henderson stated that:

9 "Leaving aside formal legislative competence, it is
10 perhaps not surprising that the proliferation of
11 organisations and groups led to confusion about which
12 body was responsible for taking decisions rather than
13 sharing information. An IfG [Institute for Government]
14 report indicates that one frustrated SAGE member
15 complained COBR was 'void of decision making' and that
16 it was not clear who was taking decisions. It likewise
17 noted that COBR tended not to commission scientific
18 analysis from SAGE and as a result lacked specific
19 answers to issues raised in meetings."

20 These deficiencies, if proven to be correct, would
21 have affected the Scottish response too, given,
22 for example, the continued reliance on SAGE, albeit via
23 the Scottish Government's Covid Advisory Group.

24 Professor Thomas Hale of the University of Oxford
25 also provided a report and gave evidence to the Inquiry,

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1 involving the imposition of NPIs to have effect.

2 Professor Hale stated that the evidence was
3 supportive of lockdown, at least as far as the
4 suppression of the virus was concerned, expressing the
5 view that strict requirements to not leave one's home
6 were by far the most effective policy measure in
7 reducing the transmission of the virus.

8 However, his report also highlights the generally
9 experienced negative impact of NPIs, particularly when
10 they are prolonged, including on mental health, the
11 likelihood of substantial increases in domestic
12 violence, experiences of significant drop in student
13 achievement, economic output impact, and the unequal
14 effects on different parts of society.

15 He explained that fast, stringent policy matters,
16 such as school closures, business closures and
17 stay-at-home mandates. He explained that these were
18 indispensable in the pre-vaccination era when Covid-19
19 began to overwhelm health systems, but because such
20 measures came with clear trade-offs, the most effective
21 governments were able to minimise the use of stringent
22 measures by relying on effective systems to test people
23 for Covid-19, rapidly trace their contacts, and ensure
24 that infectious or potentially infectious individuals
25 did not spread the virus.

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1 in particular about the response tracker which he
2 operated from March 2020. It used a numerical scale to
3 rate the depth of the NPIs which were applied globally,
4 including in the four nations of the UK, to facilitate
5 an understanding of the way that the restrictions varied
6 both over time and amongst the four nations of the
7 United Kingdom. This included an assessment, which was
8 done in real time, of the restrictions imposed by the
9 Scottish Government and others with which this module is
10 concerned. A number of key messages emerged from his
11 evidence, which included the following:

12 As far as the stringency, speed and effect of the UK
13 response to Covid-19 was concerned, he stated that the
14 UK was slower than the average country to adopt stricter
15 measures across nearly every domain of response.
16 Furthermore, tragically, he reported that Scotland had
17 the 38th highest death rate per capita globally in the
18 period from 2020 to 2022. He reported that it was 66th
19 in the world for the stringency of its restrictions.

20 In responding to a pandemic like Covid-19, he
21 reported that the evidence showed that speed matters.
22 He was of the view that even a single day could have
23 a significant impact on the death toll. However, he
24 also expressed the view that once a certain scale of
25 infection was reached, it was much harder for any policy

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1 He stated that studies show that such testing,
2 tracing and isolation strategies were a viable and
3 attractive way to keep the transmission of a virus like
4 Covid-19 under control. He stated that evidence showed
5 that such strategies are particularly effective when
6 combined with fast, stringent, but limited NPIs should
7 an outbreak escape the test, trace and isolate system.

8 He expressed the conclusion that during the second
9 wave of Covid-19 in Europe, between August 2020 and
10 January 2021, school closures had only a minimal --
11 a small impact on the transmission of the virus, whereas
12 business closures and gathering bans were the most
13 effective interventions in curbing the contagion.

14 He pointed out that numerous studies showed that
15 stronger economic support policies played a key role in
16 bolstering compliance with NPIs, as individuals who
17 receive significant economic support have better
18 economic means to afford losses caused by strong policy
19 interventions such as stay-at-home mandates and business
20 closures, and also economic support policies could
21 augment trust in both institutions and government, which
22 in turn have been linked to increased compliance with
23 stringent containment measures.

24 Amongst the nations of the UK, Scotland in his view
25 had the highest number of cumulative days with

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1 an overall stringency greater than 80 on his team's
 2 numerical scale marked out of 100. In that regard, his
 3 overall international analysis was that estimates from
 4 cross-country analyses suggested that prolonged and
 5 strict NPIs negatively affected short-term economic
 6 growth, reduced economic activity by about 10% and
 7 increased wage inequality and poverty. Additionally,
 8 prolonged and strict NPIs increased gender inequalities
 9 in his view because the pandemic had hit more severely
 10 contact-intensive sectors, where women tended to be
 11 over-represented, and intergenerational inequalities
 12 because older people had more savings and tended to
 13 receive stable retirement income, whereas young workers
 14 typically relied on their job earnings, which were more
 15 likely to be affected by lockdown measures.

16 You have also heard evidence, my Lady, equally
 17 relevant to this module, as you have heard in the
 18 tributes and the testimony in the video this morning,
 19 from Long Covid experts who have explained to you the
 20 nature of the condition and also its emergence across
 21 the period with which we are concerned.

22 These experts have pointed out in their testimony
 23 the fact that in Scotland the Scottish Government
 24 invested £10 million for health boards to support local
 25 services for Long Covid, and that in a paper dated

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1 be concerned.

2 You have obviously, my Lady, heard enormous volumes
 3 of evidence about the UK Government decision-making,
 4 both in oral and written form. I do not intend at this
 5 stage to go into that. It would take me weeks to
 6 summarise it. However, it is our intention in this
 7 module, where significant, as regards Scottish
 8 decision-making, to put matters that were raised by
 9 UK Government ministers, advisers and others, to
 10 Scottish ministers, advisers and others in this module.

11 To turn, then, my Lady, to the analysis of the
 12 pandemic in Scotland, the ebb and flow of the pandemic
 13 in Scotland was in some regards similar to the way in
 14 which the pandemic was experienced elsewhere in the UK.
 15 The arrival of the virus, the waves of infection, the
 16 effects of variants, are all elements of the pandemic
 17 which have certain common features on both sides of the
 18 border.

19 However, there are many significant differences in
 20 that regard and in the way that transmission was handled
 21 by key decision-makers. I intend to set out
 22 a chronology of the key events which shaped the way that
 23 the pandemic developed in Scotland, highlighting as I go
 24 along the key decisions which we intend to analyse, as
 25 well as the key issues which we have, to this point,

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1 30 September 2021 the Scottish Government set out its
 2 approach to supporting those with Long Covid in
 3 Scotland.

4 In their report, these experts expressed the view
 5 that not having hibernating studies or of planned
 6 follow-up in clinical care, with embedded research,
 7 meant that there was significant delay in starting the
 8 research studies into Long Covid during the first wave
 9 of the pandemic, despite studies having been designed,
 10 protocols written and governance approved at
 11 unprecedented speed. They concluded that Long Covid was
 12 foreseeable and that it would remain a major health
 13 problem.

14 They said that there was and is minimal focus on
 15 preparedness for the long-term consequences of viral
 16 outbreaks like Covid, and insufficient surveillance for
 17 Long Covid that was planned at the outset of the
 18 pandemic.

19 They say that there was insufficient research and
 20 clinical services planned when Covid struck.

21 My Lady, that concludes my summary of the evidence
 22 which you have heard to this point, which is no doubt
 23 very familiar to you, although perhaps less familiar to
 24 some of our audience, in the hope that it provides some
 25 useful context to some of the matters with which we will

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1 identified as being key to the analysis of the
 2 reasonableness of the Scottish governmental response.

3 Of course, as was the case in Module 2, this is
 4 a political module, and we will focus on the key
 5 political decisions, the strategy which was adopted by
 6 the government in Scotland to fight the virus, its
 7 coherence, its basis on the available evidence and its
 8 effectiveness.

9 The module's scope starts where Module 1 left off,
 10 namely in January 2020. At this stage, as the M1
 11 evidence shows, although Scotland had its own minister
 12 for resilience, part of the portfolio of the Deputy
 13 First Minister at the time, John Swinney, the
 14 Scottish Government's ability to react to the early
 15 emerging signs of danger was largely bound to the
 16 emergency structures at UK Government level. The
 17 evidence gathered by the Inquiry shows, however, that at
 18 some point during the first lockdown, in the response to
 19 the pandemic, the Scottish Government developed its own
 20 structures, both for decision-making and for advice.

21 This resulted in the Scottish Government pursuing
 22 its own strategies to fight the virus, its own
 23 regulations and restrictions, and its own mechanisms for
 24 communicating with the public about them.

25 The Inquiry has already looked at the key questions

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1 in M2 of whether the UK Government reacted with
2 sufficient speed in the early months of 2020 on learning
3 of the emergence of the virus in China, whether it was
4 provided with the right information to enable it to do
5 so. These questions equally apply in Module 2A when
6 looking at the Scottish Government response.

7 Given the Scottish Government's later adoption of
8 a more autonomous approach, ought it to have taken heed
9 of earlier advice received directly from experts or via
10 UK Government systems to which it had access, like COBR
11 and SAGE? Given the differences in health and age
12 profile in Scotland, and its pre-existing autonomous
13 structures to deal with a public health emergency, ought
14 it to have done more to make plans to deal with the
15 virus earlier? Ought it to have done more to seek to
16 influence the decision-makers in key positions within
17 the UK Government in the best interests of the people of
18 Scotland?

19 Had the Scottish Government taken a different
20 approach, it may have been able in these early months to
21 alter the course of the pandemic significantly. Some
22 may suggest that it ought to have done so, despite the
23 limitations on its ability to do so in the pre-existing
24 UK constitutional framework.

25 Evidence heard by your Ladyship in Module 2 has
53

1 They also recorded that:
2 "... the UK currently has good centralised
3 diagnostic capacity ... and is days away from a specific
4 test, which is scalable across the UK in weeks."

5 On 24 January COBR, the Cabinet Office Briefing
6 Rooms crisis committee, met for the first time. COBR
7 agreed a series of actions to be put in place when
8 certain trigger points were reached, and that these
9 trigger points be shared quickly with the CMOs for all
10 four nations. The UK CMOs met. The Cabinet Secretary
11 for Health and Sport, Ms Jeane Freeman, attended this
12 first Covid-19-related COBR meeting, the First Minister
13 of Scotland did not.

14 On 25 January, five people had been tested for Covid
15 in Scotland, all returning negative results, as
16 an incident team was established for the disease. It
17 was reported that one of the patients was a Chinese
18 student who was being treated in Edinburgh and that the
19 man was thought to have become unwell after visiting
20 family in Wuhan.

21 Professor Jürgen Haas, Edinburgh University's head
22 of infection medicine was reported as having said that
23 it was "very likely" that cases would be confirmed in
24 the UK, pointing out that:

25 "Here at the University of Edinburgh we have more
55

1 covered in great detail the events of the first few
2 months of the pandemic leading to the first lockdown.
3 I do not intend to rehearse that evidence here, though
4 many of the issues which were ventilated had either
5 a direct or indirect effect on Scotland, given the broad
6 four nations approach which appears to have been adopted
7 over that period.

8 I will focus here, as we will in the module more
9 generally, on the particularly Scottish elements.

10 The evidence heard in Module 2 indicates that from
11 the very early days of January 2020 it was clear that
12 UK Government scientists and medical officers, including
13 the Scottish Government's Chief Medical Officer,
14 Dr Catherine Calderwood, were already in communication
15 with one another and with a number of external academic
16 scientists about a new viral pneumonia outbreak.

17 On 9 January the WHO issued a statement concerning
18 a cluster of pneumonia cases in Wuhan.

19 On 21 January, the WHO published its first Novel
20 Coronavirus (2019-nCoV) Report.

21 By 22 January, the first SAGE group meeting was
22 activated on a precautionary basis by the UK CSA. The
23 minutes recorded that:

24 "There is evidence of person-to-person
25 transmission."
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1 than 2,000 students from China and they are always
2 coming and going back to China so we are relatively sure
3 we will have cases in the UK from travellers coming back
4 from China."

5 He warned that the spread of the virus might
6 increase as more people travelled around for Chinese New
7 Year, within China and to other countries.

8 Professor Mark Woolhouse, professor of infectious
9 disease epidemiology at the University of Edinburgh,
10 wrote to the Scottish CMO stating:

11 "If you were to put those numbers into
12 an epidemiological model for Scotland (and many other
13 countries) you would likely predict that, over about
14 a year, at least half the population will become
15 infected, the gross mortality rate will triple (more at
16 the epidemic peak) and the health system will become
17 completely overwhelmed ... Please note that this is
18 NOT a worst-case scenario, this is based on the WHO's
19 central estimates and currently available evidence. The
20 worst-case scenario is considerably worse ..."

21 On 27 January, Health Protection Scotland initiated
22 the Incident and Emergency Response Plan. This
23 implemented response arrangements, including the
24 structure and governance of the incident response going
25 forward, and the establishment of an incident room at
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1 the Meridian Court offices in Glasgow. The emergency
2 response co-ordinator was Dr Jim McMenemy, from whom we
3 will hear later this week.

4 On 29 January, the Scottish Government activated its
5 Scottish Government Operational Response Room (SGORR).
6 The first SGORR(M), the ministerial forum of SGORR
7 meetings, was chaired by the First Minister on that
8 date. By way of context, MSPs also voted 64 to 54 to
9 back calls for a second Scottish independence
10 referendum.

11 On 30 January the WHO declared a public health
12 emergency of international concern, or PHEIC. The UK
13 current risk level was raised from low to moderate. On
14 this day too the first case of infection with the virus
15 in the UK was confirmed: two members of the same family,
16 one a 23-year old Chinese student who had travelled back
17 to York from a family home in Hubei.

18 On 31 January the novel coronavirus was discussed in
19 the UK Cabinet for the first time.

20 A number of questions arise. What information was
21 received, understood, assimilated and acted upon by
22 government in Scotland in the period before the
23 lockdown? Was the fact that the virus would inevitably
24 spread to Scotland given its international connections
25 and land border with England properly appreciated by the

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1 a team of epidemiologists at Imperial College provided
2 a first estimate of the severity of the virus, giving
3 an overall case fatality rate in all infections,
4 symptomatic or asymptomatic, of around 1%. That is to
5 say 1 in 100 of every confirmed case, as opposed to
6 those who are infected, would die.

7 PHE started to roll out its Covid-19 diagnostic test
8 to laboratories across the UK. On 21 February news
9 emerged of a cluster of locally-transmitted cases in
10 Lombardy, Italy. A lockdown began in Italy covering ten
11 municipalities of the province of Lodi in Lombardy and
12 one in the province of Padua.

13 Scotland men's international rugby team played Italy
14 on 22 February 2020 in Rome. Scotland's women's team
15 had been due to play in Legnano, just outside Milan in
16 the Lombardy region in Italy, on 23 February. The match
17 was cancelled due to local concerns about Covid, though
18 the Scotland team had travelled to northern Italy for
19 the match.

20 On 22 February passengers from the cruise ship the
21 Diamond Princess arrived back in the UK. The
22 Diamond Princess had been quarantined on 3 February by
23 the Japanese Government, after a passenger from
24 Hong Kong tested positive for Covid-19, after having
25 earlier left the ship on 25 January. Of the some

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1 Scottish Government? Were the consequences of the
2 likely lack of efforts made to control the virus
3 adequately understood? What role did Scotland expect to
4 play in the overall UK resilience response? Was this
5 role the right one to have adopted? Why did the lesson
6 to act quickly not appear to have been part of the
7 initial thinking? Did previous pandemic experiences or
8 the fact of the WHO not declaring a PHEIC until
9 30 January cause an unduly relaxed approach?

10 As to the practical aspects of the response, what
11 consideration was given to the state of Scotland's
12 preparedness, in light of previous recommendations for
13 this type of threat which had apparently not been acted
14 upon? What analysis was done of Scotland's own capacity
15 and responsibility, acting alone and within the UK
16 context? What capacity was there for diagnostic testing
17 or procurement or PPE? Who was deemed to be most at
18 risk? What was done to protect them? What analysis was
19 done of the likely capacity of testing, contact tracing
20 and isolation to keep the infection under control? What
21 was done to put them in place?

22 On 4 February the WHO issued guidance recommending
23 scaling up country preparedness and response operations.

24 On 10 February 2020, 57 tests had been conducted in
25 Scotland. All were negative. On 10 February also

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1 2,600 passengers and 1,000 crew, over 500 people became
2 infected. Early reports showed, however, that around
3 18% of the people infected had shown no symptoms. How
4 was the possibility of asymptomatic or presymptomatic
5 spread factored into the thinking and planning within
6 Scottish Government?

7 By 25 February 2020, 412 tests had been carried out
8 in Scotland, all negative. There was a Covid-19
9 outbreak at the Nike conference, which took place in
10 Edinburgh on 25 and 26 February 2020, from which at
11 least 25 people linked to the event were thought to have
12 contracted the virus, including eight residents of
13 Scotland. This conference and the extent to which the
14 dangers associated with it were known about around the
15 time it took place within the Scottish Government, as
16 well as the steps taken to control the risk and to
17 inform the public about the dangers associated with it
18 will be examined in the course of this module.

19 On 2 March it was reported that Health Protection
20 Scotland had been alerted by international authorities
21 about a person not from the UK who had tested positive
22 after the conference in late February. Despite this,
23 the public were not told. Further details of the extent
24 to which the conference posed a risk to the Scottish
25 public and the extent of what they had not been told

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1 emerged in the spring of 2020 via press reporting.
 2 These will also be explored within the module.
 3 COBR met again on 28 February, by which time the UK
 4 had confirmed its first case of confirmed community
 5 transmission.

6 On 29 February the total number of confirmed cases
 7 in the UK rose to 23 after 10,483 people had been
 8 tested.

9 It is correct to say that the evidence shows that
 10 the information about the nature and hence the threat
 11 from the virus emerged over time. However, it might be
 12 said that it is inevitable in situations of this nature
 13 that information will be limited and will not ever meet
 14 the standard of conclusive proof, meaning that the
 15 imperative to act will always be based on incomplete or
 16 non-ideal information. We will examine the extent to
 17 which Scottish ministers did what they could to equip
 18 themselves with the information which was available and
 19 assess when it was reasonable for them to act. Should
 20 they have known more, should they have acted more
 21 quickly in response to the emerging lethal fillet?

22 Given the increasing awareness of the threat of the
 23 new virus, to which I will return, we will examine the
 24 powers that the Scottish ministers had and their
 25 apparent decision not to impose different suppression

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1 "very high".

2 On 3 March 2020, the UK Government's coronavirus
 3 action plan launched. We intend to investigate what
 4 knowledge of or input into that plan the
 5 Scottish ministers had. How suitable was it for
 6 Scotland? What consideration had there been of Scottish
 7 matters, risks and requirements? It will be important
 8 to consider over this period the extent to which the
 9 Scottish Government considered its role to be to develop
 10 its own strategy to combat the virus in the exercise of
 11 its responsibility for the devolved area of public
 12 health. To what extent did it understand, interpret for
 13 the good of Scotland and seek to influence the
 14 containment strategy which was followed in the early
 15 part of March? What realistic chance did it have to
 16 succeed, given the known characteristics of the virus?
 17 What role did the pursuit of herd immunity play in the
 18 Scottish plans?

19 By 4 March, two further cases in Scotland were
 20 confirmed, one having travelled from Italy and the other
 21 having had contact with a known carrier.

22 By 5 March three further cases were confirmed,
 23 taking the total to six.

24 By 6 March, the number of confirmed cases in
 25 Scotland rose to 11.

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1 strategies before the national lockdown on
 2 23 March 2020.

3 Your Ladyship has heard evidence in Module 2 of
 4 delay and indecision in February 2020 within
 5 the UK Government. In light of the emerging threat, why
 6 did the Scottish Government or the Scottish ministers
 7 not take or seek to persuade the UK Government of the
 8 need to take swifter decisive action, including ramping
 9 up testing capacity, other surveillance systems and
 10 supplies of protective equipment, in particular, in
 11 light of their prior failure to implement resilience
 12 strategies looked at in Module 1? Was the inevitable
 13 spread of the virus after the end of January properly
 14 appreciated by the Scottish Government, the body with
 15 responsibility for protecting Scotland?

16 As at 1 March 2020 the first case of coronavirus in
 17 Scotland was confirmed. By that time, according to
 18 Professor Woolhouse, community transmission had already
 19 started. On the same date Scotland's Chief Medical
 20 Officer, Dr Calderwood, announced that surveillance
 21 would begin at some hospitals and 41 GP surgeries in the
 22 nation.

23 On Monday 2 March, the Prime Minister chaired a COBR
 24 meeting for the first time. It was also attended by the
 25 First Minister of Scotland. The WHO raised its alert to

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1 By 7 March cases in Italy had risen five-fold to
 2 5,800, and deaths had risen eight-fold in six days to
 3 233.

