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,

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.

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

pandemic and the high level response of the UK Government to it in the period from January 2020.

At this point, the focus turns to Scotland, and the key decisions taken by those with the responsibility for managing the pandemic response in this nation. The main thrust of the module relates to the decisions taken by the government in Scotland, in particular the questions of the reasonableness of what the public health experts would call non-pharmaceutical interventions, or NPIs, introduced by them to seek to combat the virus.

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

fell unevenly across Scotland.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

related to the ambit of Module 2A.

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

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

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

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

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

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

intergovernmental working which we will do with both Scottish Government and UK Government ministers.

This will not be a re-run of the evidence heard by you already, my Lady, in Module 2, but it will draw upon that evidence and seek to look at key aspects of the role the Scottish Government and the UK Government in their interrelation, insofar as significant in the way that the pandemic was managed in Scotland.

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

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

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

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

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

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

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

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

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

Work to prepare for the pandemic or such other emergency was done on a UK four nations basis. Preparation focused on planning for a flu pandemic, on the basis of expert scientific advice. Infectious disease was, however, also identified and considered in the Scottish Risk Assessment, which you looked at in Module 1. It was considered that the reasonable worst-case scenarios for flu would apply to other risks if they occurred and preparations could be adapted. This was on the basis that in planning for an emergency focus was not -- on the consequences, ie the impact of a pandemic, and not on the cause.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

It was concluded, however, by Messrs Bambra and Marmot that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Furthermore, my Lady, the evidence suggests there

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

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

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

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

The extent to which reliance was placed on voluntary or charitable organisations by government to inform their understanding of the needs of these communities is also significant and suggests that perhaps those were not well understood at the beginning of the pandemic.

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

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

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

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

LADY HALLETT: Thank you very much, Mr Dawson.

Yes, for those who haven't been following our

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

(11.15 am)

(A short break)

(11.30 am)

LADY HALLETT: Mr Dawson.

MR DAWSON: Thank you, my Lady.

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

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

assistance.

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

the interaction of administrations".

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

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

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

She provided evidence about the early collaboration

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

involving the imposition of NPIs to have effect.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

be concerned.

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

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

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

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

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

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

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

The Inquiry has already looked at the key questions

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

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

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

Evidence heard by your Ladyship in Module 2 has

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

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

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

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

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

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

"There is evidence of person-to-person transmission."

They also recorded that:

"... the UK currently has good centralised diagnostic capacity ... and is days away from a specific test, which is scalable across the UK in weeks."

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

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

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

"Here at the University of Edinburgh we have more

than 2,000 students from China and they are always coming and going back to China so we are relatively sure we will have cases in the UK from travellers coming back from China."

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

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

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

On 27 January, Health Protection Scotland initiated the Incident and Emergency Response Plan. This implemented response arrangements, including the structure and governance of the incident response going forward, and the establishment of an incident room at

the Meridian Court offices in Glasgow. The emergency response co-ordinator was Dr Jim McMenamin, from whom we will hear later this week.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

emerged in the spring of 2020 via press reporting. These will also be explored within the module.

COBR met again on 28 February, by which time the UK had confirmed its first case of confirmed community transmission.

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

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

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

strategies before the national lockdown on 23 March 2020.

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

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

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

"very high".

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

By 16 March, the four new ministerial implementation groups were established to aid collective government decision-making. Imperial College published Report 9, which models the potential impact of stringent conditions and concludes that epidemic suppression was the only viable strategy at that time. The model used to produce Report 9 generated a worst-case scenario of over 500,0000 deaths in the UK by the end of July 2020.

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

She stated that the advice applied especially

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Government.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

by the virus itself, remained the priority.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Shopping centres reopened from 13 July.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

On 28 August, Nicola Sturgeon announced the

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

For example, on 28 June 2020, following two days with no reported deaths in Scotland, Professor Devi Sridhar, an expert in public health at

Edinburgh University, had predicted that Scotland could eradicate Covid-19 by the end of the summer.

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

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

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

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

than the hospitality sector. Cases however continued to rise both generally and in the Glasgow area.

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

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

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

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

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

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

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

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

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

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

until the 25th.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(12.45 pm)

(The short adjournment)

(1.45 pm)

LADY HALLETT: Mr Dawson.

