Wednesday, 17 January 2024

(10.00 am)

LADY HALLETT: I don't seem to have any papers, or my notebook. I think they're in my room. If we carry on, by the time someone's been upstairs ... can we get a message? Okay, thanks.

MR DAWSON: Thank you, my Lady.

I was simply going to introduce to you this morning that, as I said yesterday, we have a number of witnesses this morning who are giving evidence from a number of impact organisations. The first witness this morning is Mrs Jane Morrison.

LADY HALLETT: Thank you.

MRS JANE MORRISON (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 2A

MR DAWSON: Good morning, Mrs Morrison. If you could try to speak, as best you can, into the microphone so we can hear you nice and clearly, that would be much appreciated, thank you.

You are Mrs Jane Morrison?

A. Correct.

Q. And you have already given evidence, I think, to the Inquiry in its Module 1?

A. Correct.

Q. And you give evidence this morning on behalf of an organisation to which you're affiliated called Scottish Covid Bereaved; is that correct?

A. Correct.

Q. And you provided a witness statement to the Inquiry dated 20 March 2023 under reference INQ000144794. That was your witness statement in the first module, to which you speak to an extent already, and Scottish Covid Bereaved has also provided a response to the Inquiry's impact questionnaire which can be found at reference INQ000099718. Is that a document with which you're familiar?

A. Yes.

Q. I think you must at the very least have had a significant part in its creation, if not you're actually its creator?

A. Well, a wee bit.

Q. Yes, there are some references in it, I think, to your personal situation?

A. Yes.

Q. If I could just ask you some questions about that, Mrs Morrison. I understand that in October 2020 your wife, Jacky Morrison-Hart, died from Covid?

A. Correct, yes.

Q. And she caught Covid in hospital, as I understand it?

A. Correct.

Q. As I understand it from the testimony that you've provided to the Inquiry, she was an inpatient in hospital, having developed jaundice, and she was undergoing some tests.

A. Correct.

Q. She had been in hospital for two weeks when she caught Covid, catching it on the 15th day of her stay in hospital?

A. Correct.

Q. I understand that the tests for her underlying health condition had taken much longer than would have been the case before the pandemic?

A. That's correct, yes.

Q. Why was that?

A. There are things like scans -- every time someone went in the scan it had to be thoroughly disinfected afterwards, and then they had to wait at least 20 minutes before they could let another patient come in and use the scanners, so it was tending to be three days between tests rather than just following one after the other.

Q. I see, so this prolonged her stay in hospital?

A. Very much so.

Q. As I understand it, she had been in hospital for 14 days and she caught Covid within the hospital, and that's -- a term which is often applied to that, which I see in some of your testimony, is a nosocomial infection?

A. That's correct, yes.

Q. Meaning one which is caught within a hospital environment?

A. Mm-hm.

Q. I understand that her condition deteriorated quickly and sadly she died only five days after the onset of her infection?

A. Yes, it was very quick, because in the five days the Covid, which -- many people still think of it as a respiratory condition, but it has a very big vascular element and it destroys the lining of the blood vessels, and in those five days it had clogged up her lungs, her kidneys had failed, her pancreas had failed and her liver had failed, all because of the Covid, and they tried to do dialysis and they couldn't do it because her blood was so sticky because of the Covid it actually broke the machine.

Q. May I pass on the Inquiry's condolences for your loss.

A. Thank you.

Q. Were you given an opportunity to say goodbye to her?

A. I was. I was very lucky, because I didn't think I was going to be given the opportunity, because Jacky had been told because of the liver failure in particular,

she was not a candidate for ITU, because it would only be prolonging the inevitable, so she was told that on -- I think it was Saturday afternoon, the afternoon of the 24th, and we knew then it was just a matter of time, she was on maximum CPAP and they couldn't get her oxygen levels above 60% because of the Covid. And I thought -- I had a phone call with her and I thought that was the final phone call, but the consultant very kindly managed to find a side room, this -- in that particular hospital they made a hospital within the hospital, so they had Covid ward, a high dependency unit and intensive care, so they managed to find a side room in the Covid ward so I didn't -- because I wouldn't have been to go into the high dependency unit. And it's an hour's drive from home to the hospital, so I managed to get there just in time, I had about 15, 20 minutes with her. Yeah.

Q. I think after your experiences, you met up with or you came into contact with some other people via Facebook, I think, who had had if not similar, but broadly similar, experiences of the Covid pandemic in Scotland; is that right?

A. Yes. What happened, it was -- the Facebook group at that stage covered the whole of the UK, which was the Covid Bereaved Families for Justice, and I joined that. And within that Alan Wightman was identifying all the

Scots, so we became initially the Scottish branch of that unit, but subsequently we became an autonomous -- a completely separate group, of Scottish Covid Bereaved.

Q. I think that was in about March 2021, was that right?

A. March 2021 was when we met Nicola Sturgeon.

Q. Right.

A. And spoke to her. And it was -- it was over quite -- well, once we knew the public inquiry was happening in Scotland, we were aware we would need a Scottish legal team to deal with that, and they were introduced to us by the English lawyers for the UK group, they actually approached Aamer Anwar & Co and got them on board, and then the more we thought about it, the more our own personal knowledge grew, it seemed to us eminently sensible to have the same lawyers for both inquiries and then nothing falls through the gaps and we don't miss -- and it also avoids a lot of duplication as well. So we decided that we'd do that.

And it was a process over several months, really, and by the latter half of 2022 we had a completely separate group, and prior to that we still had been part of the UK group.

Q. We certainly hope that nothing will fall through the gaps, Mrs Morrison.

Could I just ask you a few questions then about the

group. Obviously it's evolved over time, as you've just explained, but I understand that the group represents people from many different backgrounds who have had varied experiences of the Covid pandemic.

A. Yes.

Q. And in particular, given its name, they represent a number of people who have had different experiences of bereavement.

A. Yes.

Q. But there are a number of different people who are not necessarily directly bereaved who are involved with the group too; is that right? Some who perhaps work at frontline workers?

A. No, everybody in the group has been bereaved, but within that group of bereaved people, we have a variety of people such as frontline workers, healthcare professionals, teachers and so on. So we have a very wide variety of people with a lot of experiences in addition to their bereavement experiences.

Q. I see. And I understand the group may also represent some people with Long Covid?

A. We have some people in the group with Long Covid, but we do not represent a Long Covid group, if you follow my logic on that.

Q. I see. But the group has a wide variety of people and

experiences upon whom it can draw --

A. Yes.

Q. -- in order to form views and raise concerns about the Covid-19 pandemic in Scotland?

A. Yes.

Q. And it has people from different parts of Scotland?

A. Yes, yes, all over Scotland.

Q. And it has people, whose relatives have died, of different ages?

A. Yes.

Q. And it has people in it who have suffered bereavement at different stages of the pandemic, as it ran over our scope of more than two years?

A. Yes.

Q. I would like to ask you a few questions about a number of the issues that you have very helpfully raised with us, and I understand you may have raised with government in Scotland, arising out of the experiences of the group, in order to understand them a little bit better. As you'll understand, this module concerns government decision-making and you have raised a number of significant matters, important matters, for us, and I'd like to understand the group's perspective on those a little more, if I might.