4 On 8 March, further proposed measures to curb the
 5 spread of Covid-19 were announced. In Italy the
 6 quarantine was extended to all of Lombardy and 14 other
 7 northern provinces, and then on 9 March to the whole
 8 country.

9 On 8 March 2020, Scotland played France in a rugby
 10 union international at Murrayfield Stadium in Edinburgh.
 11 France had been the first country in Europe to have
 12 reported an official death from Covid-19, on
 13 15 February 20. On the same day as the rugby France had
 14 banned mass gatherings of over 1,000 people. France
 15 would go into national lockdown on 17 March 2020,
 16 six days before the UK. The previous day the scheduled
 17 Scotland against France women's game had been cancelled
 18 as a player had tested positive for Covid.

19 On 9 March 2020, cases had more than doubled again
 20 in Scotland to 23 cases. The eighth meeting of COBR
 21 took place, chaired by the PM. The DHSC and the
 22 UK Government circulated a report to Number 10 showing
 23 that NHS demand would greatly exceed capacity, by
 24 240,000 beds/19,000 ICU beds, if the government were to
 25 implement the measures then under consideration. The

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1 14th meeting of SAGE took place. PHE was informed of
 2 the first Covid-19 outbreak in care homes. PHE data
 3 presented at SAGE suggested that the true number of
 4 cases was 5,000 to 10,000 infections but maybe as many
 5 as 30,000.

6 On 11 March 2020, the WHO declared Covid-19
 7 a pandemic. On that date, the first case of community
 8 transmission which was not linked to contact or travel
 9 was confirmed in Scotland. There had been 36 positive
 10 tests. Scotland remained in the containment phase of
 11 its management strategy.

12 On 13 March 2020 the first death from coronavirus in
 13 Scotland was confirmed. Little information about the
 14 circumstances of the death were released by the
 15 Scottish Government, other than to say that the
 16 individual who had died was a man who had existing
 17 health complications and had been under the care of
 18 NHS Lothian. It was later reported that he was a French
 19 national who had come to Edinburgh for the rugby
 20 international on 8 March. By 13 March positive tests
 21 had risen to 85.

22 On 12 March, the Scottish Government announced that
 23 all indoor and outdoor mass events of 500 people or more
 24 should be cancelled. It was emphasised by the
 25 First Minister that the Scottish Government at that time

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1 longer a priority, and testing resources were directed
 2 towards hospitalised patients instead of being used to
 3 identify new cases in the community.

4 By 16 March, the four new ministerial implementation
 5 groups were established to aid collective government
 6 decision-making. Imperial College published Report 9,
 7 which models the potential impact of stringent
 8 conditions and concludes that epidemic suppression was
 9 the only viable strategy at that time. The model used
 10 to produce Report 9 generated a worst-case scenario of
 11 over 500,000 deaths in the UK by the end of July 2020.

12 On 17 March 2020, Cabinet Secretary for Health and
 13 Sport, Ms Jeane Freeman, told MPs the NHS in Scotland
 14 would be placed on an emergency footing for
 15 three months, with non-urgent elective operations being
 16 cancelled. On the same day, in a keynote address to the
 17 Scottish Parliament, the First Minister said that "life
 18 will change significantly" and emphasised the need for
 19 every citizen to reduce all non-essential social
 20 contact. She further explained that everyone should
 21 minimise social contact as much as possible, avoiding
 22 crowded areas and gatherings, including bars,
 23 restaurants and cinemas, use public transport as little
 24 as possible, and also to work from home if possible.

25 She stated that the advice applied especially

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1 had no power to compel the cancellation of such events
 2 and that her announcement about cancellation was in the
 3 form of guidance only. What was the
 4 Scottish Government's thinking behind the issuing of
 5 this guidance? How did it consider it to fit in with
 6 the UK strategy? Why were the measures recommended in
 7 Scotland at this time thought to be the best course for
 8 nation? What consideration was applied to alternative
 9 strategies? Why were they not taken? What lessons were
 10 learned from the pattern in Italy, France, Spain or
 11 London, where the pandemic's effects were seen earlier
 12 than in Scotland? Did delay cost lives?

13 On the same day, Scotland's CMO advised that people
 14 with symptoms suggestive of coronavirus -- a fever or a
 15 new cough -- should stay at home for seven days from
 16 that Friday. She advised that those who had been in
 17 contact with someone who is experiencing symptoms should
 18 only stay at home they began to experience symptoms
 19 themselves.

20 On 15 March, the Scottish Government judged that
 21 containment of the virus was no longer possible and the
 22 country should be moving into the delay phase. This
 23 meant that rather than trying to stop the virus
 24 altogether, the focus switched to trying to manage its
 25 spread through the population. Contact tracing was no

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1 strongly to people who were over 70, people with
 2 underlying health conditions for which they got the flu
 3 vaccine, and pregnant women. They were strongly advised
 4 to stay at home as much as possible. She also stated
 5 that steps would be taken to shield the most vulnerable,
 6 which was limited to those with compromised immune
 7 systems.

8 On 19 March, the Deputy First Minister announced
 9 that the Scottish Government was advising that at the
 10 end of the following day schools and nurseries should
 11 ordinarily close for children and young people.

12 Also, on 18 March the Cabinet Secretary for the
 13 Constitution, Europe and External Affairs,
 14 Mr Michael Russell, sent a letter to Michael Gove,
 15 Chancellor of the Duchy of Lancaster, setting out the
 16 Scottish Government's intention to pause campaigning for
 17 a second independence referendum in light of the
 18 coronavirus threat.

19 The extent to which the approach to the management
 20 of the pandemic was influenced by the Scottish
 21 Government's key objective of achieving independence for
 22 Scotland is also an issue which we will seek to address
 23 in the module.

24 On 20 March 2020, the Scottish Government told
 25 cafes, pubs and restaurants to close as well as other

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1 similar establishments. The Scottish Government's
2 website indicated these establishments were being told
3 to close but in an address by the Chief Medical Officer,
4 she indicated that they were being asked to do so.

5 On 22 March 2020, the First Minister of Scotland
6 gave her first daily media briefing.

7 On 23 March, with the UK death toll hitting
8 335 deaths, with 14 in Scotland, the Prime Minister
9 announced a nationwide stay-at-home order would come
10 into effect as of midnight and that it would be reviewed
11 every three weeks. The Scottish Government also
12 announced a full national lockdown, closure of
13 hospitality and non-essential retail, a requirement to
14 work from home, work from home where possible, and
15 restrictions on indoor and outdoor gatherings. These
16 restrictions came into legal force when the Scottish
17 Parliament gave consent to the Coronavirus Act 2020 on
18 25 March.

19 We will examine in this module the powers and the
20 strategy of the Scottish Government with regard to the
21 management of the pandemic over this period, the reasons
22 why it acted as it did and why it did not do more, how
23 it perceived its role as against that of the
24 UK Government, its access to advice and the limitations
25 on that.

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1 UK and the extent to which consideration was given to
2 how these new powers would be exercised and co-ordinated
3 will also be addressed in the module.

4 Further, on 25 March, the First Minister confirmed
5 that the Scottish Government would establish its own
6 Covid-19 Advisory Group to supplement the advice which
7 it already received from SAGE. We will examine the role
8 of this group in the overall divergence of the
9 Scottish Government policy from the priorities and
10 strategy of the UK Government, the reasons for that, and
11 the reasonableness of such divergence in the context of
12 a global viral pandemic.

13 I will return to the theme of divergence in due
14 course. I will also return to particular aspects of the
15 Scottish Government's advisory structures which were
16 devised during the course of the pandemic in Scotland in
17 due course.

18 There will be particular focus in this module on the
19 role the Scottish Government played over this period
20 with regard to the protection of individuals within
21 care homes or cared for at home.

22 On 26 March 2020, the Scottish Government produced
23 clinical guidance for the management of clients
24 assessing care at home, housing support and sheltered
25 housing.

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1 We will ask whether the Scottish Government could
2 and should have done more over this period to protect
3 the people of Scotland from the virus.

4 By the time we reach March, to what extent had there
5 been inadequate engagement by key decision-makers in the
6 process and hence a failure to progress protections as
7 they were needed? To what extent did the Scottish
8 Government have power to do something about it? What
9 was their role in the UK Government's decision-making
10 process over this period? What role did the possibility
11 of the collapse of Scotland's NHS, the possibility of
12 a second peak, have in decision-making? Was enough done
13 by the Scottish Government to protect the Scottish
14 people, given its responsibility for the health of the
15 nation? Was Scotland's voice, given its particular
16 characteristics, heard? Why did Scotland go into
17 lockdown on 23 March? Who made that decision and why?
18 Could and should earlier measures have been taken,
19 either in the form of an earlier lockdown or alternative
20 social distancing measures in a bid to regain control?

21 On 25 March, the Scottish Government made
22 a declaration of serious and imminent threat to public
23 health under schedules 21 and 22 of the 2020 Act. The
24 role of the Scottish Government in the settlement of how
25 powers would be allocated amongst the governments of the

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1 On 27 March, the Scottish Government published rules
2 on staying at home and social distancing which now
3 required to be followed in terms of powers from the
4 Westminster Coronavirus Act 2020. The
5 Scottish Government used those powers to make it
6 a criminal offence not to follow its social distancing
7 rules. People in Scotland were only permitted to go
8 outside if they had a reasonable excuse.

9 On 1 April, construction started at the SEC in
10 Glasgow on what was to become the NHS Louisa Jordan,
11 Scotland's Nightingale hospital.

12 On 5 April, the Scottish Government's CMO,
13 Dr Calderwood, resigned as a result of revelations that
14 she had broken lockdown rules to visit her holiday home.
15 In this module we will examine the circumstances in
16 which this resignation occurred and its management by
17 the Scottish Government, including the way in which it
18 was presented to the Scottish public.

19 On 6 April 2020, the Coronavirus (Scotland) Act
20 2020, introduced as an Emergency Bill in the Scottish
21 Parliament on 31 March, gained Royal Assent becoming
22 law.

23 On 17 April, the Scottish Government's announced the
24 establishment of an independent advisory group set up to
25 provide expert economic advice to the Scottish

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1 Government.
2 On 20 April, the NHS Louisa Jordan in Glasgow opened
3 as confirmed cases passed 8,400, with 915 fatalities
4 having been recorded in hospitals.

5 On 21 April, Cabinet Secretary for Health and Sport,
6 Jeane Freeman, announced a change in the
7 Scottish Government's strategy towards the management of
8 infection in care homes. Scottish Government guidance
9 on isolation in care homes had been in place since
10 13 March requiring clear social distancing, active
11 infection prevention and control, and an end to communal
12 activity. The extent to which there had been any proper
13 assessment of the capacity of the care sector to deliver
14 on this guidance will be undertaken in the module.

15 The reasons why these measures had not been
16 introduced before this point, the consequence of the
17 Scottish Government's failure to do so, and the
18 effectiveness of these measures once they were
19 introduced, will be considered in this module as a part
20 of the Scottish Government's overall Covid-19 management
21 strategy and in light of the high burden of infection
22 and death in the care sector in Scotland.

23 On 22 April 2020, the National Records of Scotland
24 released data up to 19 April which gave some context to
25 the change in strategy which Ms Freeman had announced

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1 examine in the module. It appears to us on the evidence
2 currently available that although the seeds of
3 divergence were sown at the time of the creation of the
4 powers for the Scottish Government to impose its
5 restrictions which could be enforced by force, with
6 criminal sanctions, in late March and the formation of
7 the Covid-19 Advisory Group at the same time, the
8 framework announced at this time, in April, represented
9 a clear statement of intent to adopt a wholly distinct
10 Scottish policy. The strategy which was announced by
11 the Scottish Government at that time involved, amongst
12 other things, the creation of a multiplicity of new
13 advisory committees. New decision-making structures
14 within Scottish Government also emerged, including the
15 four harms group, based on the four harms strategy,
16 though it did not meet until October.

17 The extent to which the development of these new
18 advisory and decision-making bodies, created in the heat
19 of the pandemic as opposed to relying on structures
20 which had pre-dated it, will be examined in the module.

21 Equally, changes were made to the internal
22 structures of the Scottish Government's pre-existing
23 directorate system to cater for the response. The
24 Directorate-General [for the] Constitution and External
25 Affairs took on the main co-ordination function in the

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1 the day before. The number of deaths from any cause in
2 Scotland was up 80% above the five-year average.
3 537 deaths on death certificates had been recorded in
4 care homes, double the number of the previous week.
5 910 deaths recorded on death certificates had been
6 recorded in hospitals, and 168 deaths in homes or other
7 settings. In addition, it was reported that Public
8 Health Scotland's daily figures were undercounting these
9 deaths, even at those rates.

10 On 23 April 2020 the Scottish Government published
11 details of its strategy for ending lockdown, the
12 *Covid-19: framework for decision-making* document. The
13 stated aim of this strategy was to suppress the virus so
14 that the R number remained below 1, demands on the NHS
15 did not exceed capacity and people were able to return
16 to some semblance of normality. The document set out
17 the position during lockdown and outlined the factors
18 that would be considered as the country moved gradually
19 to ease restrictions. This constituted the basis of the
20 Scottish Government's four harms strategy to the ongoing
21 management of the pandemic in Scotland which was aimed
22 at Scotland's transition out of the lockdown.

23 I mentioned earlier the theme of divergence of
24 Scottish Government policy in the management of the
25 pandemic from that of the UK Government which we will

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1 Scottish Government's response to Covid-19. These
2 included organisation of Covid business, four nations
3 liaison, legislation, regulations and guidance as well
4 as travel restrictions. Within it sat various new
5 directorates, the role of which we will examine.

6 Within the Scottish Government's Directorate-General
7 for Health and Social Care, a Covid response team was
8 set up by Scottish Government in the week commencing
9 16 March to focus on the emergency response for people
10 who were considered most vulnerable to Covid. It was in
11 place by the end of the week commencing 23 March and
12 operated until 31 May 2020.

13 Further structural alterations were numerous and
14 included new directorates, divisional and advisory
15 structures being created under the auspices of the
16 Director-General for Health and Social Care and its
17 existing directorate structure.

18 These changes also included the following for
19 decision-making or to assist decision-making in addition
20 to the Scottish Cabinet:

21 SGoRR (Scottish Government Resilience Room) was, as
22 you heard in Module 1, an existing means by which the
23 Scottish Government dealt with emergencies through its
24 Resilience Division. SGoRR as an entity did not make
25 decisions but enabled relevant parties to come together

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1 to make decisions and coordinated their activity. Its
2 specific activation for the Covid-19 pandemic occurred
3 on 29 January 2020.

4 In addition, meetings in which the First Minister
5 and/or Deputy First Minister, and occasionally other
6 Cabinet Secretaries, would meet with senior policy
7 advisers became colloquially known within Scottish
8 Government as "Gold" or "Gold-type" or "Gold Command"
9 meetings. These would typically take place over the
10 weekend or on the Monday immediately before Cabinet,
11 which tended to meet on a Tuesday. It appears that no
12 minutes of the meetings of this group were kept.

13 The four harms group, which met from October 2020,
14 though the Scottish Government's four harms strategy
15 with which it was connected had been in place from
16 April 2020. On a weekly basis from that point it
17 considered the current and potential future state of the
18 epidemic, and any measures under consideration,
19 including any legal restrictions or requirements. It
20 tended to prepare a paper on Friday which the Deputy
21 First Minister would present to Cabinet at its Tuesday
22 meeting the following week, setting out the issues and
23 relevant analysis, and usually, but not always, making
24 specific recommendations.

25 As I've said, my Lady, we have intimated to

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1 decision-makers, including ministers in the
2 UK Government. They also concerned communications
3 between Scottish Government ministers and key
4 representatives of those affected by this pandemic
5 within Scottish society.

6 These new structures evolved gradually, these new
7 advisory and decision-making structures upon which
8 reliance was placed tended to be more
9 Scottish Government entities, such as the four harms
10 group, the Scottish Covid Advisory Group and its
11 subcommittees, and other advisory bodies providing
12 advice beyond the management of Covid-19 infection,
13 which inevitably meant moves away from the structures
14 which had existed before the pandemic. Those tended to
15 be more UK based, such as COBR or SAGE. Whether the
16 creation of these brand new Scottish systems was
17 a reasonable approach in the face of a virus which did
18 not respect man-made administrative boundaries will be
19 considered, as will new structures which sought to
20 maintain some level of cross-border co-ordination, such
21 as the four nations meetings led on behalf of the
22 UK Government by Michael Gove.

23 Connected to this, we will examine the extent to
24 which divergence by the Scottish Government from the
25 UK Government approach and systems was based on proper

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1 core participants a note by the Inquiry team setting out
2 the evidence we have gathered about the identity of key
3 individuals involved in the pandemic response and the
4 key elements of these decision-making systems, in the
5 hope that that will be of assistance to their navigation
6 amongst the obvious complexity of these structures.

7 We will examine how key decisions were made, by
8 which individuals, bodies and directorates within that
9 complex structure. We will examine the identity of the
10 decision-makers and the changes to these structures and
11 bodies and to decision-making practice, why these
12 changes were made and the appropriateness and
13 effectiveness of them.

14 In assessing the effectiveness of the pre-existing
15 and altered decision-making practices and structures, we
16 will examine the effectiveness of systems and practices
17 designed to facilitate effective communication,
18 discussion and information sharing between those making
19 key strategic decisions within government in response to
20 the pandemic.

21 Those strategies related to discussions between
22 ministers in the Scottish Government, between ministers
23 in the Scottish Government and their advisers, both
24 medical and administrative, and between Scottish
25 Government ministers and other government

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1 advice and a reasonable balancing of the competing
2 considerations, whether there was truly separate
3 Scottish evidence which could and should be used to
4 justify a separate different Scottish approach, whether
5 points of difference were substantive or merely
6 cosmetic, whether they led to different outcomes, and
7 whether they were to any extent motivated by factors
8 other than the very best response to the virus for the
9 safety of the people of Scotland.

10 By 5 May, further information about the framework
11 for decision-making was released. This was issued in
12 the context of what were described as signs of hope, not
13 least in the declining numbers of people requiring
14 intensive care or treatment as a result of the virus.

15 In updating the details of the assessment mechanism,
16 the document issued on 5 May identified the means by
17 which advice was taken to inform the four harms
18 approach.

19 On 7 May the Scottish Government announced that it
20 had reached its testing goal of 3,500 tests a day in NHS
21 labs made out in April, with 4,661 tests carried out on
22 30 April. They also announced that their next target
23 was 8,000 tests a day in NHS labs across Scotland by
24 mid-May. The four harms based framework had
25 acknowledged the importance of testing as part of the

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1 surveillance strategy to monitor cases. We will examine
2 in this module the extent to which testing strategy was
3 prioritised sufficiently, predominantly but not
4 exclusively in the early months of our scope.

5 On the same day, 7 May, the First Minister extended
6 the lockdown restrictions in Scotland for another
7 three weeks, but said they could be changed if evidence
8 emerged that it was safe to do so.

9 On 8 May, the First Minister reported that there was
10 some recognition that each of the four nations of the UK
11 might move at different speeds with regard to loosening
12 the lockdown and that she would not be pressured into
13 lifting restrictions prematurely.

14 On 10 May, about which you have heard in Module 2,
15 the UK Government updated its coronavirus message from
16 Stay at Home, Protect the NHS, Save Lives, to Stay
17 Alert, Control the Virus, Save Lives. The leaders of
18 the devolved governments in Scotland, Wales and
19 Northern Ireland said that they would keep the original
20 slogan. The messaging represented a significant
21 divergence in strategy on the part of the UK and
22 Scottish Governments, the former signalling a move
23 towards easing the lockdown and the latter sticking with
24 the existing restrictions, in effect taking the view
25 that the fight against the first harm, the harm caused

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1 said that 50% of the Covid-related deaths in Scotland
2 between March and June 2020 had involved the residents.

3 On 21 May 2020 the Scottish Government published
4 a more detailed four-phase route map laying out the
5 order in which restrictions would be relaxed. These
6 measures included allowing people to meet up outside
7 with people from one household in the first phase.

8 It was announced that lockdown could be eased from
9 28 May which it subsequently was, subject to the numbers
10 continuing to fall. It was announced that schools would
11 re-open on 11 August, when students would receive
12 a blended model of part-time -- until which time
13 students would receive a blended model of part-time
14 study and learning at home.

15 Mid-August, I should say, my Lady, is around the
16 traditional time for schools to return after the summer
17 holidays in Scotland, unlike in England when they tend
18 to break up and return later.

19 The details of this route map were subsequently
20 revised on 18 June, 2 July, 9 July, 20 August and
21 10 September as further evidence emerged of the
22 effectiveness of restrictions on reducing transmission.

23 On 26 May 2020, the Scottish Government announced
24 plans for Test & Protect, its testing and contact
25 tracing system. Though again the details of the testing

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1 by the virus itself, remained the priority.

2 By way of explanation of the Scottish Government's
3 position, on 11 May in a national address to Scotland at
4 the beginning of the 7th week of lockdown,
5 Nicola Sturgeon asked the nation to "stick with lockdown
6 for a bit longer -- so that we can consolidate our
7 progress, not jeopardise it". She declared that
8 "I won't risk unnecessary deaths by acting rashly or
9 prematurely".