MR DAWSON: Thank you, my Lady.

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

LADY HALLETT: You had.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

including in Glasgow and Dundee.

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

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

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

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

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

On 17 July, with the mass vaccination centre at

Glasgow's SSE Hydro set to close, opposition politicians urged the Scottish Government to keep it operating. The clinic was being closed in order to prepare the venue for the UN Climate Change Conference, which eventually took place in November 2021.

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

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

Covid deaths in Scotland continued to rise: 47 in death certificates in the week between 12 and 18 July, a rise of 16 on the previous week. A key feature of this period in Scotland from the summer of 2021 was that hospitals started to become overwhelmed as a result of the impact of local cases of infection caused by the Delta variant. As early as 7 July 2021, NHS Grampian had placed two hospitals on code black status, meaning the cancellation of non-urgent procedures. They reached full capacity following a rise in Covid cases in the area and a consequent rise in hospital admissions, combined with staff absences due to self-isolation

requirements.

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

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

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

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

By late August 2021, figures indicated that Covid cases had virtually doubled each week since the lifting of restrictions on 9 August, leading to an increase in hospitalisations. National Clinical Director Professor Jason Leitch suggested a reverse gear may be needed with some restrictions.

A number of large scale events were reintroduced, and Nicola Sturgeon confirmed on 1 September that vaccine passports would be required for people who wished to enter nightclubs or attend large events. The practicality of the plans was questioned by a number of organisations, including the Scottish Professional Football League.

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

Opposition to the scheme culminated in an ultimately unsuccessful legal challenge against Scotland's vaccine passport scheme the day before its launch. In the midst of rising cases and the launch of schemes like the vaccine passport scheme to manage infections in a low restriction environment, on 7 September 2021 Nicola Sturgeon confirmed that work would resume on plans for a second independence referendum. She said the next day that her plans to hold a second

independence referendum in two years were realistic despite the difficulties of Covid. On the same day it was estimated that one in 45 people had Covid in Scotland, the highest number since records began.

The pressures on the stretched NHS in Scotland which had required a number of areas to suspend non-urgent procedures in the summer continued. By 6 September 2021 the Scottish Government required to ask the Ministry of Defence for military assistance for Scotland's ambulance service. Nicola Sturgeon described the situation as being the most challenging set of circumstances in history because of Covid.

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

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

cancellations the very next day.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LADY HALLETT: Thank you very much, Mr Dawson.

Claire Mitchell KC.

Submissions on behalf of Scottish Covid Bereaved by MS MITCHELL KC

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

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

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

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

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

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

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

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

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

The reason for highlighting the foregoing, my Lady,

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

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

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

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

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

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

after spring 2021?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr Freeman, Danny Friedman KC.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a failure to consult at all with the Scottish DPO on the subject.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Scotland and two times more likely to be hospitalised.

Third, as Scotland was dependent on UK economic packages to support NPIs, SAGE advice would trump Scottish advice, because Covid could not afford to fund significant countermeasures that were not part of UK-wide virus suppression decisions.

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

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

Compared to England, Scottish civil servants were

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

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

Compared to the UK and England, Scotland does it better. However, the disengagement in the first months mattered, because that is the point in time when the

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

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

The eighth area is protection. How far was Scottish Government able to protect its disabled

population from the damage of both Covid and the countermeasures? The powerful criticism of Inclusion Scotland in its report *Rights At Risk* was that there was "an abyss between the rhetoric of national policies and what happens on the ground".

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

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

The ninth area is redistribution. Was it enough to recognise the vulnerability of disabled people in Scotland without sufficient economic redistribution to support their needs? The DPO criticism of UK pandemic economics is that rather than being radical as presented and sometimes criticised, it involved the deliberate

maintenance of the status quo. For disabled people furlough payments were focused on those able to work or temporarily unable to work in standard wage sectors and did not reach lower, informal or non-wage earning people. The increase in Universal Credit was small compared to sums spent on business. Limited provision of sick pay was known to be highly relevant to part-time and zero hours workers already in poverty continuing to work, with fatal consequences. Covid economics was not always Scotland's alone to define, but its own lump funding into local authority schemes was difficult to access and not particularly accountable.

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

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

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

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

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

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

My Lady, thank you.