A. Yes.

Q. I understand, as you've already said, that you've been able to have a number of meetings with Scottish Government, one of which took place with the First Minister, Nicola Sturgeon, in March 2021?
A. 2022.
Q. 2022?
A. Sorry, no, you're right, it's 22 March 2021.
Q. Yes, 2021.
A. Yeah, sorry.
Q. So obviously at that time, in 2021, as our summary of the chronology yesterday showed, the pandemic was very much still going.
A. Yes.
Q. We were roughly at the stage, I think, to contextualise it, of coming out of the second lockdown.
A. Yes.
Q. Roughly.
A. Mm-hm.
Q. And I understand that you, at that meeting with the First Minister, raised a number of the group's concerns, and that the principal purpose, if you like, of raising these concerns was to address those individually but also to try to make progress about having an inquiry into the Covid-19 pandemic in Scotland?
A. Yes, the main purpose of our meeting with the

First Minister was to share our experiences with her, and to get her agreement to a Scottish public inquiry. And whilst -- naturally, we're sharing our own experiences, and we told her about some other issues as well, we were doing -- so she did hear a wide variety of issues.
Q. I'd like to address some of those issues with you. Helpfully you've produced a number of these issues in a list in the impact questionnaire response.
So if we could have that up, please, it's INQ000099718, and I'm looking at page 5, which is appendix 1. Thank you very much.
You've helpfully in this section of this document raised for us a number of matters that you raised verbally with the First Minister at the meeting, and I'd like to address some of these with you.
Issue 1, you raise a question relating to care homes. Is it the case that there are a number of people who are within your organisation who have experienced bereavement of relatives who were in care homes in Scotland?
A. Yes, 9% of our members have experienced a bereavement in care homes, yes.
Q. So this is a significant cohort?
A. Yes.

LADY HALLETT: Sorry, was that 9 or 90?
A. 9.
MR DAWSON: And you raise at issue 1, as we can see there, it says:
"How, at a time when there was said to be a 'protective ring' around care homes and WHO was repeatedly stating 'Test Test Test' does the Government justify sending untested hospital patients into care homes full of vulnerable people?"
Is there a particular time period that this particular concern relates to in our pandemic chronology?
A. This was predominantly in March and April 2020 of the -- at the start of the pandemic, where we had all these issues with care homes. As time has gone by, and I've learnt more, I do wonder how much of it is linked with the guidance that initially came out that was -- SAGE 6, on 11 February, said we had to proceed with the assumptions of a flu pandemic, and with a flu pandemic it's decided that the elderly were the least at risk because of years of vaccine and years of exposure, and in 25 February Public Health England, who were the lead public health people for the joint approach, they issued guidance saying it was very unlikely that care homes would get any infection in them. And they said that

a couple of times. And I think that existed until 13 March.
So we had that, and of course as we now know there was a lack of testing capacity.
But that also raises its own issues, because when we get to 25 March, the British Geriatrics Society issued guidance saying that geriatric patients do not exhibit the same symptoms, and I believe it's only 20% to 30% that will actually present with a fever, their other symptoms are completely different. So there's all those -- there's an awful lot of stuff, and I'm glad you're having a separate module on it, my Lady, to do that. So ...
Q. And you were raising these matters with the Scottish Government in 2021?
A. Yes.
Q. And you were looking, I suppose, for answers from them as to how these things had been allowed to happen?
A. Yes.
Q. Some of which you've managed to find some answers to --
A. Yes.
Q. What role did you understand that Scottish Government had played in the period, the early period that you've referred to, as regards care home --
A. Yes, my understanding is that -- I don't know who made

the actual UK decision that so-called "bed blockers" should be discharged into care homes, I don't know who was the author of that decision, but the Scottish Government followed that approach, and it started on the latter half of March 2021, as I understand it.

I also believe that, apart from the not having enough tests at that stage, that it had come from SAGE and Chris Whitty, as the UK CMO, that they thought the tests would not recognise asymptomatic transmission or presymptomatic cases, so they only thought it would recognise those who actually had the Covid symptoms.

Q. I think you referred there, inadvertently I think, to March 2021. I think we were talking about March 2020 --

A. Sorry, yes.

Q. -- Scottish Government. It is extremely difficult to remember which year we're talking about. I think I fell foul of that myself yesterday in the opening.

A. Thank you for clarifying that.

Q. Thank you.

Did your members who had suffered bereavement around that time -- you mentioned a moment ago pressures on hospitals as being a factor in this story -- did the members of SCB have experience of pressure being applied to them or the individuals who subsequently died to be transferred from hospitals to care homes around the

period we were discussing?

A. Yes. Yes. We actually had instances of some members actually pleading with the hospital not to discharge their relative.

There seemed to be a lot of things that hadn't been considered. For example, the difference between a care home, which is more a residential place where people will help you with your daily living, and nursing homes, which of course will have a nurse on staff. So for those who were in care homes as well, they very often didn't have the experience or the facilities to cope properly with patients who had been discharged, if they had to isolate or if subsequently it turned out they did have Covid.

Q. So let me get this right, there are stories of pressure being applied to move people out of hospitals to care homes --

A. Yes.

Q. -- but there were issues about infection control measures and other aspects of the way that care homes function that meant that that might well not have been suitable at the time?

A. Yes.

Q. Thank you very much.

I'd just like to ask you a few questions also about

issue 2, which is still on the screen. It says there that:

"We all saw the scenes on the news from Italy and Spain depicting the COVID devastation in care homes. Why was the 'lead' time we had in Scotland not capitalised on to provide infection control and PPE training and support in care homes?"

I think -- would it be fair to say that the theme of Scotland having a degree of advance warning about things is something that comes up on a number of occasions in the statement that you've given?

A. Yes.

Q. And that this is one example of it where you're drawing attention -- in the context of care homes, but one might perhaps say more widely -- to scenes of devastation, problems arising in other countries --

A. Yes.

Q. -- and there being an issue on the mind of Scottish Covid Bereaved so to whether that warning had been properly heeded?

A. Correct.

Q. Does that apply specifically to care homes or is there a more general concern about that?

A. In the early days of the pandemic, it was generally, and -- because it related as well to issues such as PPE.

You know, I think in February the UK Government sent PPE to China, for example, you know. So there was not this -- well, there was a sort of "It won't happen to us, you know, we're on a little island, we'll be all right". That was the impression we got. I mean, whether or not that was their actual thought or not, I don't actually know.

Q. Because in this regard you also raise -- if you could just go over the page, I wanted to jump to issue 8, which seemed to me to be connected to this. At issue 8 you say:

"Did trying to go for a uniform UK-wide approach at the beginning of the pandemic delay an earlier response if Scotland had just gone for it alone?"

A. Yes.

Q. So, again, you're focusing there on this very early period, and one of the questions that you wanted an answer to was whether Scotland could and should have taken an autonomous approach?

A. Yes.

Q. I mean, the issues that we've touched upon, health and social care, are devolved matters to the Scottish Government?

A. They are, yes.

Q. So what you wondered was whether going along with

a uniform UK approach was something that the Scottish Government might have done otherwise?

A. Yes, I mean, for example we asked about border controls: why didn't we just shut the borders and keep everybody out? And the -- it was explained to us that, yes, we could shut the border, but the Border Force, the monitoring of it is controlled by Westminster, not by Scotland, so they couldn't have the monitoring done at the border. And also the financial aspects of everything, Scotland does not have its own authority to raise funds such as a UK Government has. So they were very limited what they could do within the financial constraints as well.

Q. So it sounds like from your obviously extensive analysis of matters, Mrs Morrison, that in the early stages issues arose from the devolution settlement which, given the all encompassing nature of Covid, created difficulties about whether the Scottish Government should go one way or the other, but you wanted to know, I think, issue 8 suggests, why did they not go their own way?

A. Yes.

Q. Did you, other than what you've said, give -- did they give you what you consider to be a satisfactory answer to this, either at your meeting with the First Minister

or subsequently? Does this remain an issue for you?

A. It does remain an issue, and hopefully we can identify some of that in this module.

Q. I very much hope so.

There's another issue which I wanted to ask you about, in particular because it relates to your own situation. Again if we could go over the page, please, to issue 13. You say there:

"There is real concern around hospital acquired Covid-19 and hospital transmission and yet my wife [which was the reference earlier I think why you must have written this] was allowed to walk through the corridors of Hairmyers Hospital having tested positive for covid 19 at her leisure without so much as a facemask on."