10 As of 11 May, people could go outside more than once
11 a day to exercise in Scotland. This activity was to
12 continue to be undertaken close to home and it was
13 supposed to be done alone or with members of the same
14 household. A second Coronavirus (Scotland) Bill was
15 introduced to the Scottish Parliament. It included
16 emergency measures to protect people facing financial
17 hardship and allow public services to operate
18 effectively in response to the pandemic.

19 On 17 May the Scottish Government published guidance
20 for arrangements that care homes should put in place to
21 improve professional oversight of care provided during
22 the pandemic. A report from the University of Edinburgh
23 said that 50% of all Covid-related deaths in Scotland
24 between March and June 2020 had involved care home
25 residents. The report from the University of Edinburgh

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1 and tracing systems in Scotland will require to wait
2 until later modules of the Inquiry, the role of testing
3 in the Scottish Government's strategy in the fight
4 against the virus and its capacity to deliver it will be
5 examined here.

6 On 28 May, Nicola Sturgeon announced an easing of
7 lockdown measures in Scotland the following day when
8 people from two different households could meet up
9 outdoors so long as they were in groups of eight or
10 less.

11 On 8 June, no new deaths were recorded in Scotland
12 over the most recent 24-hour period. This was the first
13 time Scotland had recorded no new deaths since lockdown
14 began in March.

15 On 19 June, Scotland entered the second phase of its
16 route map, the Scottish Government replaced its Stay at
17 Home message with Stay Safe.

18 On 22 June, the wearing of face coverings became
19 compulsory on public transport, with exemptions made for
20 children under 5 and people with certain medical
21 conditions.

22 On 24 June, the Scottish Government published
23 an updated route map with indicative dates for phase 2
24 and 3 measures, announcing major changes to lockdown
25 restrictions.

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1 On 26 June, Scotland recorded no new deaths or new
2 cases of Covid for the most recent 24-hour period.
3 Nicola Sturgeon predicted that Scotland was not far away
4 from eliminating the virus. On the same day the
5 Park Inn stabbings took place in Glasgow, an incident in
6 which an asylum seeker was shot dead by police in
7 Glasgow after apparently having stabbed a number of
8 individuals in a city centre hotel in which he had been
9 staying under Covid restrictions.

10 On 27 June, travel insurance companies reported that
11 holiday bookings had "exploded" since the UK Government
12 had announced plans to ease quarantine restrictions on
13 travel abroad. The Scottish Government's position was
14 that it was yet to decide precisely on its view on the
15 matter. Both the external and internal borders will be
16 matters which we will address in this module. In terms
17 of the devolution settlement, the UK Government has and
18 has(sic) authority over border controls as a reserved
19 matter, though the general arrangement was the
20 Scottish Government would be consulted on border control
21 and quarantine in Scotland as these could impact on the
22 devolved area of health. In effect, as we will see,
23 my Lady, the Scottish Government seemed to control
24 border policy for Scotland, though this is a matter we
25 will seek to investigate.

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1 On 9 July, the move to phase 3 of the
2 Scottish Government's route map out of lockdown was
3 announced.

4 People in Scotland were able to meet up outdoors
5 with two other households from 10 July, and also in
6 extended groups of up to 15.

7 Shopping centres reopened from 13 July.

8 On 10 July, the wearing of face coverings became
9 mandatory in shops in Scotland, though this rule was not
10 in place in England.

11 On 15 July, Scotland recorded its seventh
12 consecutive day without any Covid-19 deaths and had also
13 had three days with no admissions to hospital. On the
14 same date hairdressers and barbers, pubs, restaurants,
15 cinemas, places of worship were allowed to open.
16 Nicola Sturgeon described this as "the biggest step so
17 far" in the easing of lockdown restrictions.

18 However, no sooner had this important development
19 occurred than the position started to turn.

20 On 18 July 2020, Scotland experienced its biggest
21 daily rise in Covid-19 cases since 21 June, with 21
22 cases reported in the most recent 24 hours, eight of
23 them in the Glasgow and Clyde area.

24 In this context, on 20 July, Scotland lifted
25 quarantine restrictions for people arriving from Spain,

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1 Travel abroad would later become significant as
2 cases started to rise in late summer and early autumn,
3 to which I'll return. Reports indicated that a Spanish
4 variant of the virus could be associated with as many as
5 80% of the cases in Scotland, by 9 December
6 Nicola Sturgeon acknowledged in the Scottish Parliament
7 that we should have been much tougher on travel
8 restrictions. This was in the context of a genomics
9 sequencing report provided to SAGE that showed that
10 travel was the main cause of the second wave in Scotland
11 from late summer 2020.

12 On 29 June, non-essential retailers were permitted
13 to re-open.

14 On 8 July, the Scottish Government announced that
15 passengers arriving from Spain and Serbia would still
16 have to quarantine on arrival, which differed from
17 the UK Government's list of countries exempt from
18 quarantine restrictions. However, on the same date the
19 Scottish Government announced the lifting of quarantine
20 measures for passengers arriving from 57 overseas
21 destinations and 14 UK overseas territories.

22 On 3 July, Scotland lifted its 5-mile travel
23 restriction.

24 On 6 July 2020, beer gardens and pavement cafés were
25 reopened in Scotland, after fifteen weeks of lockdown.

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1 though on 26 July quarantine restrictions were reimposed
2 on travellers arriving from Spain after a spike in
3 Covid-19 cases.

4 As far as deaths were concerned, the National
5 Records of Scotland figures showed deaths had fallen to
6 their lowest level at this stage since the beginning of
7 the pandemic, with six death certificates mentioning the
8 virus in the week ending 19 July.

9 On 23 July, the Scottish Government announced
10 changes to shielding.

11 On the 29th, the first signs emerged of an issue in
12 Glasgow, as a possible Covid-19 cluster was investigated
13 in the city.

14 On 31 July, the Scottish Government warned people
15 against visiting areas of England, subject to lockdown
16 rules, after measures were imposed by the UK Government
17 there in Greater Manchester and other areas.

18 On 10 July, the Scottish Government had given the
19 Scottish Football Association permission to launch the
20 Scottish Premier season on 1 August. However, by
21 2 August, health officials announced they were
22 investigating certain outbreaks, including a cluster of
23 13 Covid-19 cases linked to a pub in Aberdeen. In this
24 context, Eat out to Help Out launched on 3 August,
25 including in Scotland. The decision-making process

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1 which lay behind the launch of this scheme has been
2 examined in Module 2, not least with the current Prime
3 Minister, Mr Sunak. In accordance with our general
4 remit, we will look at the Scottish perspective on the
5 scheme, which, importantly, was a UK Government
6 initiative which also applied in Scotland.

7 In early August 2020, the Scottish Government agreed
8 to upgrade thousands of exam results following
9 controversy over their marking and accept teachers'
10 estimates of pupils' results, requiring 75,000 new exam
11 certificates to be issued.

12 On 11 August, pupils returned to school for the
13 first time since March, as had been anticipated earlier
14 in the summer.

15 On 20 August, the Scottish Government announced that
16 Scotland was to remain in phase 3 of the route map as
17 Covid-19 remained a significant threat to public health.
18 The government published an updated route map setting
19 out new dates for further changes. Aberdeen remained in
20 lockdown until 23 August when it was partially lifted.
21 Bars and restaurants were allowed to re-open there from
22 the 26th. This was the same date on which Scotland
23 recorded two Covid-19 deaths, the first deaths to be
24 recorded since 16 July.

25 On 28 August, Nicola Sturgeon announced the
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1 Edinburgh University, had predicted that Scotland could
2 eradicate Covid-19 by the end of the summer.

3 We will examine in this module whether this was, in
4 fact, the policy of the Scottish Government or, if not,
5 whether it should have been. This will involve
6 consideration of whether such a policy would ever have
7 been achievable in Scotland, given its land border with
8 England and the two nations' considerable commercial and
9 other links.

10 In this context we intend to look at the steps taken
11 by Scottish Government over that period and the extent
12 to which they did or could have achieved an elimination
13 goal, including the complex issues born from the
14 devolution settlement of travel restrictions and border
15 controls during the summer.

16 So August had seen a gradual re-opening of society,
17 against the emergence of rising cases and local clusters
18 of cases in Glasgow, Aberdeen and Tayside, amongst
19 others. Local restrictions were used where it was
20 thought to be appropriate.

21 On 2 September, Deputy First Minister John Swinney
22 defended the Scottish Government's decision to allow
23 pubs to remain open in Glasgow following the
24 introduction of stricter lockdown measures in the city,
25 saying the virus is being spread by households rather

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1 Scottish Government had been holding talks with business
2 leaders about a phased return to offices, but by
3 30 July, 123 Covid cases were recorded, the highest
4 number of new cases over 48 hours since 22 May. Despite
5 this, gyms, swimming pools and indoor sports courts were
6 permitted to open the next day. The position in
7 Scotland by the late summer of 2020 was that the
8 Scottish Government had eased the lockdown more slowly
9 than the UK Government had decided to do. It has been
10 suggested that the Scottish Government's strategy all
11 along had been that no death from Covid-19 was
12 acceptable, which meant, on one interpretation, that the
13 first harm of the four harms strategy was to be
14 prioritised over the others. This would at least be
15 logically consistent with the slower easing of
16 restrictions. The reasons for this strategy appear, on
17 the evidence we have, to be linked to the possibility
18 that the Scottish Government had adopted a policy of
19 zero Covid, an elimination strategy, by this point.
20 Some commentators opined that this was achievable given
21 the trajectory of the infection rate in Scotland at that
22 time.

23 For example, on 28 June 2020, following two days
24 with no reported deaths in Scotland,

25 Professor Devi Sridhar, an expert in public health at
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1 than the hospitality sector. Cases however continued to
2 rise both generally and in the Glasgow area.

3 By 3 September, 101 new cases were confirmed, 53 of
4 them in the Greater Glasgow areas. Scotland's border
5 restrictions continued to be slightly differently
6 applied from those imposed elsewhere in the UK.

7 On 7 September, a further 146 Covid-19 cases were
8 reported. Nicola Sturgeon said it may be necessary to
9 put the brakes on the further easing of the lockdown in
10 Scotland.

11 With cases continuing to rise, on 14 September
12 Nicola Sturgeon indicated there were very serious
13 concerns about Covid testing backlogs and that she was
14 seeking urgent discussions with the UK Government about
15 the issue.

16 On 22 December [sic] it was announced that the ban
17 on visiting other households, which had been in place in
18 the west of Scotland, would be extended across Scotland
19 from the following day, and that a 10 pm curfew on pubs
20 and restaurants would follow from the 25th.

21 You have heard evidence, my Lady, in Module 2, of
22 the advice given by SAGE to impose a further lockdown in
23 the autumn of 2020, and the lockdown in November 2020 in
24 England. Neither the proposed lockdown nor the actual
25 lockdown which was imposed in England took place in

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1 Scotland. We will examine in this module what the
 2 reasons were for why no lockdown took place in Scotland
 3 over this period against the background of rising cases
 4 which did occur, the extent to which the restrictions
 5 actually imposed were appropriate in the circumstances,
 6 as well as the advice upon which the decisions to impose
 7 them and not deeper restrictions were taken.

8 With outbreaks at universities in Glasgow,
 9 Edinburgh, St Andrews and Aberdeen around 24 September,
 10 students at Scottish universities were advised not to
 11 visit pubs, restaurants or parties, and to socialise
 12 only with members of their accommodation in a bid to
 13 stem the spread. This led to concerns that students
 14 were being singled out for the acceleration of the
 15 virus.

16 Cases continued to rise steadily, but on
 17 1 October 2020 the Scottish Government did not impose
 18 any additional rules.

19 By 5 October, ministers met and discussed the
 20 possibility of a two-week circuit-breaker to stem the
 21 escalation of cases. No such lockdown was imposed.

22 By 7 October, Scotland recorded more than 1,000 new
 23 Covid cases in a day. The Scottish Government announced
 24 that bars and restaurants in the central belt must close
 25 from 6 pm on 9 October, the closure remaining in place

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1 of 2.3 million people. These restrictions caused
 2 a degree of controversy and there were expressions of
 3 frustration at a local level regarding the levels
 4 imposed, which were at times not well received.

5 The remit of our module will also include
 6 consideration of the extent to which Scottish local
 7 authorities were involved in key decisions being
 8 reached. Were they or their representatives adequately
 9 consulted? Were they given adequate information to
 10 permit reasonable participation in the process? Were
 11 their views given adequate consideration, in particular
 12 where the fight against the virus became more regionally
 13 based? What role did they have in the communication of
 14 local restrictions and the need for them to be
 15 communicated to the residents of their areas?

16 In light of rising cases towards the end of 2020,
 17 attention started to turn to the question of what would
 18 happen around Christmas.

19 On 8 December, the Scottish Government announced its
 20 first vaccinations against coronavirus had been given in
 21 Scotland to those who would be carrying out the
 22 vaccination programme. On the same day it was announced
 23 that all 11 areas living under level 4 restrictions
 24 would be downgraded to level 3 from Friday the 11th.
 25 The announcement prompted anger from council leaders in

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1 until the 25th.

2 On 14 October, the Scottish Government warned people
 3 against travelling to Blackpool after the town was
 4 linked to a "large and growing" number of Scottish
 5 Covid-19 cases.

6 On 23 October, Nicola Sturgeon unveiled Scotland's
 7 new five-level Covid-19 management system which was due
 8 to come into effect from 2 November. The purpose of
 9 this system was intended to allow the Scottish
 10 Government to respond more flexibly to localised
 11 outbreaks. We intend to explore in the module the
 12 rationale for this system, in particular in light of the
 13 fact that on 12 October the Scottish Government had
 14 announced plans to draw up a three-tier Covid
 15 restriction system similar to the one which had been
 16 announced for England.

17 The level system was used over this period, with the
 18 Scottish Government controlling the levels into which
 19 each local authority would be put and its position being
 20 that the use of this system was keeping the spread of
 21 infection relatively stable.

22 However, on 17 November 2020, level 4 restrictions
 23 were announced for 11 council areas in the west of
 24 Scotland due to rising cases, effective from 6 pm on
 25 20 November until 11 December, and covering a population

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1 Edinburgh and Midlothian that their areas remained in
 2 level 3 despite expectations they would move to level 2.
 3 This led to an ultimately unsuccessful challenge by
 4 Edinburgh City Council in court against that position.

5 By 19 December, following the emergence of a new,
 6 faster-spreading variant, the Alpha variant,
 7 Nicola Sturgeon announced that festive relaxation of
 8 restrictions would be limited to Christmas Day, with
 9 mainland Scotland placed under level 4 rules from
 10 Boxing Day. Travel between Scotland and the rest of the
 11 UK would not be legal. Restrictions were relaxed for
 12 Christmas Day to allow people to mix indoors and travel
 13 more freely.

14 Despite concerns which had been raised by business,
 15 on 26 December mainland Scotland moved into level 4
 16 restrictions close to full lockdown.

17 By 29 December, 1,895 new Covid cases were reported,
 18 the highest number in a single day. First Minister
 19 Nicola Sturgeon urged people to stay at home at Hogmanay
 20 and not mix with others, declaring it to be vitally
 21 important.

22 On 30 December 2020, 2,045 Covid cases were
 23 recorded, the highest daily total since mass testing
 24 began. First Minister Nicola Sturgeon described the new
 25 variant of concern as "fast becoming the dominant one".

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1 On Hogmanay 2020, Scotland reported 2,622 positive
2 tests. Hogmanay events were cancelled and people are
3 warned to stay at home.

4 My Lady, if it's convenient to you, that would be
5 an appropriate point to break for lunch.

6 **LADY HALLETT:** Certainly, Mr Dawson, thank you. I shall
7 return at 1.45.

8 (12.45 pm)

9 (The short adjournment)

10 (1.45 pm)

11 **LADY HALLETT:** Mr Dawson.

12 **MR DAWSON:** Thank you, my Lady.

13 In my odyssey through the Covid pandemic in
14 Scotland, I had got, I think, to the end of 2020.

15 **LADY HALLETT:** You had.

16 **MR DAWSON:** So I'm going to turn to 2021 in the hope that
17 I will be able to deal with this a little bit more
18 quickly from this point on.

19 At the beginning of 2021, with cases continuing to
20 be recorded at record levels, on 4 January, mainland
21 Scotland was placed under a lockdown until the end of
22 January. Beginning from midnight, schools were closed
23 and people ordered to stay at home except for essential
24 purposes. For the sake of clarity, this lockdown, which
25 is normally referred to in Scotland as the second

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1 Scottish Government confirmed that the NHS Louisa Jordan
2 would stay open for the time being, however by 18 March
3 it was announced that it would close at the end of the
4 month.

5 On 16 March, Nicola Sturgeon set out the easing of
6 restrictions in Scotland. The plan was the stay-at-home
7 order would be lifted on 2 April in favour of
8 a stay-local order within local authority areas.

9 However, by 26 March 2021, figures from the Office
10 for National Statistics indicated Scotland to have the
11 highest Covid infection rate in the UK.

12 On 2 April, the stay-at-home order was, however,
13 lifted and replaced with a three-week stay-local order
14 that required people to stay within their local council
15 areas.

16 On 16 April, the stay-local rule was lifted for
17 Scotland.

18 6 May 2021 was a significant day in Scotland.
19 Figures published by Public Health Scotland showed
20 Scotland had experienced its first seven-day period
21 without any Covid deaths for eight months, with no
22 deaths recorded between 29 April and 5 May. 6 May 2021
23 was also the day on which elections to the Scottish
24 Parliament took place. Voter turnout was the highest in
25 a Scottish Parliament election to date, at 63%. The SNP

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1 lockdown, was not in reality a national lockdown as the
2 first had been, as it covered only the mainland of
3 Scotland, which had been in Tier 4 restrictions to that
4 point. The island areas remained in Tier 3, although
5 certain island areas were moved into Tier 4 during
6 January 2021 to control spikes in cases there.

7 On 19 January 2021, the Scottish Government extended
8 the second lockdown until mid-February, schools remained
9 closed.

10 On 2 March, it was confirmed that all secondary
11 school pupils return to the classroom part-time from
12 15 March, with priority given to those in years due to
13 take public examinations. With Covid cases at their
14 lowest in five months, the First Minister suggested
15 lockdown measures could be lifted faster than scheduled.

16 On 9 March, the Scottish Government announced
17 a slight easing of the rules, allowing four people from
18 two separate households to meet up outdoors or four
19 youngsters aged 12 to 17 from four separate households
20 to meet up from Friday the 12th. Outdoor non-contact
21 sports would be allowed on the same day. Communal
22 worship of no more than 50 people would be allowed from
23 the 26th.

24 On the same date following England's announcement
25 that five of its Nightingale hospitals would close, the

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1 finished with 64 seats, just short of an overall
2 majority. In the aftermath of the election, previous
3 Cabinet Secretary for Health and Sport, Jeane Freeman,
4 not having stood for recollection, Nicola Sturgeon
5 appointed Humza Yousaf to the role of Cabinet Secretary
6 for Health and Social Care. The picture at that time
7 faced by the new Health Secretary, whose previous
8 portfolio had been Justice, involved a plan for
9 a gradual move out of the restrictions which had led to
10 the second lockdown. Indeed, on 8 May Scotland recorded
11 a day without any Covid-related deaths.

12 The changing roles of the key decision-makers in the
13 Scottish Government at around this time due to the
14 election and the government's changing priorities will
15 be examined during the course of the module.

16 In the aftermath of the election, on 18 May, Deputy
17 First Minister John Swinney was appointed as Minister
18 for Covid Recovery.

19 On 17 May, most of mainland Scotland, with the
20 exception of Murray and Glasgow, which had seen a recent
21 rise in cases, moved from level 3 to level 2
22 restrictions. As before, the Scottish Government over
23 this period continued to prescribe which level of
24 restrictions should apply to which local authority area
25 based on local data. Local outbreaks took place,

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1 including in Glasgow and Dundee.
 2 On 22 June 2021, the Scottish Government set a date
 3 of 9 August for the lifting of all Covid restrictions in
 4 Scotland, whilst delaying the next tranche of changes,
 5 the move from level 1 to level 0 for the Scottish
 6 mainland, from 28 June to 19 July.

7 The decision was in the context of the highest
 8 number of daily Covid cases since the start of mass
 9 testing, 2,969, in Scotland being reported the very next
 10 day, with a gender gap having appeared up in recent
 11 days: two-thirds of those aged 13 to 54 testing positive
 12 for the illness being male.

13 On 30 June 2021, a total of 1,991 COVID cases in
 14 Scotland were linked to Euro 2020 football matches, with
 15 two thirds of them stemming from Scotland's game against
 16 England at Wembley on 18 June.

17 On 1 July the number of daily Covid cases in
 18 Scotland passed 4,000 for the first time. This led to
 19 significant pressure on contact tracing systems.