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

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

Submissions on behalf of the Trades Union Congress by MR JACOBS

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

LADY HALLETT: Carry on, if you can.

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

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

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

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

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

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

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

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

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

politics.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

with employees and trade unions".

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

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

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

That included not just calls from unions but from UK

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

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

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

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

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

appropriate consultation.

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

Next, we address the differences in culture between Scottish Government and Westminster. We set out in our written submissions in more detail some of the differences which appear to us to be apparent. For example, the Scottish Government appears to have been quicker to work within clear and agreed frameworks for decision-making. The Inquiry can consider whether Westminster's careering between different objectives was a feature of the characters in power, the Prime Minister who was widely referred to internally as the trolley, or whether it may have been assisted by the frameworks for decision-making more readily used in Scotland.

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

informally and guided by the belief that the intellect of a very small few will come good.

There also appears to have been an important basic professionalism that was lacking in parts of Number 10 and Westminster more generally. Nicola Sturgeon describes that the working environment within Scottish Government during the pandemic was professional, serious and formal, and titles such as First Minister, Deputy First Minister, Cabinet Secretary would be used in meetings. At the same time in Westminster, a male-dominated group of ministers were urging each other to "back the Gavster", a reference to Sir Gavin Williamson, were laughing about "Hancockian timetables", a reference to Mr Hancock, and other examples which must be thousands in number.

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

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

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

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

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

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

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

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

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

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

Thank you, my Lady.

LADY HALLETT: Thank you very much, Mr Jacobs.

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

(3.06 pm)

(A short break)

(3.20 pm)

LADY HALLETT: Rory Phillips King's Counsel.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

those most affected.

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

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

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

Thank you.

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

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

MS DOHERTY: "Docherty".

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

(Pause)

MS DOHERTY: My Lady ...

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

my coughing.

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

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

LADY HALLETT: "Bough-ee", sorry.

Submissions on behalf of Public Health Scotland by MR BOWIE KC

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

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

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

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

As Professor Paul Cairney stated in his report

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

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

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

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

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

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

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

I now want to turn to the pandemic itself.

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

In relation to particular areas involving PHS

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

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

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

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

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

There are three points worth highlighting.

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

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

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

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

experienced in pandemic response.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

infection protection and control.

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

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

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

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

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

LADY HALLETT: Thank you very much, Mr Bowie.

Geoffrey Mitchell KC, Mr Mitchell.

Submissions on behalf of the Scottish Government by MR MITCHELL KC

MR MITCHELL: Thank you very much, my Lady.

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

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

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

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

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

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

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

Finally, it need hardly be said that all decisions

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

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

The first is the period January to March 2020.

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

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

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

minimisation of social contact.

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

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

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

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

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

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

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

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

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

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

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

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

During the pandemic, careful note was kept both of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

supported that.

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

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

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

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

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

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

and their counterparts in the UK, Wales and Northern Ireland governments.

Co-operation with the UK Government was on the whole reasonably effective. However, this is not to say that there is no room for improvement. For example, on occasion it appeared to the Scottish ministers that the UK Government treated certain fora as opportunities to inform the Scottish Government of decisions which had already been taken. This meant that meaningful discussion with the Scottish Government was sometimes absent in respect of UK Government decisions that affected Scotland.

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

Where the Scottish Government reached decisions that were different to those which were deemed appropriate in

other parts of the United Kingdom, it did so after consideration of the facts and circumstances facing it. It is respectfully submitted that this reflects devolution working as it was intended. The result was decision-making that responded to local circumstances and that was accountable to an evolved legislature.

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

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

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

registered with a GP in Scotland, the study successfully tracked the pandemic in near real time, as well as the effectiveness of the vaccines across Scotland. The research of EAVE II produced findings that had a global impact on the response to the pandemic.

The final area is communication.

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

My Lady, those are the six areas that I wish to look at today. They are explored in much greater detail in our written statement, but for now I would close by saying that the Scottish Government is of course committed to learning and adapting as a result of the Inquiry's findings, and it is grateful to the Chair for the opportunity to make today's submission.

Thank you.

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

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

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

MR DAWSON: Thank you, my Lady.

LADY HALLETT: Thank you.

(4.20 pm)

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

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