A. Sorry to stop you there, that's not --

Q. Oh, that's not your story? I'm sorry.

A. No, it's -- these bits are from the five of us who were there, just a little bit of stories. This was another member's wife.

Q. I understand.

A. But I can --

Q. I'll just finish the quote and then ask you to explain:

"At this time the hospitals were not particularly busy why were you sending covid patients home[?]"

So I had understood this was your story, but it bears a number of familiar hallmarks from your story.

A. Yes.

Q. Could you explain, therefore, what this story emanates from and, to the extent that you're able within the group, explain the significance of nosocomial infection and the efforts made to prevent it within the group's concerns?

A. Yeah, just as it says later down in the statement, as a group, 25% of our members have lost someone to nosocomial infection, and that has stayed a fairly consistent figure as we've grown as a group. And this particular issue had a number of points into it. This gentleman's wife was shielding, and then the shielding stopped and she was told to go back to work. She got Covid, went into the hospital, but they thought she was well enough to send home. But they said to her to just go, and she was able to walk through the whole hospital without wearing a mask, whilst having tested positive for Covid on that -- and this is what the situation was. And she subsequently passed away with Covid.

Q. And is the issue of the extent to which infection was controlled within hospitals a wider issue for the members, the 25% of the SCB?

A. Yes, there's a number of elements to it. I mean, I've

read quite a few infection control plans -- one of my ways of coping with everything was to do a lot of research -- and they focused solely on the nursing medical staff and what they have to do. The only reference I've seen in relation to patients or visitors is they're invited to use an alcohol hand gel, and I have not seen any procedures for visiting tradesmen or repair people, porters -- sorry, porters are covered -- on that. So there's some gaps.

But to us, one of the biggest gaps is when Covid started, certainly in the hospital that Jacky was in, they set up a system you could only have one named visitor for the duration of that patient's stay, this was before she got Covid, and they had to make an appointment so they didn't have too many people on the ward at once, and wear hospital face masks, gloves and a pinny -- sorry, apron. Which we were doing, every time I went to visit Jacky. Outside of the hospital you had patients who had come outside and they were meeting friends and families in the car parks, with no masks, no social distancing and in groups of up to half a dozen, and then, and I saw it with my own eyes, when they finished they walked back into the hospital and they wouldn't even use the hand gel. So, you know, it makes a mockery of much of the infection control, because it's

like putting down a portcullis to stop a swarm of bees.
Q. As we did with the care homes, can you give me some idea of the timeframe over which these concerns about I think the guidance but also the enforcement of any guidance caused concerns to the members of the SCB?
A. It's throughout the duration of the whole pandemic.
Q. Thank you.
There's another issue I'd like to touch on, two other issues I'd like to touch on with you, if I possibly could. It's issue 11.
So if we could go back a page, please, Lawrence.
Issue 11 relates to shielding, which is something that I think we will touch upon in this module, and a particular issue relating to Scotland which I wanted to raise with you on behalf of the members:
"Why did the shielding end at the start of August when people were being allowed to go on holiday and no doubt bring variants back into the country, the eat out to help out scheme was started, the schools were returning mid August and the universities shortly after? Surely if there was modelling being carried out it would show this was probably the most dangerous time to stop shielding."
Again, could you explain this? There's a lot in that about factual information, some of which I'd

summarised yesterday, but I think this relates to a decision in August to stop the shielding scheme; is that right?
A. That's correct, yes.
Q. Was it on 1 August, I think?
A. I'm not sure of the exact date, sorry.
Q. Yes (inaudible).
A. But it seemed that -- I'll come back to the shielding, if I may, but it would seem that when you've got your numbers down that you should gradually release the controls, and what was happening was everything was being released at once, plus additional things like the Eat Out to Help Out scheme was introduced. So people going from social distancing, minimal contact, suddenly they were let out and everybody went a bit wild, and that coincided with stopping shielding. So where you would have been in a position where the person who had stopped shielding would have gradually readjusted, it meant that if they were told they had to go back to work by their employer, for example, they were just exposed to every possible source of contamination with the virus.
Q. So at that point, and at that point these decisions were being made by the Scottish Government, what you wanted to point out was that there seemed to be an incongruity

between the fact that there were releases happening on the restrictions but also the most vulnerable re-exposed to that?
A. Yes.
Q. Is that a common issue, that particular issue, amongst the membership?
A. Yes, there's quite a few -- quite a few members who are affected like that. I understand, and again it's one we need to understand what was the UK decision that started off, because of course it happened in the whole of the UK and how much autonomy did the Scottish Government have.
Q. That would be one of the questions that you would like an answer to?
A. Yes. Yes.
Q. Another issue that I wanted to touch on briefly with you is issue 15.
So if we go back over the page again, please, Lawrence. Issue 15, which is something that comes up on a number of occasions in the SCB materials, is that you say there:
"Symptoms are poorly understood and are not well publicised outside of the usual three: fever, persistent cough and loss of taste and/or smell. More symptoms need to be listed and a good education campaign

launched."
And you wanted to ask Nicola Sturgeon and others would they commit to that.
To what extent is this a concern? What are the sorts of symptoms, for example, you would like to see added either at the time you were having this meeting in March 2021 or indeed now?
A. To go back to this just before, I know that Mr Yousaf wrote to UKHSA, because they are the owners of the symptoms, so to speak, to ask if it could be extended and they declined to do that. The issue is, for us, we've got an awful lot of people who have been bereaved by Covid and those symptoms were not the primary symptoms, particularly in the early days when it only went with fever and persistent cough, before they added loss of taste or smell, and, as I mentioned earlier, particularly with older patients who didn't present with those symptoms as well. So it was a big concern.
I suspect that a lot of it, again, was down to lack of testing capacity, but we should have had -- even if we couldn't test for it, we should have had more education given to the public saying "These are the main symptoms, but you might also experience gastric symptoms, you might experience lethargy, confusion and things like that".

Q. So would the result of such an approach have been more precautionary in the way that it would have perhaps prompted more people to take a test or more people to regulate their conduct such to minimise the risk that they might spread of the virus if they had it?
A. Yes, yes.
Q. Rather than being restrictive, a wider definition may have had that effect?
A. Yeah. And it also had the effect that we do have some -- a few people who lost someone where they thought they had Covid but because they didn't have those three symptoms -- well, this is particularly in the beginning when it was just the two, they were told "You don't have Covid", they were denied a test because they didn't meet the criteria, and it was very difficult for them to get help, because they were told through 111 or the testing system "Well, you haven't got these symptoms so it's not Covid".
Q. Thank you.

I understand from the materials that you've provided, your own statements and those on behalf of the group, that there were a number of meetings, not just the one we've mentioned with Ms Sturgeon, but a number of meetings with others, including Mr Swinney and Mr Yourself, subsequently and you've referred to an

extent to a reply that Mr Yousaf was able to get you on that particular issue about symptoms.

Broadly speaking, having looked at the materials for this, it seems to be our impression that the focus of these meetings, as far as the Scottish Government was concerned, was really about securing a Scottish Inquiry?
A. Yes.
Q. But that other than that particular issue about symptoms, you didn't seem to get very many answers to the many legitimate issues that you've listed. Would that be a fair summary?
A. Yes, I think that would be, yes.
Q. So what that means, in effect, is that these questions still remain questions for the group?
A. Yes.
Q. And you are turning to this Inquiry and the Scottish Inquiry to try to find them out?
A. Yes.
Q. Although you had been trying to get these answers for a long time, at least -- certainly at least since March 2021?
A. Yes.
Q. There are a number of other areas that are covered in the statements, all of which have been taken into account, I can assure you, Mrs Morrison, in the way that

we've prepared this module and indeed others. I have no further questions for you, but I would like to offer you the opportunity to say what you would like, and if there's anything else you'd like to add, please do so.
A. Thank you.