20 On 5 July the World Health Organisation in its
 21 figures placed Scotland as one of the top Covid hotspots
 22 in Europe, something National Clinical Director
 23 Jason Leitch attributed to a lack of natural immunity in
 24 the population.

25 On 17 July, with the mass vaccination centre at
 101

1 requirements.

2 By 13 August, four health boards had cancelled
 3 non-urgent procedures and outpatient appointments amidst
 4 rising pressure from Covid. However, on 9 August, the
 5 bulk of pandemic related restrictions were removed.

6 As for the later period, this was dominated,
 7 my Lady, as you know from Module 2 evidence, by the
 8 later Delta infection and the arrival of Omicron.

9 On 16 August 2021, most schools returned after the
 10 summer holidays. Following the move in August to
 11 level 0, on 24 August Scotland recorded 4,323 daily
 12 cases. Nicola Sturgeon indicated that she could not
 13 rule out the reintroduction of some Covid measures, but
 14 said that these would be limited and as proportionate as
 15 possible.

16 Cases continued to rise significantly. 27 August
 17 showed Scotland had recorded 6,835 new cases,
 18 Nicola Sturgeon said the Scottish Government was not
 19 considering the introduction of a circuit-breaker.

20 By late August 2021, figures indicated that Covid
 21 cases had virtually doubled each week since the lifting
 22 of restrictions on 9 August, leading to an increase in
 23 hospitalisations. National Clinical Director
 24 Professor Jason Leitch suggested a reverse gear may be
 25 needed with some restrictions.
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1 Glasgow's SSE Hydro set to close, opposition politicians
 2 urged the Scottish Government to keep it operating. The
 3 clinic was being closed in order to prepare the venue
 4 for the UN Climate Change Conference, which eventually
 5 took place in November 2021.

6 By 18 July 2021, all adults had been offered
 7 a vaccination. However, it was reported that a third of
 8 younger people in Scotland remained unvaccinated.

9 Despite the rising cases, the announced relaxation
 10 of the restrictions continued as planned, with Scotland
 11 moving to level 0 restrictions on 19 July, allowing
 12 a larger number of people to meet up indoors as well as
 13 attending weddings and funerals.

14 Covid deaths in Scotland continued to rise: 47 in
 15 death certificates in the week between 12 and 18 July,
 16 a rise of 16 on the previous week. A key feature of
 17 this period in Scotland from the summer of 2021 was that
 18 hospitals started to become overwhelmed as a result of
 19 the impact of local cases of infection caused by the
 20 Delta variant. As early as 7 July 2021, NHS Grampian
 21 had placed two hospitals on code black status, meaning
 22 the cancellation of non-urgent procedures. They reached
 23 full capacity following a rise in Covid cases in the
 24 area and a consequent rise in hospital admissions,
 25 combined with staff absences due to self-isolation
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1 A number of large scale events were reintroduced,
 2 and Nicola Sturgeon confirmed on 1 September that
 3 vaccine passports would be required for people who
 4 wished to enter nightclubs or attend large events. The
 5 practicality of the plans was questioned by a number of
 6 organisations, including the Scottish Professional
 7 Football League.

8 The next day Humza Yousaf claimed the benefits of
 9 Scotland's planned Covid passport scheme for large scale
 10 events outweighed the concerns and were preferable to
 11 another lockdown. This would prove to be
 12 a controversial means of seeking to manage infections
 13 over this period. The Scottish Parliament voted to
 14 approve the scheme on 9 September, meaning adults had to
 15 be fully vaccinated to enter nightclubs and large events
 16 from 1 October.

17 Opposition to the scheme culminated in an ultimately
 18 unsuccessful legal challenge against Scotland's vaccine
 19 passport scheme the day before its launch. In the midst
 20 of rising cases and the launch of schemes like the
 21 vaccine passport scheme to manage infections in a low
 22 restriction environment, on 7 September 2021
 23 Nicola Sturgeon confirmed that work would resume on
 24 plans for a second independence referendum. She said
 25 the next day that her plans to hold a second
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1 independence referendum in two years were realistic
 2 despite the difficulties of Covid. On the same day it
 3 was estimated that one in 45 people had Covid in
 4 Scotland, the highest number since records began.
 5 The pressures on the stretched NHS in Scotland which
 6 had required a number of areas to suspend non-urgent
 7 procedures in the summer continued. By 6 September 2021
 8 the Scottish Government required to ask the
 9 Ministry of Defence for military assistance for
 10 Scotland's ambulance service. Nicola Sturgeon described
 11 the situation as being the most challenging set of
 12 circumstances in history because of Covid.

13 The unrelenting pressure on the NHS and the drastic
 14 measures required to combat it continued throughout
 15 October. On 23 October, NHS Greater Glasgow urged
 16 patients only to attend A&E if their issue was
 17 life-threatening. On 3 November, the Scottish
 18 Government set out proposals for non-emergency A&E
 19 patients to be redirected to other areas of the NHS,
 20 military help for hospitals continued.

21 In late November reports of a new Omicron variant
 22 were received. By 9 December Public Health Scotland
 23 urged people to cancel Christmas parties, claiming
 24 a number of Omicron cases were linked to these. This
 25 led to the hospitality industry reporting non-stop

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1 On 6 January, the number of confirmed cases in
 2 Scotland since the start of the pandemic had passed
 3 1 million. On that day Humza Yousaf indicated that the
 4 then current Covid infection rates in Scotland were in
 5 line with the worst-case scenario.

6 On 23 January, First Minister Nicola Sturgeon
 7 appeared on BBC's Sunday Morning programme and stated
 8 that although she understood the very adverse effect of
 9 Scotland's Covid measures, and the effect the measures
 10 had had on business and hospitality, she believed they
 11 been worth it.

12 On 28 January, the rules on physical distancing and
 13 the wearing of face masks in certain circumstances were
 14 relaxed. The changes applied to indoor settings such as
 15 religious services.

16 On 8 February, Nicola Sturgeon announced that
 17 Scotland was "through the worst" of Omicron though
 18 31 people were still being treated for Covid in
 19 intensive care.

20 By 21 March, the number of hospital patients testing
 21 positive for Covid in Scotland reached a new high of
 22 2,182, but ICU admissions remained relatively low in
 23 comparison as the latest variant caused more mild
 24 symptoms. Even late in the period with which this
 25 module is concerned, on 23 March 2022 NHS Glasgow and

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1 cancellations the very next day.

2 By 10 December 2021, the First Minister indicated
 3 that Scotland faced a tsunami of Omicron cases, with it
 4 likely to become the dominant variant of Covid within
 5 days. She announced changes to self-isolation rules
 6 from the next day.

7 On 24 December Professor Leitch urged people to
 8 enjoy Christmas but to be cautious. On that day the
 9 number of daily Covid cases in Scotland hit its highest
 10 point since August with 7,076 new cases reported.

11 On Boxing Day, fresh restrictions were brought in as
 12 an attempt to halt the spread of Omicron, including the
 13 cancellation of all large scale events. As in the
 14 previous year, Edinburgh's Hogmanay street party was
 15 cancelled, although this year crowds did gather.

16 On 27 December, 1 metre of physical distancing was
 17 reintroduced for the hospitality and leisure sectors,
 18 while hospitality were required to provide table service
 19 only.

20 On 29 December, a further 15,849 cases were
 21 reported, the highest daily figure so far. Scots were
 22 warned not to travel to England as a way of
 23 circumventing Scotland's tighter Covid rules.

24 On 3 January 2022, Scotland reported 20,217 cases,
 25 again its highest daily figure.

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1 Clyde, Scotland's biggest health board, was warning it
 2 was facing Covid pressures that were as serious as it
 3 gets, due to a combination of record numbers of Covid
 4 patients and staff absences. Advice remained that
 5 people should only attend accident & emergency units if
 6 their condition was very serious or life-threatening.

7 On 28 April the Scottish Government announced that
 8 public health advice would change to the stay-at-home
 9 message, replacing self-isolation from 1 May. Testing
 10 for the general population and contact tracing would
 11 end, with testing sites closing, though testing would
 12 remain available to certain groups. It was announced
 13 that NHS Scotland would be taken out of its emergency
 14 footing at the end of 30 April.

15 My Lady, we intend to examine these later
 16 significant outbreaks of infection in Scotland at a time
 17 when statistics suggest that both infection and the
 18 consequences were higher in Scotland than in other
 19 areas. Though there was a focus in the early stages of
 20 the pandemic on the need to manage the pressures on the
 21 NHS, it seems to be the case that over this period
 22 hospital services were allowed to wane for all.

23 My Lady, I'll turn briefly now to deal with a number
 24 of other areas which we intend to deal with in the
 25 module, having come to the end of my chronology.

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1 I intend to deal with these briefly, and I've touched
2 upon a number of them already, but the purpose of this
3 really, my Lady, is to give people an indication,
4 insofar as we are able publicly at this stage, to tell
5 people the types of witnesses that we intend to call.

6 I've already said, my Lady, that both data and
7 advisory systems are a key part of the module, and that
8 we will be looking at them in some detail.

9 The starting point of the process of providing
10 accurate advice to government is of course the
11 requirement to have access to accurate and timely data.
12 We will in this module investigate with a number of
13 relevant witnesses the data access systems that were
14 available to the Scottish Government, in particular
15 access to local data as the pandemic progressed, and
16 more local solutions became the way that the pandemic
17 was managed.

18 Furthermore, my Lady, the significance of data and
19 in particular local data and modelling will be examined
20 with appropriate witnesses from as early as tomorrow, as
21 well as whether accurate local data was available to
22 assist modellers in the Scottish response.

23 We will ask about the extent to which factors such
24 as the economy, non-Covid health-related concerns,
25 inequalities, education, mental health and societal

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1 We will examine also the methodology behind the way
2 in which key public health messages was formulated and
3 disseminated by the Scottish Government.

4 We will consider what advice was taken, including
5 from behavioural scientists and other expert advisers,
6 as to how the way in which the pandemic was being
7 managed should best be communicated and what was
8 required in accordance with government policy. We will
9 examine the rationale for the communication policy and
10 the reasons why it was or was not effective.

11 We will also, as has been the case, extensively if
12 I recall, in the previous module, look at ways in which
13 ministers, other decision-makers and key advisers
14 themselves went about complying with the regulations,
15 although this I think, on our analysis, plays a lesser
16 role than the extensive evidence you've heard about that
17 in Module 2.

18 We will also, my Lady, have a look with appropriate
19 witnesses, including ministerial witnesses, at the
20 funding arrangements to which I've made reference.
21 Given the fact that the Treasury is a reserved matter,
22 looking at funding necessarily has a cross-border
23 element, but it appears to be the case that this played
24 an important role in the way in which the pandemic was
25 managed or could be managed in Scotland.

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1 issues formed part of modelling in Scotland. Were they
2 modelled effectively by or on behalf of the
3 Scottish Government, and were the models assimilated
4 effectively into their decision-making systems?

5 We will also hear, my Lady, as I've already said,
6 from a number of key representatives from the advisory
7 bodies which provided advice to the Scottish Government.
8 That, of course, will mean hearing from a number of
9 members of the Scottish Covid Advisory Group, to which
10 I've already made reference. We will also examine with
11 witnesses a number of other groups that were set up
12 during the course of the pandemic to provide
13 Scottish Government with advice on various matters.

14 The role and operation of all of these bodies and
15 the extent to which they provided advice to the
16 government, the extent to which that advice was properly
17 understood, assimilated and acted upon in the
18 Scottish Government's ongoing response will be assessed
19 with appropriate witnesses.

20 We will, as I've already said, my Lady, touch in our
21 analysis of the overall Scottish Government strategy on
22 a number of key components of that strategy, including
23 NHS capacity, the important issue of care, to which I've
24 already made significant reference, the role of border
25 controls, and schools.

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1 My Lady, we will also hear from witnesses in
2 relation to the way in which Covid-19-related
3 legislation and regulations were enacted in Scotland, in
4 particular the use of emergency powers, and you'll hear,
5 my Lady, from a legal academic who has looked at the
6 issue of whether the way that powers was used was
7 appropriate and adequately ensured that the Executive's
8 use of the legislative process was proportionate in the
9 circumstances.

10 We will also, my Lady, look to an extent at the
11 enforcement of the rules, in particular the rationale
12 for the use of criminal sanctions, the use of threats of
13 greater sanctions by the Scottish Government to seek to
14 maximise compliance. We will examine research and
15 conclusions reached by an academic, a member of Police
16 Scotland's Independent Advisory Group during the
17 pandemic on the police's used of fixed penalty notices
18 to enforce coronavirus-related rules.

19 My Lady, in the course of the hearing, in order to
20 deal with these matters, you will hear tomorrow first of
21 all from a number of interest groups who happen to be
22 core participants in our module. You will hear from
23 a representative of Scottish Covid Bereaved, from whom
24 you've heard in previous modules, a representative from
25 Inclusion Scotland, and from the Scottish TUC. Later in

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1 the week you will also hear from a representative of
2 Scottish Care.

3 During the course of the hearings, my Lady, you will
4 hear, as I have said, from witnesses who played
5 a pivotal role in a number of aspects of decision-making
6 in Scotland, including those who were responsible for
7 the compilation of data, those who carried out
8 modelling, civil servants, and other political advisers,
9 and ultimately, as well as medical and other
10 administrative advisers, those who made decisions, the
11 ministers themselves.

12 My Lady, I've set out what I hope is a helpful
13 introduction to the issues and the key events which will
14 be addressed in the module. We intend to address the
15 key decisions of government in Scotland in order to be
16 able to assess their reasonableness, proportionality and
17 effectiveness. It would be right to acknowledge that
18 none of these key decisions was an easy one. Decisions
19 taken during the course of a pandemic by our political
20 leaders were a matter of life or death. They were thus
21 taken under circumstances of considerable pressure.
22 They were often taken with imperfect information, both
23 about the threat but also about the consequences of any
24 proposed countermeasure. In light of these
25 considerations, it would be wrong in these circumstances

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1 may differ from what was done in other countries, based
2 on the particular characteristics and priorities of the
3 Scottish people, for example the state of their health
4 and thus the threat which the virus posed, the presence
5 of health inequalities, or the age of the population.
6 What was reasonable may differ from time to time, given
7 the particular dynamics of the spread of the virus and
8 other practical matters such as the capacity of the NHS,
9 the availability of protective measures such as testing,
10 PPE or vaccine, and the shifting priorities and
11 requirements of the people at any given time.

12 Equally, what was reasonable in the early pandemic
13 may be judged differently from what was done as the
14 pandemic progressed. It would have been reasonable, we
15 submit, to have learned from the experience as it was
16 going along, to seek to improve the quality of the
17 response. We will examine whether this occurred.

18 In evidence which has been heard by the Inquiry in
19 previous modules, in particular Module 2, of which much
20 has been made by political leaders of the need to use
21 hindsight to reflect upon decisions. In our view, the
22 use of hindsight has a value, but it is not necessary or
23 useful always to judge action or inaction in light of
24 what we now know but which may not have been known or
25 reasonably anticipated at the time.

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1 to seek to judge the actions of those who took decisions
2 about the management of the pandemic in Scotland by the
3 application of a counsel of perfection. No political
4 leader can be expected to perform perfectly in
5 everything they do.

6 However, in a civilised country like Scotland, which
7 claimed, as you have heard in Module 1, to have had good
8 readymade systems for the management of emergencies like
9 the pandemic, leaders ought to be judged by the standard
10 of whether they took reasonable decisions in the
11 interests of the public in whose name they were
12 empowered to act.

13 The judgement of what was or was not reasonable will
14 ultimately be a matter for you, my Lady, when you write
15 your report. What was reasonable at one point of the
16 narrative may differ from what was reasonable at
17 another. Given the fast-moving pace of a deadly virus,
18 emerging and developing levels of knowledge, differing
19 priorities and potential harms, the reasonableness of
20 decision-making depends not only on the knowledge which
21 was available but what ought to have been available to
22 maximise the chances of the best decisions being made.
23 Equally, it depends on practical considerations, which
24 may vary from time to time and from country to country.
25 For example, what was reasonable for the Scottish people

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1 A key function of the Inquiry is to seek to make
2 recommendations as to how things may be done better in
3 the future, both as regards general systems for taking
4 good decisions but in particular for any future health
5 emergency of the nature of a pandemic. Often hindsight
6 may be used to seek to avoid responsibility by claiming
7 that it is only in light of what is now known and not
8 what was known or ought reasonably to have been known at
9 the time that certain alternative courses of action
10 could be deemed to have been preferable or more
11 reasonable. Though using what is now known has a value
12 in seeking to inform the most up-to-date and hence
13 useful recommendations for the future, your function
14 requires us also to take care not simply to excuse
15 decision-makers from taking responsibility based on
16 their assertion that it is only by the use of hindsight
17 that we now know that decisions could or should have
18 been taken, not as they were. We intend to do so.

19 In order to assess both the reasonableness and
20 proportionality of decision-making at the time and how
21 to inform things which might be done better in the
22 future, we intend to analyse in some detail the systems
23 which were employed to reach key decisions in the
24 management of the pandemic in Scotland. The extent to
25 which these systems and defects in them contributed to

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1 the outcomes which have been experienced by the people
2 of Scotland deserves careful reflection and assessment
3 for the future. What were the key decisions? Who took
4 the key decisions in the then current system? Upon what
5 evidence base did they do so? Was there proper
6 consideration of the relevant competing harms which
7 inaction or action would entail? If not, why not? Did
8 systems change? If they did, why did they, and how
9 effective were those changes? If they did not, why did
10 they not? These are the questions which we will
11 explore.

12 As I've set out already, decision-making in Scotland
13 requires to be judged and analysed in the context of its
14 particular political system. It shaped the decisions
15 which individuals or groups were able to make and hence
16 plays an important part of the process of analysing the
17 reasonableness of the key decisions taken.

18 We intend to examine whether that system passed the
19 test. If it did not do so, it cannot be fit for its
20 primary purpose, to protect the welfare of the people of
21 Scotland. Equally, limitations on the ability to act
22 should not be used as an excuse for a failure to act in
23 circumstances where the power and responsibility existed
24 to find a way to protect the Scottish people against the
25 threat.

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1 As we have seen, the Scottish Government devised its
2 own advisory systems, largely during the first lockdown,
3 on a variety of social and medical matters. To what
4 extent were the new advisory systems adequately
5 constituted? And was scientific and non-scientific
6 advice properly taken into account when the key
7 decisions were reached?

8 Those who were charged with taking the key decisions
9 in the management of the pandemic response in Scotland
10 and in the exercise of their public responsibilities
11 require to be held to account for the decisions they
12 took or at times did not take.

13 Our terms of reference require us to seek to do so.
14 In circumstances such as this, where the Scottish public
15 has faced unprecedented harm, physical, mental and
16 emotional, and ultimately death and bereavement as
17 a result of the rampaging virus, they deserve
18 an investigation into the key decisions which were
19 designed to prevent these things occurring.

20 Equally, those who have suffered as a result of the
21 untold harm caused by the countermeasures taken to
22 combat the virus, the physical, mental, social,
23 educational, personal, economic and other harm, deserve
24 to have these decisions analysed too. We intend to do
25 just that in this module.

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1 We will explore the extent to which those charged
2 with the responsibility to do so sought to find the best
3 way within our constitutional system to serve their
4 primary purpose. As the narrative shows, Scotland
5 developed its own strategies for fighting the virus at
6 some point early in the first lockdown. Could and
7 should it have done so earlier? When it developed new
8 systems to facilitate doing so, was that the right path
9 to take? To what extent was it reasonable to have
10 developed new systems for decision-making when the
11 existing systems, both Scottish and UK-wide, existed?
12 In the fight against a virus which did not respect
13 man-made boundaries or systems, was going it alone
14 a reasonable course to take?

15 Central to the determinations with which the Inquiry
16 and ultimately you are charged in this module, my Lady,
17 are the advisory systems which were employed in reaching
18 key decisions for Scotland. Ministers said they were
19 following the science, and often appeared, both at UK
20 level and within the Scottish Government, publicly
21 alongside medical or other scientific advisers to add
22 the weight of scientific advice to their judgements.
23 Did they understand, probe and analyse the advice which
24 they received sufficiently? What did they make of it,
25 and what advice did they base their key decisions on?

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1 Thank you very much, my Lady. That concludes my
2 opening statement.

3 **LADY HALLETT:** Thank you very much, Mr Dawson.
4 Claire Mitchell KC.

5 **Submissions on behalf of Scottish Covid Bereaved by**
6 **MS MITCHELL KC**

7 **MS MITCHELL:** I am Claire Mitchell King's Counsel and, along
8 with my colleagues Kevin McCaffery and Kevin Henry, I am
9 instructed by Aamer Anwar & Company solicitors on behalf
10 of the Scottish Covid Bereaved in both the UK and
11 Scottish public inquiries.

12 In Module 1 we learned that as a result of the
13 policy of austerity, the vulnerable became more
14 vulnerable, the poor, poorer, the sick, sicker. Life
15 expectancy declined. The NHS was chronically
16 underfunded. Added to this, preparations for Brexit
17 took place, replacing any work on pandemic planning,
18 leaving the UK virtually defenceless.

19 Despite the benefit of time, of watching in real
20 time the wave of Covid sweep towards the UK shores, the
21 politicians, and in particular the then Prime Minister
22 Boris Johnson, prevaricated, trolleyed, flip-flopped in
23 the deadly days of delay during which action ought to
24 have been taken as the disease quickly multiplied and
25 overtook the UK.

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1 So far in Module 2 the Scottish Covid Bereaved has
2 sought to understand the UK Government's initial
3 response, to find out about decision-making by our
4 central government, the politicians, civil servants,
5 special advisers. Repeatedly politicians, and it is
6 politicians in particular, asked to offer their
7 condolences to the bereaved, they expressed their views
8 on how important this Inquiry was, yet when it came to
9 answering questions there were repeated instances of
10 obfuscation.

11 The view taken on the evidence is a matter for the
12 Chair alone, but the view of the Scottish Covid Bereaved
13 is that when presented with evidence or asked to comment
14 on issues not in their favour, explanations were
15 tendered that would strain of belief of even the most
16 gullible.

17 The then Prime Minister Boris Johnson's inability to
18 act decisively was repackaged with a philosophical spin.
19 His lack of ability to harness what he considered to be
20 the greatest tool in the pandemic, that of
21 communication, was not reflected on with any form of
22 acceptance, despite there being very many significant
23 examples flagged up by an independent expert of his and
24 his colleagues' inability to properly define what rules
25 were to be followed by whom.

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1 is that in this present module the Scottish Covid
2 Bereaved wish to say loudly and clearly to the
3 politicians in Scotland that they want better. On
4 behalf of their relatives, they deserve better. They
5 want politicians to answer questions put to them
6 directly, to reflect upon their time during the
7 pandemic, and they want them to wholly engage in the
8 process of finding out what happened, putting politics
9 and political careers aside. Quite frankly, the work of
10 this Inquiry is more important.

11 Considered and careful reflection on what went on
12 and how things could have been done better may literally
13 save lives in the next pandemic.

14 We would ask that politicians in particular remember
15 this when they come to give evidence.

16 In Module 2, some of the best evidence, the most
17 unguarded contemporaneous evidence, came from informal
18 methods of communication such as WhatsApps. The sorry
19 history of the difficulty that this Inquiry has had
20 obtaining those documents from the Scottish Government
21 is cause for considerable concern to the Scottish Covid
22 Bereaved. Media reports have suggested that senior
23 figures in the pandemic decision-making, such as
24 Nicola Sturgeon and Jason Leitch, have failed to retain
25 messages. If these reports are correct, the Scottish

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1 In evidence, he seized upon the idea that in
2 a future pandemic any Prime Minister should speak to the
3 whole of the UK as if it was a revelatory idea, rather
4 than the actual job he should have been carrying out.
5 Finally, both he and Mr Gove seemed interested in
6 exploring a topic, the source of the pandemic, which was
7 not within the scope of the Inquiry, terms indeed which
8 Mr Johnson had set. A red herring which the press ate
9 up.

10 The toxic misogynistic and macho atmosphere at the
11 centre of government was presented as an environment to
12 get the best out of people, where there appeared to be
13 no recognition of the fact that their characterisation
14 was not shared by the senior civil servants working in
15 it, and that this environment sidelined and excluded
16 women and, perhaps more specifically importantly for
17 government, side-stepped the procedural safeguards of
18 collective decision-making in Cabinet.

19 Our present Prime Minister, Mr Rishi Sunak, was able
20 to remember very little of some very important decisions
21 and conversations that took place when he was present,
22 yet when on more solid ground was able to point to the
23 detail of evidence which supported his position, his
24 recollections were clear.

25 The reason for highlighting the foregoing, my Lady,

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1 Covid Bereaved hope that, whatever evidence may be
2 gleaned from surviving WhatsApps, nothing of
3 significance has been lost as a result of this
4 apparently wilful deletion of messages.

5 The Scottish Covid Bereaved are further aware from
6 media reports that it may be suggested that as final
7 decisions were not taken via WhatsApp, there was no need
8 to retain these important messages. They look forward
9 to hearing how politicians and civil servants attempt to
10 justify this position. Are the people of Scotland to
11 believe that the Scottish Government placed no reliance
12 on informal messaging services which were routinely used
13 by individuals and businesses throughout the pandemic?
14 As the Inquiry will no doubt hear, in March and
15 April 2021, promises were made not only to the Scottish
16 Covid Bereaved but the people of Scotland, in the
17 manifesto on which the members of the
18 Scottish Government stood, that there would be a public
19 inquiry into the handling of the pandemic. It ought to
20 have been obvious to politicians, advisers and civil
21 servants from at least then, if not earlier, that
22 evidence of contemporaneous discussions in relation to
23 the pandemic response would be of vital importance to
24 the subsequent Inquiry. Were no steps taken to secure
25 these messages? Did the deletion of messages continue

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1 after spring 2021?

2 The Scottish Covid Bereaved listened with great
3 concern as Counsel to the Inquiry set out at the
4 previous preliminary hearing the difficulties faced by
5 the Inquiry in securing evidence from the Scottish
6 Government. It is hoped that this is not indicative of
7 the approach to be taken at the hearings.

8 As noted, one of the recommendations suggested by
9 the group at the end of Module 2 is the retention of all
10 messages in whatever form that relate to the business of
11 government. It's hoped that this is a lesson which has
12 not been learned too late.

13 As the Inquiry is aware, the Scottish Covid Bereaved
14 represent just some of those who lost their loved ones
15 in Scotland. As of June last year there were more than
16 17,000 deaths in Scotland where Covid-19 was mentioned
17 on the death certificate. Each one of those deaths is
18 a tragedy. While witnesses in this module may point to
19 opinion polling during the pandemic favourably
20 contrasting the Scottish Government's communication and
21 strategy with that of the UK Government, positive poll
22 numbers are no consolation to the bereaved. If
23 Bute House was not as chaotic as Downing Street, if the
24 Scottish Government's public health messaging was to be
25 preferred to that of the UK, if at no point were

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1 valuable time and valuable resource wasted in pursuing
2 futile elimination strategy?

3 The Scottish Covid Bereaved hope these questions and
4 of course the very many questions posed by my learned
5 friend this morning will be answered in full. As the
6 Chair knows, questions about decisions taken in relation
7 to Covid contracted in hospital and care home deaths are
8 of the utmost interest to those in the Scottish Covid
9 Bereaved. It is of course acknowledged and must be
10 remembered that further additional evidence will be laid
11 about those in later modules.

12 The SCB would also like to take the opportunity to
13 highlight what was said in the closing speech in
14 Module 2 regarding the press. The press, as the fourth
15 estate, has an important part to play in acting as
16 a legitimate political safeguard, performing a watchdog
17 function over the branches of government. The SCB
18 welcomes the part the press has to play in doing so.
19 However, there have been calculated attempts to
20 undermine the work of this Inquiry in some sections of
21 the media, including not only attacks on the work of the
22 Inquiry but personal attacks on those involved.

23 It is clear that such attacks have had no effect,
24 but let the Scottish Covid Bereaved be clear: any attack
25 on the work of the UK Covid Inquiry is an attack on the

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1 decisions taken in Scotland for political reasons, why
2 did so many lose their lives in Scotland? Did our
3 politicians fail to protect some of the most vulnerable
4 in our society, such as those in care homes?

5 Of course it's been suggested that the then
6 First Minister, Nicola Sturgeon, and other Scottish
7 politicians, were playing politics rather than properly
8 engaging in the decision-making to save lives. Was this
9 projection by the UK politicians as to their own
10 behaviour, or is there truth in this? Were
11 cancellations of mass gatherings totemic? Were
12 decisions taken to lift lockdown at a different time
13 from England just for the sake of doing things
14 differently or a reflection of a different stage of the
15 progress of the virus? Was a decision to change face
16 masks in school policy another example of taking
17 a separate decision from the rest of the UK? Was the
18 Scottish Government sidelined, excluded from crucial
19 decision-making? Were meetings of COBR a sham to be
20 nice to the devolved administrations? Was the
21 democratic process in Scotland undermined by the
22 UK Government?

23 Equally, were politicians happy to accentuate
24 political and constitutional differences to distract
25 from similar policies either side of the border? Was

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1 bereaved, who want the work of this Inquiry to be
2 a legacy for those that they loved and lost.

3 Finally, we would like to place on record the
4 assistance and forbearance of the Inquiry team, and in
5 particular Mr Dawson KC, who, in particular in the last
6 few days as we've had discussions, has made every effort
7 to ensure that he has considered a number of specific
8 issues that the Scottish Covid Bereaved would like to
9 raise.

10 These are the opening submissions for Module 2A on
11 behalf of the Scottish Covid Bereaved.

12 **LADY HALLETT:** Thank you very much indeed, Ms Mitchell, very
13 grateful.

14 Mr Freeman, Danny Friedman KC.

15 **Submissions on behalf of Disabled People's Organisations by**
16 **MR FRIEDMAN KC**

17 **MR FRIEDMAN:** Good afternoon. We act for two disabled
18 people's organisations, or DPO, they are
19 Inclusion Scotland and Disability Rights UK, and we are
20 grateful to be addressing you in Scotland as part of
21 an Inquiry that is looking at all four governments in
22 a way that no UK Inquiry has done before.

23 My Lady, the Scottish Government is a government
24 that seeks to adhere to the social model of disability,
25 that disabled people are disabled by the barriers they

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1 face in society rather than the impairments they
2 overcome, and in that sense their inequalities are
3 chosen.

4 It is a government that also wants to be judged by
5 its compliance with human rights law, not just the civil
6 and political rights contained in the European
7 Convention of Human Rights but the broader obligations
8 and social and economic rights contained in the
9 United Nations Convention on the Rights of Persons with
10 Disabilities, or the UNCRPD.

11 However, despite this, the social model and equal
12 rights of disabled people remain a work in progress in
13 Scotland. Across the UK, the pandemic shows that
14 recognition of values without redistribution of assets
15 is not enough. It is not enough to recognise the value
16 of disabled people's lives. There must be
17 redistribution: redistribution of political resources in
18 terms of the influence that disabled people can have
19 upon the policies that affect them; and redistribution
20 of economic resources, in the sense that if a society is
21 serious about valuing the dignity and diversity of human
22 life, disabled people will need more economic resources,
23 not less.

24 My Lady, five points of context, please, that are
25 important to this module.

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1 happening to him, and likewise the very significant
2 numbers of people like him who lost services and were
3 trapped in their homes.

4 Fourth, the Scottish Government has staked its
5 reputation on its commitment to being more values-based
6 than its Westminster counterpart. Before the pandemic,
7 it sought to mainstream awareness of health inequalities
8 as a cross-government concern. It registered its
9 commitments to human rights and specifically disabled
10 people's rights by introducing a delivery plan to
11 achieve better compliance with the UNCRPD. While
12 Westminster government was often silent about or against
13 international human rights law and any dedicated
14 economics to end health inequalities,
15 Scottish Government was vocal in its commitment to both.

16 Fifth, the pandemic took place amidst a crisis of
17 devolution, and disabled people's experience exemplifies
18 this crisis. Scotland has used its finances to mitigate
19 some features of austerity economics, for example
20 refusing to apply the bedroom tax, and maintaining
21 existing guarantees of the Independent Living Fund when
22 the fund was abolished across the rest of the UK.

23 However, in key ways that would impact during the
24 pandemic, Scottish Government was neither independent
25 nor alternative, for instance in the provision of

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1 First, the number of disabled people in Scotland may
2 be as high as 35% of the population, compared to UK
3 overall figures that range from 20% to 22%.

4 Second, health inequalities in Scotland are the
5 highest in the UK, and some of the highest in western
6 and Central Europe. This is, with respect, an older,
7 more unwell and lower income population, that was more
8 susceptible to Covid-19 harm, and especially so for some
9 of its disabled population, given the virus's risk to
10 people of older age, with learning disabilities, and
11 with certain comorbidities.

12 Third, disabled people were in an emergency before
13 Covid-19 began. They were made vulnerable, and their
14 resilience compromised, by cuts to benefits and
15 services. You will see the truly humbling figures
16 concerning standard of living, housing, employment gaps
17 and pay gaps.

18 My Lady will also hear this week from
19 Dr Jim Elder-Woodward. He is both a renowned exponent
20 of independent living and one of its great experts. His
21 evidence tells you that despite all the insight and
22 extended network that he has, his situation before the
23 pandemic was near to collapse, and by the end of
24 March 2020 he had suffered a nervous and physical
25 breakdown under the weight of the changes that were

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1 social care, which has been allowed to operate beyond
2 proper central government control.

3 Overall, Scotland's capacity for any type of
4 unilateral governance was compromised by the
5 constitutional funding arrangements under devolution.
6 Scotland's choices on the timing and scope of NPIs were
7 starkly limited by the choices of UK Government. It did
8 not have the funding to do otherwise.

9 Turning then to Covid governance. As my Lady knows
10 from Module 2, the DPO encourage you to see how
11 government can go wrong for disabled people generally
12 but especially during an emergency by considering nine
13 critical areas. The purpose of the method is to break
14 down the various points and decision-making when
15 disabled people can be overlooked or damaged even when
16 a government believes itself to be doing the right
17 thing.

18 The first area is system. How did disabled people
19 feature in the overall system of Scottish Government of
20 emergencies? Despite concern for health inequalities in
21 Scottish politics and its stated priorities to protect
22 disabled people's rights, the Scottish Government, like
23 its English UK counterpart, did not systematically
24 assess social and economic inequalities in the context
25 of pandemic planning at all before 2020. That included

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1 a failure to consult at all with the Scottish DPO on the
2 subject.
3 Then in the first months of the pandemic, previous
4 levels of government consultation with DPO on matters
5 affecting disabled people, which were otherwise better
6 than in England, dramatically diminished as regards the
7 emergency response. Under conditions of an unplanned
8 for crisis, a Scottish Government that aspired to be
9 genuinely and deeply engaged with civil society, and in
10 that respect different from its Westminster counterpart,
11 reverted to a system of more conventional top-down elite
12 control, not how it would like to be seen, but maybe
13 what it needs to acknowledge.

14 Devolution also mattered. It meant Scotland
15 initially followed an outdated UK plan that was based on
16 influenza, considerably dependent on UK funding, and
17 complicated by Brexit. All of which narrowed options
18 for any radical independent initiative to alter the fate
19 of disabled people and other at-risk groups.

20 The second area is planning. What planning was
21 there for disabled people in Scotland going into the
22 pandemic and thereafter? Going in, we know there was
23 essentially nothing, and in that respect Scotland had
24 violated an obligation under Article 11 of the UNCRPD to
25 plan to protect disabled people in disasters, just as

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1 But how actually responsive to disabled people's
2 needs was the Scottish Government? It seems to have
3 been slightly ahead of the UK in realising the needs of
4 socially vulnerable people beyond the shielding list.
5 It corrected its initial disengagement from the DPO when
6 pushed to do so and continued that engagement for
7 somewhat longer when the UK Government quickly
8 jettisoned their own DPO Forum. The Scottish Government
9 also enjoyed a more sustained level of support from
10 society than its Westminster counterpart.

11 However, not all features of Scottish Government
12 worked effectively, which begins with our third area:
13 machinery of government.

14 How did that machinery configure in order to
15 properly represent disabled people's interests? In the
16 Scottish directorate-based structure there was no
17 Minister for Disabled People. That responsibility was
18 part of Christina McKelvie's portfolio, as Minister for
19 Older People and Equalities. However, she describes
20 herself as having "no decision-making responsibility"
21 with regard to Covid-19. Consequently, like minister
22 Justin Tomlinson in the UK, she did not attend the
23 public sector ministerial group or the four harms
24 groups, which begs the question as to who during Covid
25 decision-making was holding the line for disabled people

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1 the UK had done. What Scotland then did was to design
2 a decision-making strategy and publicise its approach.
3 In late April 2020 the government published the
4 *Covid-19: framework for decision-making*, which
5 incorporated considerations of the direct and indirect
6 harms posed by the virus to health, to society, and to
7 the economy, the so-called "four harms" approach.

8 The policy emphasised that "harms caused do not
9 impact everyone equally", and combined to "protect those
10 most at risk and protect human rights".

11 This was a clearer, more human-centred and
12 values-based approach than ever emerged from
13 the UK Government with a degree of consistency or
14 stability.

15 Health and broader inequalities were also
16 an immediate focus across government civil servants
17 responsible for equality, who from the outset were
18 involved in key public sector planning meetings.
19 Officials of the Equality, Inclusion and Human Rights
20 Directorate attended the communities and public services
21 ministerial group from its inception on 2 April 2020 and
22 both briefed and attended the formal four harms
23 meetings.

24 My Lady knows that their attendance in the UK
25 ministerial meetings was far later and far fewer.

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1 and ensuring that the social model of disability was
2 upheld and the human rights of disabled people were
3 complied with?

4 The fourth area concerns expertise. Did expert
5 advice to Scottish Government sufficiently take disabled
6 people into account? The DPO say no. Despite the
7 creation of a Scottish scientific advisory group,
8 decisions in Scotland remained affected by UK SAGE
9 advice and/or the significant role played by the UK CMO
10 and CSO.

11 First, it was Professor Whitty's unplanned comments
12 that promulgated the notion of "behavioural fatigue"
13 that UK ministers relied on to delay the first lockdown.
14 This concept was not supported by SAGE members of SPI-B,
15 nor by Professor Stephen Reicher, also a member of the
16 Scottish Covid Advisory Group. Scotland with its
17 greater clinically at-risk population could all the less
18 afford that margin of error.

19 Second, on core issues of clinical vulnerability,
20 Scotland followed England, such that the timing of
21 placing those with Down's Syndrome on the CEV list was
22 dependent on the English QCovid initiative and was
23 delayed until November 2020. The implication of that
24 would contribute to those with learning disabilities
25 being three times more likely to die of Covid in

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1 Scotland and two times more likely to be hospitalised.
 2 Third, as Scotland was dependent on UK economic
 3 packages to support NPIs, SAGE advice would trump
 4 Scottish advice, because Covid could not afford to fund
 5 significant countermeasures that were not part of
 6 UK-wide virus suppression decisions.

7 Finally, notwithstanding that my Lady will hear from
 8 Professor Reicher, the Covid Advisory Group remained
 9 predominantly biomedical in expertise and focused on the
 10 epidemiological harm posed by the virus. As with SAGE,
 11 and the Whitehall Disability Unit, what was lacking was
 12 a broader scope of expert to deal with health
 13 inequalities including both practitioners, DPO and other
 14 end user groups that understood the social determinants
 15 of disabled people's vulnerability.

16 All of that has consequences for the fifth area in
 17 terms of what recognition was given to disabled people
 18 in pandemic decision-making. Was it recognition that
 19 realised disabled people's discrete experience and
 20 agency in relation to the NPIs? Or were disabled people
 21 subsumed into a notion of vulnerability that conceals
 22 more about the social and economic making of
 23 vulnerability than actually addressing disabled people's
 24 needs?

25 Compared to England, Scottish civil servants were
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1 lives of disabled people were dramatically turned
 2 upside-down. If one reason why there was disengagement
 3 from the DPOs at the beginning of the crisis was because
 4 Scottish Government reverted to a Westminster governing
 5 style, another reason might be that progressive
 6 governments can sometimes fall foul of the belief that
 7 because they are progressive they know best. However,
 8 to respond effectively to emergency, you must also know
 9 what you are responding to.

10 The seventh area is data. Was the impact of both
 11 the virus and the NPIs on disabled people properly
 12 counted and deployed by Scotland's data architecture?
 13 Under Article 31 of the UNCRPD, it should have been, but
 14 there are significant reasons to find that it was not.
 15 Mortality rates for disabled people in Scotland were
 16 only compiled once, in March 2021. Until then, Scotland
 17 had to rely on English data. As in England, there was
 18 also a design fault in failure of health services to
 19 gather data or broader surveys to ask social questions.
 20 Instead, the tendency was to focus on individual
 21 impairment alone. Access to reliable and timely data
 22 was not available in relation to care homes, with
 23 potentially grave consequences.

24 The eighth area is protection. How far was
 25 Scottish Government able to protect its disabled
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1 more focused on the issue. There was early caution
 2 communicated to Cabinet ministers to "refine use of
 3 terminology of 'vulnerable' and 'high-risk' to avoid
 4 alienating effect". But the critique of vulnerability
 5 is not just about being kind. It's about government
 6 becoming sufficiently responsive to needs. It remains
 7 unclear how the four harms approach translated into
 8 solutions to problems identified or whether it simply
 9 acted as a mechanism whereby harms were identified and
 10 considered but actions went ahead in any event. The
 11 four harms group itself did not hold its first meeting
 12 until 24 October 2020. As with the general critique of
 13 expertise, it remains to be seen how informed the group
 14 was of disabled people's perspective.