Yes, it's -- we all want the same thing, which is we all want answers, to make sure that this does not happen again, and it will only work if everyone speaking to the Inquiry, particularly the politicians and the decision-makers, are completely candid and they don't have selective amnesia, which seems to have been apparent in some of the previous issues.

That's -- we need the truth and we need people to be honest, and if they made a mistake, be big enough to admit you made a mistake.

MR DAWSON: Thank you very much, Mrs Morrison. I have no further questions for you.

My Lady.

LADY HALLETT: Are there any core participant questions?
MR DAWSON: There are no core participant questions, as I understand.
LADY HALLETT: No, I have no other questions, Mrs Morrison. Thank you so much for all your help. You mentioned earlier that you carried out the research to cope with your grief. Have you found it any comfort?

THE WITNESS: I have, my Lady, thank you, yes.
LADY HALLETT: Well, it's really helpful to the rest of us, obviously, because you raise some really important points, and between us I hope the Scottish Inquiry and this Inquiry can answer as many of them as possible so with the help of people -- what I find really interesting about the way you've described your experience and the loss of your wife Jacky is that you have been constructive, you haven't just been critical, you have been trying to ask questions to which there might be an answer, so I'm really grateful to you.
THE WITNESS: Thank you, my Lady.
LADY HALLETT: And this cough is not Covid, I promise. I have tested so many times I've run out of tests. But as those who have been following me in this Inquiry will know, I do get coughs every so often.

So thank you very much for your help.
THE WITNESS: Thank you, my Lady.

(The witness withdrew)

MR DAWSON: My Lady, the next witness will be Roz Foyer from the Scottish TUC, which my colleague Mr Tariq will be conducting. So we require a little changing around, but it will only take a few seconds.
LADY HALLETT: That's fine, thank you.

(Pause)

MR TARIQ: May I please call Rozanne Foyer.

MS ROZANNE FOYER (affirmed)

Questions from COUNSEL TO THE INQUIRY

MR TARIQ: Ms Foyer, thank you for your assistance to the Inquiry to date. There are a few preliminary matters I want to talk about before we get to your evidence. Could you please keep your voice up and speak into the microphone so that the stenographer can hear you for the purpose of the transcript. If any of my questions are unclear, please say so and I will rephrase and ask the question again.

The Scottish Trades Union Congress, the STUC, has provided the Inquiry with a witness statement that's dated 6 July 2023. The statement is at INQ000103536.

Can we please have this onscreen.

This is a corporate statement that's been submitted on behalf of the STUC, and you were the author of this statement; is that correct?

A. That is correct.

Q. If we turn to the final page, which is page 33, there is a signature that is hidden behind the personal data, but it would be your signature on this statement; is that correct?

A. Yes, that's correct.

Q. Are the contents of this statement true to the best of your knowledge and belief?

A. Yes, they are.

Q. I now want to turn to the STUC's role during the pandemic.

You are the general secretary of the STUC; is that right?

A. Yes, I am.

Q. The STUC is a national lobbying, campaigning and co-ordinating body for trade unions in Scotland; is that correct?

A. That is correct.

Q. It represents over 540,000 members in Scotland; is that correct?

A. Yes, that's right.

Q. The organisation's campaigning and lobbying continued during the pandemic and covered a whole range of workers' rights, issues and interests; is that correct?

A. Yes, it is.

Q. I want to discuss the issue of the Scottish Government's engagement with the STUC during the pandemic.

Is it right that the STUC frequently had meetings with the Scottish Government throughout the pandemic?

A. Yes, we had a forum of engagement and we met the Scottish Government twice weekly, specifically to bring the views and concerns of trade unions to the table.

That reduced to once weekly and then, towards the end of the pandemic, to monthly meetings. But we had other meetings outwith those meetings with specific government ministers on a range of key issues.

Q. You personally attended a large number of these meetings; is that right?

A. Yes, I would say the vast majority of those meetings.

Q. In general terms, what is the STUC's position on the Scottish Government's engagement with the STUC during the pandemic? For example, did you find that the Scottish Government was willing to listen to your concerns raised on behalf of your members?

A. Yeah, I would say that in general terms I would describe the engagement that we had as intense and constructive. There was an established relationship there already. The Scottish Government do see trade unions as a key social partner, and they have a collaborative working approach, so we had an established relationship there already, but that relationship intensified during the pandemic because I think the Scottish Government recognised that we could be very helpful in giving them a real picture of what was happening in workplaces, and particularly in workplaces where key workers were working, delivering essential services across the economy.

Q. I want to explore a little bit more about the engagement. Within the STUC's witness statement, you identify areas where you felt that there was insufficient engagement by the Scottish Government with the STUC. One example is the return of people to office working. Your position is that the Scottish Government consulted fully with the Scottish Chambers of Commerce, but had limited engagement with the STUC about that issue.

Was this around the time that the lockdown restrictions were being eased in early summer 2020?

A. Yes, that was one of a number of examples where we were not shy in letting the Scottish Government know that we were unhappy not to be engaged. There are several examples of this that you will find throughout our evidence, in the minutes of the meetings that we provided. So although the engagement and access was there, we did have issues fairly frequently about late engagement or the order of engagement.

We always have an ethos as trade unionists that there should be nothing about us without us, and that workers' voices are very important, and that's actually part of Scottish Government's Fair Work Framework.

So we're not shy in letting the government know what we feel we have been not consulted fully enough.

Q. I want to just focus on that issue that I raised, which is return of people to office working. This is as we were easing out of the first lockdown in early summer 2020. At the time the Scottish Government's strategy was to ease restrictions more gradually than the UK Government, and we've heard evidence in Module 2 that the UK Government was keen to get workers back into offices and into workplaces. What views did the STUC have on the Scottish Government's position on the return of workers to offices and workplaces at that time?

A. Well, we were cautious about it, we had clear safety concerns, and we had a set of criteria that we'd laid out, that we'd communicated with government, that we felt should be met, around areas like testing and making sure that proper safety guidance was in place in the workplaces that would be returning, and we worked to produce workplace level public safety guidance for a range of key sectors.

So there were some areas where we had concerns that things were moving too quickly, but I think overall we were quite critical of the approach being taken at the time by the UK Government, which we felt in some ways was undermining the more cautious approach of the Scottish Government, and that mixed signalling could be quite confusing to the public in Scotland. So,

you know, we had times where the Scottish Government were saying that only certain types of workplace should be coming back, and there was a very gradual loosening of the restrictions, keeping a very close eye on the numbers of cases and those levels, and at the same time we had announcements coming out of the UK Government, you know, that the Eat Out to Help Out scheme and other things that were taking place where, you know, Boris Johnson made announcements about all non-essential workplaces, people should get back to work and get back into city centres. So there was a lot of differences there that we were really concerned about.

But overall, although we had some -- I mean, I think I put out a press release in July 2020 criticising Scottish Government for relaxing the 2-metre distancing down to 1 metre, so we were critical where we felt things were going too fast, but overall we were very engaged with that approach and we felt we were able to influence a more cautious approach by the Scottish Government to opening up.

Q. There's a few questions, follow-up questions that I have. Going back to particularly the issue around return of workers back into offices and work spaces, you say that the Scottish Government had consulted fully with the Chambers of Commerce, but there was limited

engagement with the STUC. Can you explain whose interests the Chambers of Commerce represents?