15 That leads to the sixth area, which is engagement.
 16 How did Scottish Covid governance engage with disabled
 17 people, and especially the DPO, as the lived experts in
 18 their own lives? The obligation under Article 4.3 of
 19 the UNCRPD is to actively involve and closely consult
 20 with disabled people, including DPO, in matters that
 21 affect them, and one of the overriding duties of the
 22 convention is to ensure effective participation.

23 Compared to the UK and England, Scotland does it
 24 better. However, the disengagement in the first months
 25 mattered, because that is the point in time when the
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1 population from the damage of both Covid and the
 2 countermeasures? The powerful criticism of
 3 Inclusion Scotland in its report *Rights At Risk* was that
 4 there was "an abyss between the rhetoric of national
 5 policies and what happens on the ground".

6 There was the sudden withdrawal of home support,
 7 which meant loss of food, medication, basic capacity and
 8 hygiene. There was mass death in residential settings,
 9 more so in the first wave in Scotland than anywhere else
 10 in the UK. Although documentation of DNACPR is woefully
 11 limited, experiential accounts show that the issue was
 12 drastically legally lacking in accountability or
 13 control. Education for disabled children was severely
 14 compromised. When lockdown measures required those with
 15 mental illness to stay at home, they were left too much
 16 in isolation.

17 Finally, the increasing resort to government via the
 18 internet resulted in massive digital exclusion for
 19 disabled people and others.

20 The ninth area is redistribution. Was it enough to
 21 recognise the vulnerability of disabled people in
 22 Scotland without sufficient economic redistribution to
 23 support their needs? The DPO criticism of UK pandemic
 24 economics is that rather than being radical as presented
 25 and sometimes criticised, it involved the deliberate
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1 maintenance of the status quo. For disabled people
 2 furlough payments were focused on those able to work or
 3 temporarily unable to work in standard wage sectors and
 4 did not reach lower, informal or non-wage earning
 5 people. The increase in Universal Credit was small
 6 compared to sums spent on business. Limited provision
 7 of sick pay was known to be highly relevant to part-time
 8 and zero hours workers already in poverty continuing to
 9 work, with fatal consequences. Covid economics was not
 10 always Scotland's alone to define, but its own lump
 11 funding into local authority schemes was difficult to
 12 access and not particularly accountable.

13 These criticisms have travelled into Scotland's
 14 post-pandemic debates about creating a national care
 15 service. That agenda is relevant to and ahead of what
 16 is being discussed in England. It still involves
 17 fundamental questions as to whether central government
 18 will fund and manage such a service and the extent to
 19 which care sector workers shall have a living wage.

20 My Lady, the overall context suggests that prior to
 21 the pandemic Scotland had greater poverty and ill health
 22 challenges than England, but was more resilient in its
 23 recognition of health inequalities and human rights and
 24 with better engagement between government and people
 25 than presently valued or provided for by the UK

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1 into all levels of government, and commit to co-design
 2 and deeper engagement with those people in communities
 3 who have first-hand experience of poverty, inequality
 4 and restricted life chances. The imperative for these
 5 changes is summed up in the title of the report, which
 6 again can be commended to this Inquiry; the title is "*If
 7 Not Now, When?*".

8 My Lady, thank you.

9 **LADY HALLETT:** Thank you very much indeed, Mr Freeman.

10 I think we can fit you in, Mr Jacobs, just before we
 11 break.

12 **Submissions on behalf of the Trades Union Congress by
 13 MR JACOBS**

14 **MR JACOBS:** Thank you, my Lady, I'll carry through to the
 15 end unless I'm wanted to pause at any point for the --

16 **LADY HALLETT:** Carry on, if you can.

17 **MR JACOBS:** This is the joint opening statement of the
 18 Trades Union Congress, the TUC, and the Scottish
 19 Trades Union Congress, the STUC.

20 The TUC and the STUC are separate organisations but
 21 with shared aims and values.

22 The 54 unions affiliated to the TUC represent over
 23 5 million working people across a range of sectors
 24 across the four corners of the UK. The STUC is
 25 a national lobbying, campaigning and co-ordinating body

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1 Government in England. And yet, the Scottish Government
 2 of Covid-19 often frustrated and harmed disabled people,
 3 despite expressed commitment to do otherwise.

4 The pandemic has therefore tested the validity of
 5 devolution both ways. It shows that Scotland does not
 6 have a fully determining government. However, as
 7 regards matters within its powers, Scottish Government
 8 does not always discharge the responsibilities that it
 9 wants to be judged by. Blaming UK Government for all
 10 shortcomings abdicates the power that Scottish
 11 Government enjoys. Generally good policy statements
 12 must align with better practice and outcomes, including
 13 at the point of local delivery, to enable independent
 14 living and equal participative citizenship. It is not
 15 enough to tender to vulnerability; there must be
 16 wellbeing. Otherwise devolved government will delude
 17 itself as to its difference and the inequities of the
 18 pandemic and its countermeasures will repeat in future
 19 crises.

20 Insofar as broader change is required, the DPO
 21 commend to both Scotland and the UK the proposals of the
 22 Scottish Social Renewal Advisory Board. It would
 23 incorporate key international human rights instruments
 24 into domestic law, take action to realise the human
 25 rights of disabled people, build inclusive communication

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1 for trade unions for Scotland and represents over
 2 545,000 trade union members.

3 Both the TUC and STUC aim to provide a voice for
 4 working people and to shine a light on the consequences
 5 of decision-making for the experiences of those at work.

6 Tomorrow the Inquiry is to hear evidence from
 7 Roz Foyer, general secretary of the STUC.

8 This opening submission will highlight the loss and
 9 sacrifice of those in the workplace in Scotland and
 10 focus on the approach to decision-making within central
 11 government.

12 From the union perspective, that decision-making was
 13 one which no doubt had its deficiencies but was, in
 14 Scotland, nonetheless underpinned by a process of
 15 meaningful consultation and partnership, which was
 16 welcome.

17 Inevitably, it is impossible not to frame the
 18 Scottish perspective, and no doubt that of Wales and
 19 Northern Ireland in due course, as a counterpoint to
 20 that of Westminster. It is an illuminating
 21 counterpoint. Module 2 has heard evidence of shocking
 22 dysfunction in the UK Government response, with
 23 decision-makers repeatedly oscillating between the
 24 pursuit of varying objectives against a background of
 25 bitter squabbling resembling something of a playground

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1 politics.

2 The decision-making in respect of Scotland is yet to
3 be explored in these oral hearings, but the indications
4 thus far, we suggest, are of a more professional, mature
5 and open form of decision-making within
6 Scottish Government.

7 As with our opening submissions in Modules 1 and 2
8 of this Inquiry, we begin, however, by acknowledging the
9 loss and sacrifice during the pandemic in the workplace,
10 on this occasion of course in the particular context of
11 the Scottish workplace.

12 We also acknowledged the power and tragedy of the
13 human stories told in the impact film this morning, and
14 we acknowledge that they are stories of a kind
15 replicated by so many others across Scotland.

16 We have provided to the Inquiry a paper by the
17 Scottish Centre for Administrative Data Research. It
18 describes that in Scotland, men working in elementary
19 service occupations, such as kitchen assistants and
20 waiters, along with large goods vehicles drivers and
21 taxi drivers, had exceptionally high mortality rates.
22 Among women in Scotland, higher rates were also observed
23 in elementary occupations, including industrial cleaning
24 operations, packers, bottlers and canners. Higher
25 mortality rates were also observed among female workers

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1 Scotland is already being examined in Module 1, as
2 Mr Dawson has explained. The evidence heard by this
3 Inquiry indicates that the deficiencies in preparedness
4 were shared across Westminster and the devolved
5 administrations. Whatever the merits of Scottish
6 decision-making, the outcomes were ultimately limited by
7 lack of preparedness. Given the misplaced confidence
8 that the UK was prepared, it was not just a standing
9 start at the beginning of the pandemic; it was
10 a standing start facing in the wrong direction.

11 We certainly wish the members of the TUC and STUC
12 affiliated unions to understand that this crucial issue
13 of pandemic unpreparedness is already under careful
14 consideration by this Inquiry, including in relation to
15 Scotland, albeit in a different module.

16 The second point of context is that of austerity.
17 The Inquiry has received bountiful evidence primarily in
18 Module 1 as to the resilience of public services going
19 into the pandemic and, therefore, inevitably, as to the
20 legacy of austerity. Just as the achievable outcomes in
21 Scotland were limited by pandemic preparedness, they
22 were also limited by public services having been
23 hollowed out over the preceding period. These two
24 features loom large over the decision-making with which
25 this module is centrally concerned.

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1 employed as process plant and machine operatives, such
2 as those in food, drink and textile industries,
3 assemblers and sewing machinists, postal workers,
4 couriers and shelf fillers.

5 The differences in mortality rates between sectors
6 reflects both occupational risk and the social class
7 gradient in health outcomes. That, of course, is
8 consistent with the evidence of Professors Marmot and
9 Bambra in Modules 1 and 2, some of which was summarised
10 this morning by Mr Dawson.

11 It all points to one of the profound consequences of
12 the pandemic, that those who were generally less well
13 off, with greater disadvantage and vulnerability, paid
14 the greater price. It was true of Scotland as it was
15 across the UK. It was the price paid by people who kept
16 parcels being delivered to our doors, who transported
17 key workers to work, who processed our food, who stacked
18 our shelves, who cared for our sick and elderly, and
19 many others.

20 We touch, my Lady, on two points of context, upon
21 which we do not focus in our written or oral
22 submissions, but we wish to acknowledge their
23 importance.

24 The first is that of pandemic preparedness, or
25 rather lack of it. The state of preparedness in

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1 We turn to the issue of government consultation and
2 partnership with the unions. As Roz Foyer explains as
3 general secretary of the STUC, the organisation has had
4 a successful history of engagement and working with the
5 government in Scotland, both through established formal
6 and informal processes. It is characteristic, we would
7 suggest, of a more open culture generally within
8 Scottish Government, that includes working
9 constructively and meaningfully with external partners,
10 whether they be unions, businesses, academics,
11 Children's Commissioners and many others.

12 This consultative approach generally managed to
13 subsist throughout the pandemic. It was framed at the
14 outset in a joint statement by the Scottish Government
15 and the STUC titled "*Fair Work during the COVID-19
16 Crisis*". It described an approach where workers, trade
17 unions and employers worked together constructively to
18 reach the right decisions on all workplace issues that
19 arise throughout the crisis.

20 The structures used for that working together, both
21 pre-existing and implemented by way of response to the
22 pandemic, are described both in the STUC's evidence and
23 in that of Scottish Government witnesses. Fiona Hyslop,
24 then Cabinet Secretary for Economy, Fair Work and
25 Culture, proactively contacted the STUC in March 2020 to

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1 seek its support in pandemic response and a regular
2 format for meetings was established.

3 The consultation was important, not least as the
4 STUC was uniquely placed to gather information, identify
5 concerns and offer advice further to its representative
6 structure covering all parts of the voluntary and public
7 sector in Scotland.

8 That structure enables direct reporting and feedback
9 from key workers who were delivering emergency and
10 essential services. To put it in the context of the
11 workplace impact we have described, it should give the
12 government a line of sight on the practical issues
13 facing those high-risk, high-vulnerability occupations
14 in which mortality was high.

15 However, it is not just that a line of communication
16 existed, to some extent lines of communications to
17 stakeholders existed in Westminster. What is more
18 fundamental is whether the communication is meaningful,
19 whether it is placatory or open to challenge, whether it
20 is dismissive or interested. As this Inquiry has heard
21 in an earlier module, the Westminster and Number 10
22 approach was best described by the less favourable of
23 those adjectives. It is encapsulated by the note of
24 Boris Johnson describing in a meeting with senior
25 ministers that he "can't have the bollocks of consulting

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1 Chief Medical Officer, the Chief Scientific Adviser,
2 from SPI-B, from the behavioural scientists, from the
3 Department of Health and Social Care, from regional
4 mayors, and others.

5 The evidence in this module indicates that the
6 Scottish Government, having listened to unions, was
7 another voice urging the UK Government to adopt
8 a different approach.

9 That is not to say, of course, that there were not
10 shortcomings. There were many examples of the STUC
11 being given little to no time to respond adequately to
12 complex documents or to ensure that representatives with
13 the right level of expertise about a sector were present
14 for meaningful dialogue.

15 The STUC often found itself inadequately resourced
16 for the engagement that was being sought by the
17 Scottish Government. There are lessons to be learned
18 about the need for Scottish Government when engaging
19 with stakeholders to ensure that the organisations are
20 given the assistance they need to develop the capacity
21 and infrastructure to contribute to decisions
22 meaningfully and at pace.

23 There were also many occasions where the STUC raised
24 serious concerns with Scottish Government ministers
25 about decisions that, in the STUC's view, had lacked

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1 with employees and trade unions".

2 In our lengthier written submissions we set out some
3 of the detail on the way in which this consultation fed
4 into and enhanced a number of areas of decision-making.
5 One of the striking examples is in relation to
6 government policy on face coverings. The
7 Scottish Government, urged by unions, generally
8 succeeded in adopting a precautionary approach and
9 advocating or requiring the use of face coverings, given
10 the potential benefits and limited costs of doing so.

11 In contrast, the UK Government lagged behind, and
12 the evidence in Module 2 revealed that it did so by
13 taking an oppositional approach to unions. Reference
14 was made in internal communications to Boris Johnson
15 backing a "no surrender to unions" approach, which he
16 totally regrets later. It was antithetical to
17 precautionary, mature and open decision-making, and in
18 contrast with the decision-making in Scotland.

19 Another example is the adequacy of financial support
20 for low income workers required to self-isolate and the
21 inadequacy of statutory sick pay. The evidence
22 considered in Module 2 revealed that the UK Government
23 was being urged from all sides to increase the support
24 for self-isolation, particularly financial support.

25 That included not just calls from unions but from UK
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1 appropriate consultation.

2 My Lady, it is, however, in the nature of
3 decision-making that aspires to be the product of
4 meaningful consultation that what is achieved is
5 progress towards that aspiration rather than perfection.

6 Next, we address the differences in culture between
7 Scottish Government and Westminster. We set out in our
8 written submissions in more detail some of the
9 differences which appear to us to be apparent.

10 For example, the Scottish Government appears to have
11 been quicker to work within clear and agreed frameworks
12 for decision-making. The Inquiry can consider whether
13 Westminster's careering between different objectives was
14 a feature of the characters in power, the Prime Minister
15 who was widely referred to internally as the trolley, or
16 whether it may have been assisted by the frameworks for
17 decision-making more readily used in Scotland.

18 Some of the evidence suggests that the meetings of
19 the Scottish Cabinet appeared to have been, in
20 substance, decision-making meetings, where various
21 members of Cabinet contributed before First Minister
22 exercised final sign-off. The use of formal
23 decision-making in Scottish Government forums contrasts
24 with the ever diminishing circle of decision-makers that
25 appears to have taken hold in Number 10, often meeting

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1 informally and guided by the belief that the intellect
2 of a very small few will come good.
3 There also appears to have been an important basic
4 professionalism that was lacking in parts of Number 10
5 and Westminster more generally. Nicola Sturgeon
6 describes that the working environment within Scottish
7 Government during the pandemic was professional, serious
8 and formal, and titles such as First Minister, Deputy
9 First Minister, Cabinet Secretary would be used in
10 meetings. At the same time in Westminster,
11 a male-dominated group of ministers were urging each
12 other to "back the Gavster", a reference to
13 Sir Gavin Williamson, were laughing about "Hancockian
14 timetables", a reference to Mr Hancock, and other
15 examples which must be thousands in number.

16 In examining decision-making in central government,
17 the Inquiry will no doubt look carefully at the extent
18 to which decision-making was influenced by the cultures
19 that existed within UK and devolved governments.

20 Finally, we touch briefly on collaboration between
21 Scottish and Westminster governments and divergence.

22 Primarily, we urge caution in considering the
23 narrative suggested by some that the Scottish Government
24 sought difference for difference's sake. On analysis,
25 differences appear to have been in appropriate pursuit

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1 to meet with the leaders of the devolved nations for
2 fear of it appearing to be a "mini EU", and such
3 meetings being, such was his view, "constitutionally
4 a bit weird".

5 It is also evident that the divergence in approach
6 between administrations worked both ways. The
7 UK Government equally diverged from the wishes of the
8 Scottish Government. It points to the force of
9 an observation by Ken Thomson, who dismisses any
10 implicit understanding that Westminster's approach was
11 orthodox, from which other parts of the UK diverged.

12 We conclude, my Lady, with this observation: to some
13 witnesses in Module 2, the deeply unattractive side of
14 the internal dysfunction within the UK Government was
15 just Westminster. Correct or otherwise, it cannot be
16 said to be just politics. As the evidence in Module 2A
17 demonstrates, a more mature, professional and open form
18 of central government is achievable. It is submitted
19 that the evidence in this module demonstrates the value
20 of a form of government that is open to and meaningfully
21 engages with the views of stakeholders, including trade
22 unions. It is an approach of consultation and
23 engagement which should be embraced and strengthened in
24 a future pandemic.

25 Thank you, my Lady.

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1 of public health objectives. It is difficult to see,
2 for example, what criticism could be levelled at the
3 Scottish Government for diverging from the UK approach
4 on 12 March 2020 in banning gatherings of over
5 500 people, or for taking a more precautionary approach
6 in respect of the use of face masks.

7 My Lady, it would be surprising if in a future
8 pandemic either nation adopts an approach that is
9 reluctant to issue guidance on face masks or to ban mass
10 gatherings when hospitals are on the precipice of being
11 overwhelmed.

12 In fact, as the Scottish Government announced on
13 12 March the banning of large events, in England the
14 Cheltenham Festival was in full flow. That doesn't
15 stand as a symbol of Scottish divergence; it stands as
16 a monument of deficiencies in UK Government
17 decision-making.

18 Divergence may also reflect limitations in
19 co-operation. The devolved administrations were not
20 routinely included in Covid-O and Covid-S meetings, many
21 in Scottish Government described the perception that the
22 government did not work together to make decisions and
23 the UK Government generally made decisions unilaterally.
24 That perception dovetails with the evidence heard by
25 this Inquiry that, for example, Mr Johnson did not want

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1 **LADY HALLETT:** Thank you very much, Mr Jacobs.

2 Right, we'll break now and I shall return at 3.20.

3 **(3.06 pm)**

4 **(A short break)**

5 **(3.20 pm)**

6 **LADY HALLETT:** Rory Phillips King's Counsel.

7 **Submissions on behalf of the National Police Chiefs' Council**
8 **by MR PHILLIPS KC**

9 **MR PHILLIPS:** My Lady, as you know, I appear on behalf of
10 the National Police Chiefs' Council, which is a national
11 co-ordinating body representing UK police forces. And
12 as again you know, the NPCC was a core participant in
13 Modules 1 and 2 and it's worked to assist the Inquiry at
14 every stage of the proceedings.

15 Now, in this module, the NPCC represents the
16 interests of the Police Service of Scotland, often
17 referred to as Police Scotland, and the police in
18 Scotland, as in the rest of the UK, were one of the
19 frontline organisations when it came to the management
20 of the pandemic.

21 Now, my Lady, in Module 2, you heard evidence from
22 Martin Hewitt, who was the chair of the organisation
23 throughout the pandemic. In this module, you won't hear
24 from any police witnesses. However, you do have
25 a written statement from Temporary Deputy Chief

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1 Constable Alan Speirs, who led the policing response to
2 the pandemic in Scotland.

3 Now, Police Scotland established a formal response
4 to the pandemic at a very early stage, with the setting
5 up of Operation Talla in January 2020. Of course the
6 policing scope of this module extends only to the issue
7 of the enforcement of the Covid-19 regulations but, as
8 you heard in Module 2, and as you will see again from
9 the written statement I've mentioned, Operation Talla
10 co-ordinated a far broader range of work over the course
11 of the pandemic. Its portfolios included the critical
12 task of maintaining core policing functions, supporting
13 the criminal justice system, establishing procedures for
14 the collation and analysis of Covid-19 data, and finally
15 procuring, delivering and training staff in the use of
16 PPE.

17 But so far as enforcement is concerned, again you've
18 already heard evidence about the central importance of
19 the NPCCC's four Es guidance -- engage, explain,
20 encourage, enforce -- its importance to policing in
21 England and Wales, and that holds equally true for
22 policing in Scotland, which adopted the same guidance in
23 March 2020.

24 Throughout the pandemic, the constant messaging,
25 both within Police Scotland and by Police Scotland to

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1 published on a weekly basis and was then analysed in
2 a series of independent reports by Professor Susan McVie
3 from the University of Edinburgh in order to ensure
4 transparency and accountability, and that data shows
5 that approximately 88% of all encounters were able to be
6 resolved by officers using one or more of those first
7 three Es without any need to progress to enforcement.

8 So in this context, where the measure of success is
9 achieving public compliance with the regulations to
10 prevent transmission, the data shows, I would suggest,
11 that the four Es guidance was effective.

12 My Lady, it was a priority for Police Scotland to
13 ensure that, in the small proportion of cases which
14 resulted in enforcement, officers were acting
15 appropriately and within the scope of the powers granted
16 to them under the novel and evolving public health
17 regulations. So, to that end, Police Scotland
18 established the Independent Advisory Group on Police Use
19 of Temporary Powers to provide oversight and also
20 assurance. The IAG, as the group became known, met
21 regularly between April 2020 and May 2022, and its
22 purpose was to help the police to ensure that the powers
23 conferred on them by these new regulations were
24 exercised appropriately, lawfully and in compliance with
25 human rights legislation. The IAG was wholly

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1 the public, was that enforcement was the last resort, to
2 be used only when the first three Es had been exhausted.

3 In Module 2, you may remember Martin Hewitt
4 explained that for police officers engaging with the
5 public on these restrictions, it was compliance and not
6 enforcement which was the measure of success. As he
7 said, in a public health context, it's compliance which
8 prevents transmission and keeps the community and indeed
9 the police safe.

10 My Lady, in my closing submissions for Module 2,
11 I made the point to you that when it comes to the
12 enforcement of the Covid regulations, the police
13 response cannot fairly be assessed solely by reference
14 to the number of FPNs issued, because that omits all the
15 encounters which successfully achieved compliance.
16 I noted then that the overwhelming majority of police
17 engagements began and ended with those first three Es.

18 In Module 2A, that submission is reinforced by the
19 data published and produced by Police Scotland because,
20 recognising the critical importance of gathering and
21 analysing data to track the progress of the pandemic, in
22 April 2020, Police Scotland created a bespoke computer
23 system called CVI to record every Covid-related
24 encounter between the police and members of the public,
25 and the data that was collated on that system was

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1 independent, was led by a respected King's Counsel, and
2 it reported publicly and directly to the Scottish Police
3 Authority.

4 In addition, Police Scotland undertook an extensive
5 lesson-learning exercise during the pandemic in order to
6 identify positive practices and ensure they were
7 implemented for the future, and that exercise resulted
8 in the production of an operational scoping report and,
9 following the pandemic, a debrief project. The result
10 of both those workstreams have been disclosed to
11 the Inquiry in the hope that they'll assist you on the
12 question of policing the pandemic in Scotland.

13 My Lady, one of the key lessons identified by that
14 process is the immense benefit which was derived from
15 collaborative working with third sector organisations
16 and with representatives of vulnerable groups. It was
17 clear from an early stage that the virus and the
18 lockdown had the potential to cause real harm to persons
19 with vulnerabilities, to children, to minority groups
20 and to victims of abuse. So the dedicated liaison which
21 was undertaken by Police Scotland during the pandemic,
22 as described in TDCC Speirs' witness statement, helped
23 to ensure that issues could be better identified and
24 then addressed, that guidance produced in response was
25 appropriate, and that policing actions were informed by

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1 those most affected.

2 My Lady, of course I understand that you have a vast
3 amount of ground to cover in a relatively brief hearing,
4 and I also acknowledge, as I did at the outset, that the
5 question of enforcement is but a single sub-issue in
6 your long list of issues -- I think it merited a single
7 sentence in your counsel's lengthy opening earlier -- so
8 it's right that the role of the NPCC in this hearing is
9 necessarily limited. Nonetheless, the NPCC will seek to
10 assist you in your work and provide insight into the
11 pandemic from that policing perspective.

12 For example, Police Scotland worked closely with the
13 Scottish Government throughout the pandemic. Again, you
14 have the written evidence on this but, in short, for
15 Police Scotland this was a collaborative and
16 constructive relationship with both sides working
17 towards the same goal: to prevent transmission and to
18 keep the public safe.

19 My Lady, it's hard to overstate just how challenging
20 the circumstances of the pandemic were, both for those
21 on the front lines of policing who put their lives at
22 risk and for senior officers who worked round the clock
23 to adapt to new regulations and the evolving virus. My
24 suggestion to you, my Lady, is that Police Scotland rose
25 admirably to meet those challenges.

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1 NHS NSS is a core participant in a number of modules
2 in this Inquiry, including this Module 2A. As a public
3 body, NHS NSS understands the responsibility it owes to
4 the Inquiry and to the people of Scotland, and it will
5 continue to support the Inquiry's work in any way it
6 can.

7 NHS NSS is conscious that, although the Inquiry team
8 is aware of the organisation NHS NSS, the wider public
9 may not know what it is or does or why it is
10 a core participant in this module. This opening
11 statement, therefore, contains a brief introduction
12 first to the NHS in Scotland and then to NHS NSS,
13 explaining its roles and its interest in this module of
14 the Inquiry.

15 The NHS in Scotland is and has always been separate
16 from the NHS elsewhere in the UK. It was created in
17 1948 as a result of the National Health Service Scotland
18 Act 1947. NHS Scotland consists of 14 territorial NHS
19 boards which are each responsible for the protection and
20 improvement of health and the delivery of frontline
21 healthcare services to the population within the
22 particular board's geographical area. In addition,
23 there are six national NHS boards -- Healthcare
24 Improvement Scotland, the national Education for
25 Scotland, Scottish Ambulance Service, NHS 24, the

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1 Thank you.

2 **LADY HALLETT:** Thank you very much indeed, Mr Phillips, very
3 grateful.

4 Una Doherty King's Counsel. Is it "Doherty" or
5 "Docherty"?

6 **MS DOHERTY:** "Docherty".

7 **LADY HALLETT:** Thank you. Sorry, I meant to check in the
8 break and I forgot.

9 **(Pause)**

10 **MS DOHERTY:** My Lady ...

11 **LADY HALLETT:** Well, there's a green light on.

12 **MS DOHERTY:** I've tried -- that's it now.

13 **Submissions on behalf of NHS National Services Scotland by**
14 **MS DOHERTY KC**

15 **MS DOHERTY:** Thank you, my Lady. I appear on behalf of NHS
16 National Services Scotland, NHS NSS for short.

17 NHS NSS welcomes this UK Inquiry which has been
18 established to ascertain the UK's preparedness for and
19 response to the Covid-19 pandemic, the impact of the
20 pandemic across the four nations of the UK, and the
21 lessons to be learned.

22 At the outset, NHS NSS offers its condolences to all
23 those bereaved as a result of Covid-19, and its sympathy
24 to the wider public who suffered as a result of the
25 far-ranging effects of the pandemic.

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1 State Hospital and Golden Jubilee National Hospital, and
2 one public health body, Public Health Scotland -- who
3 all support the territorial NHS boards by providing
4 a range of specialist and national services.

5 The Scottish Government oversees the activities of
6 the NHS in Scotland, it sets national outcomes and
7 priorities for health and social care, approves plans
8 with the territorial NHS boards and the national NHS
9 boards, and manages the performance of the NHS boards.

10 Turning now to NHS NSS, it is a non-departmental
11 public body accountable to the Scottish Government. It
12 was created in 1974 under secondary legislation derived
13 from the National Health Service Scotland Act 1972. It
14 was established to provide national strategic support
15 services and expert advice to Scotland's NHS. Its
16 headquarters are in Edinburgh, but it has staff based at
17 a number of locations in Scotland. It is structured
18 into several different units, each providing distinct
19 services.

20 Services currently provided by NHS NSS include those
21 given by the following units: National Procurement and
22 Logistics, Practitioner and Counter Fraud Services,
23 Antimicrobial Resistance and Healthcare Associated
24 Infection Scotland, Central Legal Office, Digital and
25 Security services, Health Facilities Scotland, National

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1 Specialist Services Directorate, Programme Management
2 Service, Scottish National Blood Transfusion Service,
3 and the NHS Scotland Assure.

4 Prior to 1 April 2020, NHS NSS also provided
5 a service called Health Protection Scotland. Elements
6 of that service moved on 1 April 2020 to become part of
7 a new organisation, Public Health Scotland. While
8 within NHS NSS, Health Protection Scotland planned and
9 delivered specialist national services aimed at
10 protecting the people of Scotland from infectious and
11 environmental harms. One part of Health Protection
12 Scotland prior to 1 April 2020, the antimicrobial
13 resistance and healthcare-associated infection team,
14 remained in NHS NSS and is now known as Antimicrobial
15 Resistance and Health Associated Infection Scotland.

16 Although it is not primarily a public-facing
17 organisation, all services provided by NHS NSS have had
18 a role in the response to the pandemic in Scotland. Its
19 roles during the pandemic response included the
20 following: programme management services to a range of
21 programmes including the commissioning and the
22 decommissioning of the Louisa Jordan hospital; Test &
23 Protect, and Covid-19 vaccination programmes; leading
24 the mobilisation of construction partners including in
25 contracting, design, construction and equipping of the

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1 this Module 2A, the Inquiry focuses on Scotland,
2 examining the core political and administrative
3 decision-making by the Scottish Government in response
4 to the pandemic.

5 Health in Scotland is a matter devolved to the
6 Scottish Parliament. Prior to devolution, the
7 Secretary of State for Scotland had responsibility for
8 health in Scotland. Given that health is a devolved
9 matter, the Scottish Government rather than the UK
10 Government was responsible for core decision-making on
11 the response to the pandemic in the health sector in
12 Scotland.

13 As a public body supporting Scotland's NHS, NHS NSS
14 is interested in this module's scrutiny of the
15 Scottish Government's decision-making in relation to the
16 health sector. It is particularly interested in the
17 extent of co-operation between the four nations of the
18 UK during the pandemic, specifically in relation to the
19 sharing of relevant information and epidemiological data
20 so that the Scottish Government was as well informed as
21 it could be when making decisions relevant to the health
22 sector in Scotland.

23 Thank you, my Lady, that concludes the opening
24 statement on behalf of NHS NSS.

25 **LADY HALLETT:** Thank you very much indeed, and apologies for

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1 Louisa Jordan hospital and providing technical oversight
2 on mechanical, electrical and water systems at the
3 Louisa Jordan facility; development of therapeutic
4 convalescent plasma treatments; procurement and
5 logistics for personal protective equipment;
6 procurement, development and operation of digital
7 platforms for Test & Protect and Covid-19 vaccination
8 and Covid-19 status certification of programmes,
9 including publicly accessible apps and web platforms;
10 procurement and logistics for preliminaries, chain
11 reactions, PCR testing, including consumables, equipment
12 and laboratories; procurement and logistics for lateral
13 flow tests and point of care testing, including
14 consumables and equipment; commissioning and operation
15 of the National Contact Centre providing support to Test
16 & Protect, Covid-19 vaccinations and Covid-19 status
17 certification; operational delivery of the UK national
18 and local testing programmes in Scotland, working with
19 the UK Health Security Agency, local authorities, health
20 boards, and the Scottish Ambulance Service to ensure
21 access to appropriate Covid-19 testing for the
22 population; working with other bodies on the production
23 of infection prevention and control guidance.

24 NHS NSS therefore played a significant operational
25 role in the response to the pandemic in Scotland. In

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1 my coughing.

2 Mr Bowie King's Counsel. Is it "Bow-ee" or
3 "Bough-ee"? I need to check all these.

4 **MR BOWIE:** It's "Bough-ee".

5 **LADY HALLETT:** "Bough-ee", sorry.

6 **Submissions on behalf of Public Health Scotland by**
7 **MR BOWIE KC**

8 **MR BOWIE:** Good afternoon, my Lady. This is the opening
9 statement on behalf of Public Health Scotland.

10 My Lady has of course heard of and indeed from
11 Public Health Scotland, or PHS for short. For those who
12 have not, it may assist if I start with some brief
13 remarks about the organisation and the work that it
14 does.

15 PHS is Scotland's national public health body. It's
16 a young organisation, having only become operational on
17 1 April 2020, near to the start of the pandemic, and it
18 originated in a programme of public health reform in
19 Scotland.

20 Why was it created? The rationale for its creation
21 was to establish a unified public health organisation
22 with a focus on protecting and improving the health and
23 wellbeing of Scotland's population and, no less
24 importantly, reducing societal health inequalities.

25 As Professor Paul Cairney stated in his report

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1 recently provided to this Inquiry, PHS embodied
2 Scottish Government's commitment and significant desire
3 to address health inequalities nationally.

4 The objective of the organisation has been said to
5 provide a credible, independent voice based on evidence
6 and professional judgement that can objectively assess
7 and comment on the likely impact, benefits and risks to
8 the public's health and wellbeing, of policy proposals.

9 How then, in practical terms, does it do that? It
10 seeks to identify and understand what has been
11 scientifically shown to improve and protect health and
12 reduce inequality nationally. It then shares that
13 knowledge with relevant persons and organisations. In
14 carrying out its role, it collaborates extensively with
15 the private, public and third sectors.

16 In terms of who the organisation is accountable to,
17 it's obviously accountable to Scottish Government, but
18 it's also accountable to local government, reflecting
19 the fact that public health requires action both locally
20 and nationally. This dual accountability was a feature
21 which, at the time of PHS's creation, was very well
22 received within public health spheres and viewed as
23 a progressive policy initiative on the part of
24 Scottish Government. But ultimately PHS is accountable
25 to the people of Scotland. It works to protect and

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1 working with or supporting Scottish Government, and
2 which PHS considers were particularly successful, I'd
3 refer briefly to four examples.

4 First, on modelling, PHS supported
5 Scottish Government's modelling of future projections of
6 the pandemic through the provision of data and
7 intelligence on case numbers.

8 Second, on national testing, PHS advised the
9 Scottish Government on the development of its national
10 testing strategy as part of the wider national Covid-19
11 response, and led the development of a whole genome
12 sequencing service for Scotland.

13 Third, on the importance of maintaining low levels
14 of community transmission of Covid-19 in Scotland, PHS
15 advised Scottish Government on the development and
16 roll-out of its Test & Protect programme, and played
17 a major role in the delivery of the national contact
18 tracing service.

19 Fourth, in the digital medium, PHS shaped the
20 digital infrastructure that supported the response.
21 This included creation of the PHS dashboard, and
22 publication of weekly and other statistical reports.
23 I'll say something more about this later in this opening
24 statement.

25 There are three points worth highlighting.

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1 improve the health of Scotland's population, and
2 therefore it acutely felt and continues to feel the
3 terrible impact wrought by this pandemic.

4 It's also perhaps equally important to give an idea
5 of what the organisation does not do. For example, the
6 organisation is not involved in many of the practical
7 aspects of maintaining public health at a community or
8 local level. Many of the steps to support the control
9 of the pandemic at a local level were performed by
10 public health teams within Scotland's 14 territorial
11 health boards.

12 Neither is PHS involved in regulation, or inspection
13 activities. Thus, it's a misconception held by some
14 that during the pandemic PHS was responsible for
15 inspecting care homes. That was not the case.

16 I now want to turn to the pandemic itself.

17 During the pandemic, PHS had a major role leading
18 and contributing to Scotland's response across a range
19 of areas. Its scientific knowledge and expertise were
20 relied upon by Scottish Government, and the organisation
21 was widely viewed as a key source of data, information
22 and advice. That message is reflected in a number of
23 the Scottish Government witness statements prepared for
24 this module, which my Lady will have seen.

25 In relation to particular areas involving PHS

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1 First, although Covid-19 has taken up a large amount
2 of the organisation's time and resources since its
3 inception in April 2020, its areas of work go
4 significantly beyond Covid-19. Its work involves
5 a broad range of public health matters.

6 Second, in coming into existence at the start of the
7 pandemic, PHS faced twin challenges. It went through
8 an inevitable bedding-in process associated with
9 establishing itself as a new organisation. There were
10 organisational issues to be addressed, but compounded by
11 the pandemic and its effects which were overlaid on top.
12 Of course at the same time the organisation also had the
13 responsibility of being the lead public health body in
14 Scotland's national pandemic response.

15 In the early days of the pandemic, the organisation
16 faced a number of issues relating to this bedding-in
17 period, including challenges around staff, information
18 systems, governance, and creating a new cohesive
19 organisational culture from the three legacy bodies.

20 Moreover, PHS's opening budget and staffing levels
21 were not sufficient for PHS to delivery the health
22 protection response required by the pandemic.
23 Additional funding was helpfully provided by
24 Scottish Government, but for a period there was
25 a shortage of personnel within PHS trained and

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1 experienced in pandemic response.
 2 Although PHS considers that, at an organisational
 3 level, it nevertheless responded well during that
 4 period, this was not without a cost. It recognises and
 5 acknowledges that this would not have been possible
 6 without the enormous dedication of its staff and their
 7 willingness to work long hours over sustained periods.
 8 That, combined with stressful working conditions,
 9 without a doubt adversely impacted on staff health and
 10 wellbeing, as indeed was the case throughout many parts
 11 of the NHS, local government and beyond.

12 Third, at that time, a significant proportion of the
 13 organisation's expertise in relation to pandemic matters
 14 was held by a small group of individuals within the
 15 organisation upon whom significant demands were placed
 16 throughout the pandemic. This fact underscores the need
 17 for the organisation to have been more resilient,
 18 a point highlighted in the PHS lessons learned report
 19 which has been produced to the Inquiry.

20 I now want to make some more specific comments in
 21 relation to three topics: first, PHS's role in
 22 supporting Scottish Government in decision-making;
 23 second, data; and, third, guidance.

24 So turning to the first of these, PHS's role in
 25 supporting Scottish Government in decision-making.

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1 caused was not all of the same type, but rather could be
 2 categorised into four broad groups: direct health harms
 3 caused by Covid, broader health harms, social harms and
 4 economic harms.

5 The judgements and decisions made by
 6 Scottish Government around the four harms were often
 7 complex, involving a difficult balancing exercise.
 8 Given the varied nature of the harms, Scottish
 9 Government often required to consider a wide range of
 10 evidence and expertise to enable it to take informed
 11 decisions. This included input from local and national
 12 health boards, executive agencies, non-departmental
 13 public bodies, civil society and academia.

14 It's noteworthy that PHS's expertise was in public
 15 health and, as such, its advice focused on direct or
 16 indirect health harms, ie harms 1 and 2, and
 17 particularly harm 1.

18 In consequence there were quite properly occasions
 19 when PHS's advice, being based on a more limited
 20 perspective than that of Scottish Government, was not
 21 accepted by Scottish Government. The phrase "following
 22 the science" is one that has been used in this context,
 23 and it's worth saying that this phrase is not entirely
 24 helpful because at best it oversimplifies the
 25 decision-making process.

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1 First, PHS's role was to support Scottish Government
 2 in its decision-making. The organisation's role was not
 3 to take those decisions, nor did it decide the policy
 4 upon which they were based. The key policies which
 5 underpinned the Scottish Government's approach to the
 6 pandemic were chosen by and the responsibility of
 7 Scottish Government. This was clearly correct, and
 8 respected the lines of responsibility between adviser
 9 and the Scottish ministers as the ultimate
 10 decision-makers.

11 Second, PHS gave Scottish Government scientific
 12 advice, and uniformly it sought to do so on the basis of
 13 the best available data and evidence. During the height
 14 of the pandemic, PHS staff spoke regularly to
 15 Scottish Government colleagues, providing public health
 16 perspectives on issues as well as expertise. However,
 17 as the pandemic progressed, there were times it was
 18 required to give advice at very short notice. This
 19 inevitably proved particularly challenging for the
 20 organisation.

21 Third, in taking decisions, Scottish Government
 22 applied a decision-making framework which became known
 23 as the four harms approach. The concept recognised that
 24 both the pandemic itself and measures taken in response
 25 to it could separately cause harm. Moreover, the harm

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1 All of that said, PHS's overwhelming experience of
 2 this process was that the Scottish Government considered
 3 the contributions it made with care and respect.

4 The second topic I wish to turn to now is data.

5 The use of data was particularly important in the
 6 response to the pandemic, and a number of initiatives
 7 proved very effective. Indeed, PHS was the primary
 8 source for data and intelligence on the pandemic. Daily
 9 figures were produced on the number of tests conducted,
 10 the number of confirmed cases, the test positivity rate,
 11 and mortality figures. Public reporting took place
 12 seven days a week, 365 days a year, on both the PHS and
 13 Scottish Government websites.

14 There are three initiatives which PHS considers were
 15 very successful and worthy of note.

16 First, PHS developed a range of effective data and
 17 analytic outputs that included robust estimates of the
 18 number of people with Covid-19 in Scotland,
 19 hospitalisations and deaths. Where possible,
 20 deprivation and ethnicity data with information relating
 21 to underlying health conditions were provided.

22 The information was widely shared within UK
 23 organisations such as SAGE and the New and Emerging
 24 Respiratory Virus Threats Advisory Group, or NERVTAG --
 25 bodies with which we are now familiar in this Inquiry --

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1 but also with international agencies including WHO, the
2 European Centre for Disease Prevention and Control, or
3 ECDC, and the Centers for Disease Control and
4 Prevention, or CDC, in the US. The sharing of
5 information and data with international colleagues was
6 invaluable and allowed assumptions to be tested whilst
7 additionally giving early insights into new findings.