A. So the Chambers of Commerce is a business representative organisation, it represents all sorts of different businesses and employers, and there were a number of -- I'm not sure to -- the very specific reference you're making, but there were a number of occasions where if we felt that communication had happened, you know, with employers first and there had been a document produced, for example, and we weren't in the room to put the view of workers in those sectors across, we would have taken issue with that. Because, you know, the order of consultation is quite important. It's important that views are taken on in an open way, and often some -- the best way to deal with issues like that can be through tripartite discussions at times with the government.

Q. Now, we are discussing the period around the easing of the first lockdown, and within the STUC's statement you say that there was many occasions where the STUC raised, and I think you say, "serious concerns" and had heated and robust exchanges with the Scottish Government, and one of those areas that you've identified in the statement is the easing of the first lockdown.

I think what I've seen is that the STUC had set out a criteria, and I think you've touched upon this in your

oral evidence, that the STUC wanted to be met before we would come out of the first lockdown, and that included things such as capacity to supply PPE to non-essential workplaces, the continuation of the job retention scheme and other supports for those who could not work, and the STUC's position, as far as I understand it from the statement, is that it does not consider that there was sufficient measures in place to lift the first lockdown.

What were the key measures that STUC considers were missing at the time the Scottish Government lifted the first national lockdown?

A. There were concerns that we had in relation to the provision of PPE. We had asked for surety that -- we felt there would be a much higher demand across different employment groups for PPE if more people were coming back into the workplace and we felt that this needed to be made clear to us that that provision was in place because we had real concerns. Having seen the experience of workers who were in essential services, key workers who hadn't been able to access PPE during the first lockdown, what we didn't want to happen was that supply would be diverted in any way away from frontline services, given that the rest of the economy was opening up and there would be demands for PPE.

Other areas that we were concerned about was just

making sure that there was appropriate safety guidance in place that had been worked on and put in place for different sectors of the economy for workplaces that were returning to work, and we had concerns that employers were not following that guidance, and that, you know, they were not putting appropriate safety measures in place, based on some of the feedback that we'd received.

Q. So these measures, is it my understanding that these measures were not put in place sufficiently to STUC's satisfaction at the time that Scotland came out of the first national lockdown?

A. Yes, there was definitely gaps that we could see, but equally there were some areas that had been met, so there was a good sort of track -- testing regime in place and a track and trace regime that they had put in place. So these things were things that we welcomed but we were also raising concerns.

Another area that we were still very concerned about was the ability of workers to isolate and we felt that there was a real gap in provision across the economy, because the UK Government's statutory sick pay was not adequate to allow workers in low paid jobs to isolate if they were, you know, told by the track and trace people that they had been, you know, in contact with someone

with symptoms. So that was something that we had a real concern about, and I think we actually -- there is a document within the evidence where we wrote to the First Minister, welcoming some parts of what had been done, but raising some of the concerns that we had.

Q. Do you think that the Scottish Government properly listened to the STUC's concerns prior to announcing the roadmap for the lifting of the first lockdown?

A. I think they did listen, I think they engaged. I don't think we always got everything we wanted but I think that there was a respectful engagement, in most cases, with the trade unions.

I think to some extent issues like statutory sick pay were not in their gift to resolve, that was an issue the UK Government needed to resolve, and I am aware that the Scottish Government did write to UK Government ministers seeking funds to address some of those issues, and, you know, seeking for them to address some of those issues. So the -- I think they definitely did listen; that doesn't mean they always acted. And I think that's just the nature of things, isn't it?

Q. In terms of listening but not necessarily acting on some of the approaches advocated by the STUC around this time, what were the consequences of the Scottish Government not following the STUC's approach at the time

of lifting of the first national lockdown for your members, what were the consequences for them?

A. Well, there were grave consequences potentially for our members. We had seen that -- you know, you can tell from the figures around Covid, around the deaths, that there is definitely a link with death rates to the sort of work that people carried out, and that people who were in involved in certain occupations were in more danger from the virus, and I think that we'd seen people in really frontline services on very low pay really in the eye of the storm, and not receiving proper PPE, safety measures not being in place at the beginning. So we were very cautious and very aware of the fear of our members about getting up and going to work every day, and the idea that that was going to affect more workers who perhaps weren't delivering essential services. We had real concerns that there weren't appropriate safety measures in place, and that they could come under pressure to cut corners from unscrupulous employers. So there was a real caution there on our part.

Our approach was very much safety first, that no worker should have their life put at risk in order to keep the economy going. You know, workers are not expendable.

Q. One of the areas where we've seen kind of the theme of

that in the evidence is that you raised concerns with the Scottish Government in relation to aviation workers, and the STUC has produced a note of a meeting it had with representatives of the Scottish Government on 10 July 2020.

That note can be found at INQ000107203.

I don't intend to bring up that note, but it's a meeting that was attended by you, the Scottish Government's Minister for Business, Fair Work and Skills, Jamie Hepburn, and the Minister for Older People and Equalities, Christina McKelvie, amongst others.

In relation to aviation workers, the note says:

"RF [and that's you] underlined the urgency in this area and of the real desperation for some deep and meaningful discussions with the Scottish Government and employers but reiterated the disappointment in learning that discussions between the Scottish Government and employers had already been held without Union involvement."

So this is a note from July 2020 and it touches upon a theme that you've already addressed, which is sometimes the order of engagement wasn't correct.

A. Yeah.

Q. In terms of the time period, this was a period when Scotland was coming out of the lockdown more slowly than

in England. Do you recall around that time what the concerns were of aviation workers?

A. Yes. There was a real concern about, frankly, a collapse in the industry and that -- you know, many of these workers -- aviation had virtually, you know, closed down, it was in a very precarious position, so there was a real concern that, you know, those jobs would be required in the re-opening of the economy, they were vital jobs when things went back to normal; however, the companies involved in delivering those very important services were in real trouble and there was a potential retention issue that could happen in that sector.

Our -- we were -- we very much welcomed the fact that the Scottish Government were looking at this, it was something our members had raised, but what we objected to was that they were perhaps going and speaking to employers, some employers who did not take very seriously worker voice or recognise trade unions, and part of the agreed approach of the Scottish Government is to take a fair work approach to any public funding or support that they give, and a big component of the fair work approach is to respect worker voice. So the point we were making was that we really needed workers' voices to be in that room with discussions

about what was needed.

Actually that came good in the end because what we ended up with was that the STUC did end up in the room with employers in that sector and with the Scottish Government leading discussions about investment in a skills package to upskill workers in that sector, and that actually helped resolve some of the issues that we saw when the economy re-opened.

You'll be aware that in some parts of the UK there was real difficulty with finding baggage handlers, et cetera, to re-open the airports. That wasn't quite so much of an issue in Scotland. I think some of the work that was done there actually helped further down the line.

Q. The time period of this meeting and you raising your concerns is interesting, because it's July 2020, and we know that there's some evidence that the second wave of infection in Scotland was caused by holidaymakers returning from continental Europe, in particular Spain. Did workers in the aviation industry raise concerns with the STUC about the number of people that were wanting to go abroad in summer 2020 and possibly bringing back the virus and how this would expose workers to the virus or implicate them in outbreaks in Scotland?

A. The workers in the aviation sector were primarily

concerned with the guide -- following health and safety guidance for them while they were in the workplace. We didn't have concerns so much raised around them not wishing to be in the workplace at that point.

I think the overriding concern for a lot of workers in that sector was that there was about to be a complete collapse in, you know, their jobs. So there was a lot of concern about the security of their jobs at that point, and I think that underlines the issue that we're dealing with here, that, you know, we have people who -- you know, it's important to be able to have money and not be in financial constraints and to have a job. So there was -- a campaigning approach that we had was that we were campaigning to save lives but also to save jobs.

Q. You touched earlier upon the issue of funding between the Scottish Government and the UK Government, and the STUC's position in its statement is that there was frustration that some actions that the Scottish Government agreed with the STUC as being essential could not be implemented by the Scottish Government due to the limits of devolution or a lack of funding or financial support from the UK Government. Can you provide examples of key actions that the STUC agreed with the Scottish Government but which could not be implemented because of devolution or the funding arrangements?

A. Yeah, I think that the statutory sick pay example is actually one of the most important ones, and I think there's -- there is an issue around, you know, Scottish Government through devolution has a responsibility to deliver health, you know, local government, education, all these essential services that were very crucial during the pandemic, but they don't have the budget control. So there had been, you know, a decade of austerity cuts taking place there, and similarly we had a situation with -- you know, we were in control of public safety, they were issuing guidance to the people of Scotland, saying that, you know, if you're tracked and traced as being in contact with someone that had the virus you need to isolate for so many days, but if people are materially unable to follow that guidance because it would cause them severe financial hardship, then we have a situation where the UK Government's policy was undermining the Scottish Government's devolved policy and responsibilities.

So, you know, at the end of the day there's nothing the Scottish Government can do to change statutory sick pay or those sorts of arrangements, they don't have the budgets to undertake that scale of policy. So we had a situation where -- you know, we know Scottish Government wrote to UK Government, they agreed with us

that something should be done to improve statutory sick pay, but we didn't get any shift on that, unfortunately.

Q. That's an area that the Inquiry will explore in more detail with other witnesses, but did you ever have the impression that the Scottish Government could have done more on some of the matters that you were pushing but it was easier to attribute blame to the UK Government for not being able to take some of these actions forwards?

A. I -- I often get that impression, in all sorts of areas. The STUC is very active in pushing the Scottish Government just generally to use all of its devolved powers, particularly its fiscal powers, in terms of more progressive taxation, to allow them the budgets to do more, but I also have to acknowledge that it's difficult to do that and that the powers they have fiscally are limited and, you know, you -- it's very hard for the Scottish Government to overcome ten years of austerity and budget cuts to public services. It's very hard for the Scottish Government to go beyond their devolved responsibilities.

One thing I think the Scottish Government did do when we raised particular concerns about workers in the care sector, because you had a sort of perfect storm, I think, in the care sector where you had workers on very low pay who were, crucially, in touch with some of

the most vulnerable people when it came to the virus, and providing personal care to them, whether it was in their homes or in care homes, and these workers in many cases did not have access to appropriate levels of sick pay. The Scottish Government did very early on create a fund from their own budget, I think it was launched in June, a social care fund that allowed social care workers, whether they be agency workers or working in the private, voluntary or public sector, to access sick pay to cover their pay in order to allow them to isolate. So that was one example of where I feel they did act. And they had limited ability because of budgetary constraints to do that, but that was the only -- it was almost like they picked the most important area they could, knowing their constraints, when actually what we needed was that to be happening right across all workers for them to be able to isolate properly.

Q. My question was around specific areas or actions that you agreed with the Scottish Government where you felt -- or you had the impression that maybe the Scottish Government didn't push the matter forward and it was easier to attribute blame to the UK Government. Is there anything of that nature during the Scottish Government's decision-making in the pandemic that you

can point to?

A. I don't think that there's anything I would specifically point to and say, you know, no, that was complete nonsense, that they were saying this would be difficult to enact. I think where they -- I think I could see there was reasonable reasons, budgetary constraints or otherwise, why in some cases they weren't able to do things, and I don't think that they were making that up. I think it was the reality -- the political reality of the way devolution works, that there were certain things they weren't able to do that we were calling to happen.

So I'm not sure I could point to anything that really stuck out as being something where I thought they were being disingenuous in saying that they were constrained. I think the constraints were very real.

Q. I'm now coming towards the final topic, which is I just want to touch upon in terms of impact on minorities. Is it correct that the STUC carried out surveys in respect of the impact of the pandemic on minorities such as ethnic minorities and disabled workers?

A. Yes, it is.

Q. Generally, what did these surveys show about the impact of the Scottish Government's decision-making on minority groups?

A. Well, one of the concerning things that our surveys

showed was that there was a disproportionate impact on people from BAME communities, who tended more often to be working in roles that would place them in greater exposure to the virus, so sort of low paid roles within, you know, health, social care and areas like that.

The other issue that became clear was that for a lot of disabled workers there were serious issues emerging, both in terms of not enough provision in the re-opening of the economy to workers who might have specific needs and be shielding, but also things like a lot of people losing their reasonable adjustments that they had in the workplace when they were shifted to home working, and adequate provision not following them into their home working at times.

And also a lot of our surveys showed, you know, higher rates of mental health, you know, people experiencing poor mental health, a higher rate of anxiety, I would say, among people from groups such as disabled workers or the BAME community.

Q. Did you raise these concerns with the Scottish Government at the time, and if so --

A. Yes.

Q. -- did the Scottish Government properly engage with you on these concerns, and did you see that then being actioned in the Scottish Government's decision-making?

A. So in -- quite early on our Black Workers' Committee wrote a letter to the First Minister, an open letter, raising a number of these issues, and asking the Scottish Government to put more priority into collecting data relating to black and minority ethnic communities and the impacts of the virus on them, and that's something that they did take steps to try to rectify and start to work on.

Some of the issues that we were raising were very systemic, though, and related to the fact that people from these communities are more likely to be in lower paid roles, more precarious roles, and areas that were more likely to be disproportionately impacted by the virus.

Q. I now want to conclude by asking you about potential lessons learnt by the STUC about the Scottish Government's decision-making during the pandemic. Do you believe that the Scottish Government's decision-making in relation to the concerns of workers, including engagement with the STUC, could be improved in a future pandemic situation? If your answer is yes, how?

A. So I think that definitely there could be improvements in decision-making.

I think that what we've seen is that cuts to

essential services, that that prolonged period of cuts and that austerity that was implemented by the Scottish Government -- it may have been caused by the UK Government but it was certainly followed and implemented by the Scottish Government -- it left services with no resilience and very ill equipped to meet the needs of the pandemic at a time of crisis.

I think that PPE reserves are something that, you know, must be taken into account in the future.

I think that, you know, we need to overhaul and adequately fund our whole health and social care, particularly the social care side, of our public services, and that's ongoing work that we are now engaged in with the Scottish Government. And I think that there were key lessons about enforcement agencies.

So, for example, the Health and Safety Executive, which is a UK body, I feel did not engage appropriately with the workplace guidance, safety guidance that was issued by the Scottish Government under its public health responsibilities, and I think that was a missed opportunity to disseminate this information effectively to employers and workers. What tended to happen was it was union reps in areas that were well organised that were using these tools, but what about areas where there isn't a trade union?

So that was something I think we need to think about and think about, you know, how our devolution works and the responsibilities of Scottish Government.

And I also think that given the public health data shows that, you know, there is a clear link between worker occupation groupings and the likelihood to contract and indeed have fatal consequences with this virus, that we need to start looking at Covid as being an industrial injury and see it through that lens. So I think a lesson that we need to learn for the future is that, you know, for the people who suffered long-term consequences such as death or Long Covid and their families, this should be treated as an industrial injury in the same way as, you know, people who have asbestos-related injuries or long-term health conditions are treated.

Q. The final question from me is just giving you an opportunity to say if there's anything further that you want to add to your evidence.

A. Yes, thank you.

I would just want to say that for the STUC the people whose story most deserves to be heard in this Inquiry is the key workers who put themselves and their families at risk to provide essential services at a time of real crisis. Many of those workers were on poverty

pay rates, the majority were women, and disproportionately they came from black and ethnic minority backgrounds, and the sad reality is that too many of those workers lost their lives protecting us. But I don't think we protected them enough.