8 Second, the PHS daily dashboard was considered by
9 many to be a very valuable tool. The platform allowed
10 the public, local authorities and Scottish Government to
11 gain immediate access to Covid-19 data in an accessible,
12 easy-to-use format that promoted understanding of the
13 relevant information. As a testament to its success, it
14 was accessed more than 50 million times during the
15 pandemic.

16 Such data visualisation was crucial in relation to
17 Scottish Government's communication with and subsequent
18 engagement by the public. The dashboard was publicly
19 available, updated daily, and often referred to in
20 Scottish Government press releases and media
21 appearances. It also improved over time as more data
22 became available.

23 Third, PHS worked with Edinburgh University to
24 restart a data reporting system, the Early Pandemic
25 Evaluation and Enhanced Surveillance, or EAVE, project.

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1 Surveillance in Scotland) system was critical during the
2 pandemic, but was prone to failure due to the volume and
3 speed of transactions.

4 Second, the sharing of data across organisations was
5 not straightforward because of variance in systems used.
6 Routine sharing of data with and by trusted NHS
7 authorities under updated information governance
8 arrangements are essential. Progress was made during
9 the pandemic, but there is a risk that it may slip back.

10 Third, the sharing of data between the four nations
11 of the UK to support the management of incidence was
12 challenging, and continues to be.

13 Finally, but no less importantly, access to
14 reliable, timely data was not available from care homes.
15 Having up-to-date intelligence on care home residents
16 would have allowed linkage of laboratory data to
17 care home residents, enabled quicker understanding of
18 care home outbreaks, and supported an effective
19 response.

20 The final topic, my Lady, is that of guidance.

21 PHS was responsible for producing certain health
22 protection guidance during the pandemic. The guidance
23 had the important function of informing what action was
24 necessary to combat Covid-19 infection, and contained
25 elements directed both to health protection and

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1 It had been used in the swine flu pandemic of 2009, but
2 had been in hibernation since then. The project was
3 renamed EAVE II and went on to gather vital intelligence
4 about issues such as the spread of the disease, impact
5 on health and, critically, vaccine effectiveness.

6 The project received international attention when it
7 published one of the first evaluations into the
8 effectiveness of Covid-19 vaccinations. EAVE II
9 findings showed that Oxford-AstraZeneca and the
10 Pfizer BioNTech vaccines reduced the number of people
11 being hospitalised with Covid. Randomised controlled
12 trials had already shown the vaccines were safe and
13 effective, but EAVE II provided the first evidence that
14 it had an effect at a national level. Scotland's size
15 and data infrastructure, plus the speed of the roll-out
16 of the vaccination programme, meant that the EAVE II
17 consortium was the first in the world to be able to
18 publish such findings.

19 The pandemic also highlighted data related areas
20 where PHS considers that there was and is room for
21 improvement.

22 First, in relation to data collection, the current
23 system is built on a suite of older technologies and
24 could be significantly improved to increase resilience.
25 For example, the ECOSS (Electronic Communication of

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1 infection protection and control.

2 However, the guidance served a further purpose. Its
3 other important function was to operationalise Scottish
4 Government policy. In practical terms, to ensure the
5 latter, during the pandemic PHS and Scottish Government
6 agreed a process which was known as the policy alignment
7 check process, or PAC for short. Although well
8 intended, it's fair to say that there were challenges
9 associated with it.

10 The PAC process introduced an additional layer into
11 the existing process of developing and issuing guidance
12 upon which frontline teams and services relied. Under
13 it, the final sign-off guidance was by Scottish
14 Government rather than by Public Health Scotland. At
15 times, the process was slow, resulting in delays such
16 that the guidance was not always produced timeously. On
17 occasion the guidance became out of date and the process
18 needed to be started again.

19 These issues came to light particularly in the
20 context of care home guidance. The PAC process was
21 a direct consequence of the NHS in Scotland having been
22 placed on an emergency footing during the period from
23 March 2020 to April 2022. PHS does not call into
24 question the necessity for imposing emergency powers,
25 given the exceptional circumstances. Indeed, that was

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1 a political decision and one entirely for Scottish
2 Government to make. However, it's important to
3 recognise and acknowledge that in consequence there was
4 an impact on PHS's independent voice for public health.
5 For present purposes, PHS would observe that having
6 an independent voice is vital to its role of protecting
7 the public's health.

8 PHS is grateful to you, my Lady, for the opportunity
9 to make this opening statement. We will endeavour to be
10 of whatever assistance we can to you and your team over
11 the weeks to come. Thank you for listening.

12 **LADY HALLETT:** Thank you very much, Mr Bowie.

13 Geoffrey Mitchell KC, Mr Mitchell.

14 **Submissions on behalf of the Scottish Government by**

15 **MR MITCHELL KC**

16 **MR MITCHELL:** Thank you very much, my Lady.

17 This is the opening statement on behalf of the
18 Scottish Government. I appear today along with junior
19 counsel, Jennifer Nicholson-White and Kenneth Young, and
20 we are instructed by Caroline Beattie of the
21 Scottish Government Legal Directorate.

22 We wish to begin our statement by acknowledging the
23 suffering of the thousands of families who have lost
24 their loved one due to Covid-19. This is a loss that we
25 know is felt to this very day. On behalf of the

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1 taken by the Scottish Government during the pandemic,
2 irrespective of certain consequential and deeply
3 regrettable harmful effects, were taken with the aim of
4 the protection of the people of Scotland as the core
5 guiding principle, that is to minimise the harm created
6 and to reduce the loss of life.

7 With those brief introductory remarks, I now turn to
8 the six areas in which I would wish to make comment, and
9 we deal with these in far greater detail in our written
10 opening statement.

11 The first is the period January to March 2020.

12 By late January, early February the Scottish
13 Government was well aware that it was facing
14 an increasingly serious situation.

15 By early March, all of the UK governments were
16 engaged in an intense analysis of early data on Covid
17 and its impacts. On 12 March, the response in Scotland
18 and throughout the UK moved from contain to delay as,
19 for the first time, community transmission had been
20 confirmed as occurring.

21 Events moved at a fast pace, with measures and
22 guidance introduced following scientific advice directed
23 at, amongst other things, self-isolation, mass
24 gatherings of 500 people or more, the closure of schools
25 and nurseries as well as certain businesses, and the

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1 Scottish Government, we would like once again to give
2 our condolences and sympathies to all of those who have
3 been bereaved by Covid-19.

4 The Scottish Government appreciates that legitimate
5 questions arise as to the strategic decisions made
6 during the pandemic and the way in which they were made.
7 Of course it is relevant to bear in mind the context.

8 Firstly, Covid-19 posed an unprecedented systemic
9 threat to global health, to healthcare systems, economic
10 activity and wider society.

11 Secondly, it was the Scottish Government's
12 responsibility to address that threat posed to the
13 people of Scotland. The complexity the systemic
14 challenge created by the rapid spread and evolution of
15 the virus, together with the whole of society aspect,
16 meant that there was no single simple and certain way to
17 respond. The Scottish Government's strategic aim was to
18 minimise the overall harm of the pandemic.

19 Thirdly, the Scottish Government acknowledges that
20 certain decisions could have been taken differently.
21 Whether alternative options were practicably and
22 realistically open to it and whether they would have
23 made a material difference are separate questions and
24 will no doubt be explored in evidence.

25 Finally, it need hardly be said that all decisions

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1 minimisation of social contact.

2 On 17 March, as we have heard, NHS Scotland was
3 placed on an emergency footing. Significant work was
4 done to ensure that the health service in Scotland was
5 ready to deal with the modelled high numbers of people
6 requiring hospital treatment. A large amount of
7 guidance was issued to the social care sector. Work was
8 done to ensure supplies of PPE were available as well as
9 reliable distribution routes.

10 At this point, we would like to pause and to
11 acknowledge on behalf of the Scottish Government the
12 severe impact of the pandemic on the social care sector.
13 Deaths that occurred in care homes and that were
14 attributable to Covid-19 accounted for a significant
15 percentage of all Covid-19 deaths in Scotland.
16 Restrictions on visiting caused unintended pain and
17 suffering. Residents, their relatives and care home
18 staff all suffered. The Scottish Government
19 acknowledges this. Evidence on this issue will surely
20 and understandably figure in this and future modules.

21 On 23 March, the decision was made to impose
22 a package of measures that came to be known as
23 a lockdown. Based on the clinical and scientific advice
24 from SAGE and the Chief Medical Officer for Scotland,
25 the judgement was made that additional measures had to

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1 be taken to suppress the spread of the virus in order to
2 avoid significant health harm and the overwhelming of
3 the NHS.

4 The Scottish Government was fully aware that
5 a lockdown would have far-reaching consequences, but it
6 was judged that the threat to human health was of such
7 significance that the strategy had to be pursued.

8 The lockdown was highly effective in reducing
9 community transmission and the level of infection,
10 serious illness and death within the UK. Of course it
11 was not without consequential effects on health,
12 including mental health, loneliness and isolation, and
13 levels of domestic abuse.

14 With the benefit of hindsight, possessed with
15 current knowledge as to the nature and effects of the
16 virus, the Scottish Government would have wanted to
17 impose a lockdown earlier. As stated, that is with the
18 benefit of hindsight. That desire apart, practicable
19 barriers would have stood in the way of that decision,
20 such as the need for the UK Government to provide the
21 necessary and consequent financial resources,
22 for example through schemes such as furlough.

23 The second issue that I would like to look at is
24 leadership, the underpinning structures and
25 decision-making.

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1 the decisions made and of the supporting reasoning,
2 information and advice and evidence. As required by
3 statute, since 2013 the Scottish Government has had
4 robust policies, plans and strategies regarding the
5 management of records that are designed to ensure that
6 there is a complete record of the business undertaken.
7 The information that constitutes the record may take
8 different forms or may be created in different ways.
9 Regardless, the responsibility remains to ensure that
10 such information becomes part of the record. In
11 practice, this involves the transfer of information into
12 one single location, the Scottish Government's corporate
13 electronic document and records management system.

14 In summary, the Scottish Government's structures and
15 systems that were in place throughout the pandemic were
16 clear, logical and transparent. It is submitted that it
17 resulted in governance and leadership that was both
18 effective and efficient.

19 The third area I wish to look at is Scottish
20 Government's strategies and decisions during the
21 pandemic.

22 It became clear that the Scottish Government's
23 response to Covid-19 would require a huge number of
24 decisions to be made by ministers across government, at
25 pace, and sometimes at short notice, with some decisions

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1 Core decisions regarding the handling of the
2 pandemic in Scotland were undertaken by
3 Scottish ministers. Within the Scottish Government,
4 a high degree of formality surrounds decision-making.
5 Even during the necessarily intense and rapid framing of
6 its response to the pandemic, it sought to maintain the
7 discipline of formal collective decision-making. Then,
8 as now, ministers sought to be open, transparent and
9 accountable in respect of the decisions made.

10 Decisions were made by Cabinet or by ministers with
11 appropriate delegated authority, and were subject to the
12 scrutiny of the Scottish Parliament. Some decisions
13 were delegated by Cabinet to the First Minister.

14 Formal records of decisions were kept, and decisions
15 were communicated to the Scottish Parliament in oral and
16 written statements, in the answering of Parliamentary
17 questions, and in the participation of ministers in
18 meetings of the Parliament and of committees.

19 Ministers received comprehensive briefing on the
20 course of the pandemic, drawing on material from medical
21 and scientific sources such as SAGE and the newly
22 established Scottish Covid-19 Advisory Group; advice was
23 presented by clinical advisers within the Scottish
24 Government and bodies such as Public Health Scotland.

25 During the pandemic, careful note was kept both of

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1 being taken by a more focused group of key
2 decision-makers. The framework for decision-making
3 published in April 2020 set out the Scottish
4 Government's principles and approach, as well as its
5 strategic objective to contain and suppress the virus so
6 as to minimise overall harm it could do, taking into
7 consideration the available scientific, clinical and
8 public health advice.

9 A key part of the approach was the concept of four
10 harms, of which we have heard already today. Broadly
11 speaking, the pandemic and measures in response to it
12 could cause harm in four areas, namely: harm 1, direct
13 Covid health harms, that is primarily the mortality and
14 morbidity associated with contracting the disease;
15 harm 2, broader health harms, primarily the impact on
16 the effective operation of the NHS and social care
17 services; harm 3, social harms, that is the harms to our
18 wider society, for example harm to education attainment
19 as a result of school closures; harm 4, economic harms,
20 that is harms to the wider economy.

21 The complexity of the systemic challenge posed by
22 the rapid spread and evolution of Covid-19 meant that
23 there was no single or individual correct response and
24 few, if any, harm-free decisions open to governments,
25 including the Scottish Government. The challenge was to

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1 assess risks and benefits and take decisions to reduce
2 overall harm as much as possible.

3 The Scottish Government recognised that the four
4 harms did not impact on everyone in society equally.
5 Accordingly, inequalities were seen as a factor integral
6 to the four harms. This approach was consistent with
7 the aspirations of the Scottish Government, both before
8 and after the pandemic, to build equality into policy
9 making across all areas of government. It is also
10 cognisant of its duties under equalities legislation and
11 the need for all decision-making to comply with the
12 European Convention on Human Rights. Thus, equality
13 impact assessments were used and published frequently
14 during the pandemic. A great deal of work was done on
15 this area. However, the Scottish Government does
16 recognise that one of the key questions arising from the
17 pandemic is: if, how and to what extent vulnerable and
18 at-risk groups could have been better protected.

19 In broad summary, as both the nature of the crisis
20 changed and the Scottish Government's overall strategy
21 evolved in response, so too did its approach to imposing
22 and easing non-pharmaceutical interventions. From the
23 initial lockdown of March 2020 through to the lifting of
24 the remaining legal measures on 18 April 2022, all steps
25 were guided by consideration of the four harms. Thus,

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1 supported that.

2 This levels framework was designed differently from
3 those that applied elsewhere in the UK, such as the tier
4 system in England. It was different both in terms of
5 the NPIs included within each level as well as the
6 number of levels. The levels framework proved capable
7 of responding to outbreaks and new variants without the
8 need for a further national lockdown in Scotland. By
9 defining measures in advance, the levels framework
10 enabled the Scottish Government to communicate in
11 advance what it would ask people to do and why.

12 With the success of vaccines and the reduction in
13 health risks to individuals, in particular older
14 vaccinated individuals, the Scottish Government's
15 strategic intent was adjusted. Ultimately in
16 February 2022 the strategic intent was revised for the
17 last time in recognition that, after two years of the
18 pandemic and in light of developments in vaccines and
19 treatments, a strategy that was overly focused on
20 suppression of the virus would have a disproportionate
21 impact on the other harms.

22 The fourth area that I would like to look at is
23 working with other governments and local authorities.

24 Promoting and protecting the health of the Scottish
25 people is a matter within the competence of the Scottish

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1 in 2020 and the first half of 2021, the priority was to
2 suppress the prevalence of the virus, even in
3 recognition that such an approach might cause broader
4 harms.

5 May 2020 saw the publication of *Coronavirus*
6 *(COVID-19): Scotland's route map through and out of the*
7 *crisis*, which detailed four phases of exiting lockdown.
8 The Scottish Government took a precautionary approach to
9 the relaxation of the restrictions, conscious of the
10 fragile position in relation to the suppression of the
11 virus which would affect its ability to protect
12 population health.

13 During September and early October 2020, a great
14 deal of work was done to repress a resurgent virus. The
15 focus was, insofar as possible, to manage, stabilise and
16 reduce the transmission of the virus through careful and
17 targeted use of NPIs.

18 In late October 2020, as the pandemic moved into
19 a new phase requiring an enhanced NPI response, the
20 Scottish Government published Covid-19 strategic
21 framework. The strategic framework supported the
22 overall approach, the overarching approach of taking
23 decisions in the context of the four harms, but it gave
24 the flexibility to put in place different measures in
25 different parts of Scotland, if local and regional data

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1 Parliament. Devolved control of the public health
2 response by the Scottish Government was crucial to the
3 effective handling of the pandemic in Scotland. At the
4 same time, it was recognised during the response that
5 there were areas in which it was vital to engage and
6 work with the United Kingdom, Wales and Northern Ireland
7 governments. Similarly, it was recognised from an early
8 stage that effective working with Scotland's 32 local
9 authorities would be vital in responding to the
10 pandemic. Engaged participation with local authorities
11 was forthcoming, for which the Scottish Government was
12 deeply grateful.

13 It is worth noting that current devolution
14 arrangements reflect the will of the Scottish
15 electorate. Quite properly, nothing was done to
16 reallocate the existing roles and responsibilities of
17 the Scottish Government for public health in response to
18 the pandemic. Indeed, the close connection between the
19 Scottish Government's responsibility for public health
20 and those for healthcare, justice, policing, education,
21 local government and most public services were central
22 to the response. What did happen was that liaison
23 between the Scottish and UK governments was intensified,
24 with an enhanced level of engagement between Scottish
25 Government, Cabinet secretaries, ministers and officials

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1 and their counterparts in the UK, Wales and
2 Northern Ireland governments.
3 Co-operation with the UK Government was on the whole
4 reasonably effective. However, this is not to say that
5 there is no room for improvement. For example, on
6 occasion it appeared to the Scottish ministers that
7 the UK Government treated certain fora as opportunities
8 to inform the Scottish Government of decisions which had
9 already been taken. This meant that meaningful
10 discussion with the Scottish Government was sometimes
11 absent in respect of UK Government decisions that
12 affected Scotland.

13 There was no Scottish Government response to the
14 pandemic which was guided by anything other than
15 a desire to contain and suppress the virus in order to
16 minimise the overall harm it could do. By working with
17 the other governments of the United Kingdom,
18 a commitment included within the framework for
19 decision-making, Scotland was able to benefit from the
20 best and most up-to-date expert scientific data and
21 advice. This information helped to guide Scottish
22 Government decisions, which were always made to meet the
23 specific circumstances in Scotland.

24 Where the Scottish Government reached decisions that
25 were different to those which were deemed appropriate in
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1 registered with a GP in Scotland, the study successfully
2 tracked the pandemic in near real time, as well as the
3 effectiveness of the vaccines across Scotland. The
4 research of EAVE II produced findings that had a global
5 impact on the response to the pandemic.

6 The final area is communication.
7 In respect of communication with the public, one of
8 the aims of the strategy was to provide a form of
9 ongoing support via a regular presence to assist people
10 through a worrying and distressing period. The strategy
11 was designed to reach the population of Scotland as
12 frequently as possible, with accessible information that
13 could be easily understood and would motivate and prompt
14 life-saving action by adopting protective behaviours.
15 A variety of different communication channels, such as
16 daily briefings by the First Minister, Nicola Sturgeon,
17 helped to explain why levels of public confidence were
18 consistently high.

19 My Lady, those are the six areas that I wish to look
20 at today. They are explored in much greater detail in
21 our written statement, but for now I would close by
22 saying that the Scottish Government is of course
23 committed to learning and adapting as a result of
24 the Inquiry's findings, and it is grateful to the Chair
25 for the opportunity to make today's submission.
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1 other parts of the United Kingdom, it did so after
2 consideration of the facts and circumstances facing it.
3 It is respectfully submitted that this reflects
4 devolution working as it was intended. The result was
5 decision-making that responded to local circumstances
6 and that was accountable to an evolved legislature.

7 The fifth and sixth areas that I wish to look at
8 briefly, my Lady, today are access to data and
9 communication. They are substantive topics in and of
10 themselves, and we deal with them in much greater depth
11 in our written statement.

12 Scottish data played an essential role in the
13 pandemic. Although there were difficulties in the early
14 days of the pandemic accessing the data, the
15 Scottish Government established quickly the Covid-19
16 Modelling and Analysis Hub, which was able to share
17 externally produced modelling evidence and research, as
18 well as produce a range of its own data and modelling.
19 This went into co-ordinating advice to ministers in
20 respect of the four harms.

21 The EAVE II study -- of which we have just heard
22 from Mr Bowie for PHS -- was a unique resource, created
23 through a collaborative partnership between Public
24 Health Scotland, Scottish universities and public health
25 physicians. Using data from 5.4 million people
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1 Thank you.

2 **LADY HALLETT:** Thank you very much indeed, Mr Mitchell.

3 Right, that completes the submissions of the
4 core participants and Counsel to the Inquiry. We've
5 covered a great deal of material today in summary form,
6 and I'm indebted to Counsel to the Inquiry and to all
7 the core participants' legal representatives for their
8 submissions and for the focus which have enabled us to
9 complete today's submissions in good time.

10 So thank you all very much indeed, and tomorrow we
11 shall sit at 10 o'clock and start hearing the evidence.

12 **MR DAWSON:** Thank you, my Lady.

13 **LADY HALLETT:** Thank you.

14 **(4.20 pm)**

**(The hearing adjourned until 10 am
on Wednesday, 17 January 2024)**

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