Our testimony to the Inquiry makes clear that years of brutal austerity has fundamentally altered our public services, with lethal consequences. Workers across our economy, especially in health and social care, were really dangerously exposed to the virus through a deadly combination of understaffing, PPE shortages, and poor pandemic planning from central government, with a Health and Safety Executive that was hamstrung by budget cuts and with limits on devolution. And the Scottish Government were unable to effectively legislate on employment and health and safety matters, and working people were really caught in the crossfire of that, and I think there were grave results of that.

So I think lessons really do need to be learned. I welcome this Inquiry and I welcome our opportunity to contribute to it. Governments can't repeat the same mistakes that led to, unfortunately, some very unnecessary and tragic deaths of many workers throughout our country.

MR TARIQ: Ms Foyer, thank you for your evidence.

There's no further questions, my Lady, from me.
LADY HALLETT: No, I have no further questions.
Thank you very much indeed, Ms Foyer, very grateful to you.
(The witness withdrew)
LADY HALLETT: We'll break now, because I think we need to make arrangements for the next witness. So I shall return at 11.30.
MR TARIQ: I'm obliged.
(11.13 am)
(A short break)
(11.30 am)
LADY HALLETT: Ms Arlidge.
MS ARLIDGE: My Lady, may I please call Dr Jim Elder-Woodward OBE.
DR JIM ELDER-WOODWARD (sworn)
MS PATRYCJA PASTERNAK (sworn)
LADY HALLETT: I'll just explain to people, we have asked for Dr Elder-Woodward's assistant to be sworn in, just in case she has to help in any way with any communication issues.
THE WITNESS: Thank you, my Lady.
LADY HALLETT: Not at all.
Questions from COUNSEL TO THE INQUIRY
MS ARLIDGE: Thank you very much.

Dr Elder-Woodward, you have provided two statements to the Inquiry, one in your capacity as co-convener of Inclusion Scotland and a supplementary personal statement. The reference for the Inclusion Scotland statement is INQ000371664. Hopefully you will see that on your screen in front of you, and it will be a familiar document to you.
A. Yes.
Q. On page 23 of that, you've signed that statement on behalf of yourself and Inclusion Scotland, haven't you?
A. Yes.
Q. You have also provided a supplementary statement. The INQ reference, I'm afraid I do not have to hand immediately but we'll have it in a moment, and that is a personal statement in which you exhibit a number of documents setting out your own personal lived experience of the pandemic; is that right?
A. Yes, that's right.
Q. We'll be looking at both aspects of that in the course of your evidence today. In the course of your evidence if there's anything that I say that is not clear, please do just ask me to repeat myself. Of course if there's any elements that you would like your assistant to help you with, please do so.
If we turn first to your personal experiences of the

pandemic, if we may. You suffer from -- sorry, you were, until 1999, a senior social work officer at Glasgow City Council; that's right, isn't it?
A. Yes.
Q. During your time with local government, were you involved in establishing indirect and direct payments into --
A. Yes, I was.
Q. Did you also assist in the development of the Glasgow Centre for Inclusive Living?
A. Yes, I did. Yes.
Q. So you therefore had quite the experience of dealing with bureaucracy and accessing services, because you'd been your own -- you'd done that for other people as well, hadn't you?
A. Yes.
Q. You retired, of course, long before the pandemic started, but you, as part of your needs, had a package in place for support; is that right?
A. Yes, it was a 24-hour package.
Q. 24-hour --
A. Day and night.
Q. With personal assistants assisting you for the whole 24 hours a day?
A. Yes. I've got a team of five part-time personal

assistants who I manage myself.
Q. Effectively you're given a sort of budget to employ assistants to cover your needs within that budget?
A. Yes, and Patty's one of them.
Q. Yes. When lockdown came, two of your personal assistants were unable to continue assisting you, due to their own personal circumstances; is that correct?
A. Yes, that's right.
Q. In terms of having control of the budget for employing those personal assistants, how did that cause difficulties for you?
A. Well, to begin with, I didn't know where the money would come from to pay for their self-isolation, because I had to find additional support. I also cut the hours of support because there was insufficient support available.
Q. So --
A. I was fortunate enough to receive support from the Independent Living Fund. I don't know if you've heard about that but it's a fund whereby people receiving money from their local authority can go to the Fund for additional money. And although I wasn't receiving much, I did receive support from my local authority, the Fund was able to give me more money to pay for the furlough of the people taking self-isolation. Did that answer

the point?
Q. So when you, having reduced your own personal assistant support, you effectively had to seek assistance elsewhere to try and maintain some level of support that would keep you safe --
A. Yes.
Q. -- and keep you as healthy as you could be?
A. Yes.
Q. In circumstances where you were responsible for employing your own carers -- sorry, personal assistants, and having to put two on furlough or statutory sick pay, did that in itself cause you stress and concern and extra workload at quite the time when you didn't need it?
A. Yes. I'm afraid the person that came in to help, she stole money from me and jewellery from the house, so I was under extreme stress because the police couldn't help me and I had a bit of a collapse, at which time my nephew took control of my support package.
Q. And you suffered both sort of mentally and physically as a result of this stress, didn't you?
A. Yes, I did.
Q. You were able, as a result of your previous knowledge and your previous role at Glasgow City Council, and as a result of your knowledge and experience through

Inclusion Scotland, you're a very adept, knowledgeable expert in accessing services and advocating for not only your own rights but for those other people who require assistance?
A. Yes, but even so I found it very difficult living with Covid, because everything was locked down, so even I couldn't find the support I needed. With all my professional and academic contacts, I still couldn't get the support I needed.
Q. If I may read from a document you've produced for this Inquiry, you say:

"But I often wonder: what about those who may not be so blessed by these resources? What efforts are being made to develop their agency and social networks? Doesn't this pandemic highlight the need to develop peer advocacy and group identity, peer support?"

A. Yes, that's been a long campaign on behalf of the movement that we need more peer support, because peer support is much more effective than non-peer support. With peer support there's empathy and knowledge of the situation of the person.
Q. If we move, therefore, in that very vein, on to your work with Inclusion Scotland, is it right that you're the co-convener of Inclusion Scotland?
A. Yes, I am.

Q. And you have been in that post since November 2023, so after the pandemic, but you have been a board member since 2005?
A. Yes.
Q. And in that role, you are responsible for various things, including overseeing the governance of the organisation and representing the board at meetings, including with Scottish Government and others; is that right?
A. Yes.
Q. Just to assist the Inquiry and my Lady and those listening, Inclusion Scotland is a registered charity, it's a disabled people's organisation, and it is led therefore by people who have -- are disabled themselves or deaf or hard of hearing; is that right?
A. Yes, that's right.
Q. So it's a -- is it right to say that it is both a support network for people and an advocacy network seeking to achieve change in government and to represent individuals' rights?
A. It's in support of all local disabled people's organisations. We don't support individuals.
Q. No.
A. We support local and national organisations, but we do have two programmes funded by the Scottish Government to

support people in employment and to support people to enter the political system when they join political parties or they stand for local or national elections we offer support to people to stand for elections.
Q. And the focus of the groups within Inclusion Scotland, the operational focus of Inclusion Scotland is disabled people within the community rather than, for example, in residential care homes and the like?
A. In the majority, yes.
Q. Inclusion Scotland, would you say, worked closely with Scottish Government and others throughout, prior to the pandemic, as an advocacy service and a representative service seeking to influence policy in government?
A. We found the engagement very open.
Q. And you found that there was a level of proper access and two-way dialogues; is that fair?
A. On the whole. The government isn't one entity, it's different departments and several people within the departments, but we had some good relations and some not so good relations within the government, if that's understood.
Q. It's no doubt part and parcel of the enormous machinery of government that's --
A. Exactly.
Q. And as part of the engagement with government --

sometimes good, sometimes less good -- part of that was Inclusion Scotland actively seeking to inform government -- different parts about different things, no doubt -- about things such as structural discrimination, barriers to access on the part of disabled people and the denial, you say in your statement, of human rights that disabled people face?

A. Yes.

Q. In your witness statement, for the corporate statement, you set out a number of references, for example, to the UN Committees, and is that the sort of thing, with international knowledge brought to bear and informing the Scottish Government about that, Inclusion Scotland were keen to ensure was happening?

A. We have links with our colleagues in Europe as well as internationally, so there is an international movement of DPOs, a European network of DPOs and a Scottish network of DPOs and we have links with all three.

Q. So you could bring those networks together to influence and inform Scottish Government of --

A. Yes.

Q. -- matters.

You say in your statement at paragraph 9 -- I'll just read it out, because I think it's an element of your statement that you're particularly keen to draw

out:

"Going into the pandemic, disabled people did not enjoy the human rights set out in the UN Convention on the Rights of Persons with Disabilities. Instead, disabled people already experienced unequal outcomes and lacked the support and resilience to deal with such an emergency. It was transparently clear that this was compounded by the negative impacts of Covid-19 and core decisions taken by Scottish Government."

A. Yes.

Q. Is that something that you found particularly important to bring out?

A. Yes. Pre-pandemic, disabled people were in a dire state of not being supported by the community, not supported by the government, having their benefits reduced, having their social care reduced and the reduction of services in the austerity period. We were in a crisis situation pre-pandemic.

Q. And those, that crisis was multifactorial, wasn't it? So there would be issues about access to suitable housing, accessible housing?

A. Yes.

Q. But issues within the home, within people's homes that exacerbated --

A. Yes, some people couldn't even go to the toilet in their

homes, the kitchens were inaccessible to other people and they were waiting long, long times to be rehoused. So people were imprisoned even within their own dwellings.

Q. Even before the pandemic?

A. Even before the pandemic.

Q. Then the pandemic came along and worsened the situation yet further; is that right?

A. Absolutely.

Q. Inclusion Scotland carried out a survey in April 2020, didn't they?

A. Yes.

Q. So very early on in the pandemic, and you've presented -- Inclusion Scotland produced a report based on that survey of 800 members, and in that survey, which is -- we don't need to bring this up on screen, but you comment on a couple of the findings in your statement, the reference for the transcript is INQ000366004, and you say:

"Respondents say they felt abandoned, a number reported feeling suicidal, they talked of isolation and loneliness, the impact of the loss of essential social care supported by independent living, difficulties accessing foods and necessities, fears about being denied treatment, and the involuntary

imposition of Do Not Attempt Cardiopulmonary Resuscitation."

A. Yes.

Q. Both in terms of the survey findings, also these were presumably matters that were being brought to the attention of Inclusion Scotland on an anecdotal basis as well?

A. Yes, and we informed the government of the situation. We got this information from disabled people and we gave it to the government.

Q. Because in the context of lockdown, as you've already described in your own personal stories, but that your personal story was sadly replicated across many other individuals as well, who had issues accessing their personal assistants, they were unable to access, they had their support withdrawn because of lockdown, they had issues accessing medication, washing, food preparation, all things that would ordinarily hopefully form part of a package?

A. Shopping, shopping was a problem as was the emphasis by the government on using digital information, because many disabled people because of their poverty do not have access to the world wide web so the reliance by the government on digital information hampered the knowledge of disabled people.

Q. So the isolation that existed was compounded, wasn't it, because of the lack of ability in some circumstances to access the data that was being -- or the information that was being provided by the Scottish Government; is that right?
A. Yes.
Q. Therefore both access to the knowledge of what was happening was an issue but also access to the healthcare generally and support was an issue?
A. Yes, and also the lack of being able to help them in their interpretation of the information, there were no advisory services which could interpret the information to individuals' own situation particularly those with intellectual disabilities, the information wasn't in Easy Read, nor were there any facilities, to help people interpret the information to their own situation.
Q. So it was a dual issue, people couldn't access the information themselves directly, and because of the withdrawal of support, they couldn't access the support that they needed to interpret that information?
A. Exactly.
Q. Turning to sort of some of the other practical impacts on those with disabilities and that Inclusion Scotland speak to, were there issues with, for instance, access to food and medication as a result of the imposition of

lockdown and other non-pharmaceutical interventions?
A. That was the case, that was the case in many situations. In others, they felt they had to come out of isolation, come out of the lockdown to go into the community to get aid and support and to get medication. The other problem some people had was they couldn't get access to the dietary requirements that they needed for their impairment, the availability of special diets was a problem.
Q. So people with disabilities were having to break shielding, for example, despite their own vulnerabilities, in order to access services because the support that had previously been in place was no longer there, and in order to --
A. Exactly.
Q. -- get their food, their specialist medication and the like, they were having to put themselves at further risk; is that right?
A. Yes, some people reverted to the social media, I'm talking about Twitter and that sort of thing, to find another source of medication in the social media area.
Q. And then if we look at other aspects that you've mentioned in the report -- corporate statement, I'm sorry, you talk about the impact on families and education, and you say at paragraph 34 of your witness

statement:

"Those caring for disabled children highlighted the impact of the loss of specialist educational support and respite. Parents with disabled children, including parents who were disabled people themselves, struggled with the additional strain of having to educate them at home without the skills or tools necessary. There are an estimated 10,000 children in Scotland with complex additional support needs prior to the pandemic. Many lost some or all of the specialist education and support they relied on."

So this is a sort of two-fold element to lockdown and schools closing and support being withdrawn, that you say hit those with disabled children particularly hard because they lost both the schooling and the special educational needs support that is inherent in schooling itself?
A. Yes. The lack of schooling, and the lack of support, especially for children with complex needs, particularly psychological needs, that added to the stress of parents because they had to deal with very difficult children 24 hours a day and there was no respite for them.
Q. Would you say that that was therefore compounded as well, particularly in the physical circumstances of lockdown where --

A. Absolutely.
Q. -- much closer?

You also talk in your statement about the impact of reasonable adjustments on those in the disabled community. For instance, in terms of face coverings, for those people with difficulties -- with communication difficulties, if someone was deaf, and relied upon lip-reading, for instance, the presence of face masks of course would cause them greater difficulty in accessing society?
A. That is true, very few people use the plastic masks which were see-through. Those windows in the masks help people who were deaf, and very, very few people even those working with deaf people didn't use that accommodation.
Q. You say some frontline service providers refused to step back and remove their mask or to use an alternative means of communication like pens and paper?
A. Yes, that was true.
Q. So simple adjustments that your organisation found were simply not being made; is that right?
A. Yes.
Q. Then of course for some people who were vulnerable to the infection with Covid, fear about people not following the rules, did that have an impact on social

integration and people being able to access their community?
A. Yes. There were instances where disabled people refused support for fear of being infected, that is the case. There is also the case that Professors Shakespeare and Watson brought up in Module 2, in that people particularly with learning disabilities were housed in group accommodation, which facilitated the transfer of the virus because they were living in close proximity to one another.
Q. We've spoken briefly already about the contact that Inclusion Scotland had with Scottish Government ministers and officials. You say at paragraph 53 of your statement:
"Despite it having been abundantly clear to the Scottish Government that disabled people would be gravely and disproportionately affected by Covid-19, and actions taken to mitigate it, this previously good level of engagement reduced suddenly as the pandemic took hold. This was presumably so that the Scottish Government could reset to deal with the emergency."
A. Yes.
Q. How long did it take until Inclusion Scotland became more involved again with Scottish Government?
A. I find it difficult to answer, because it didn't until

after the pandemic. I can't give an exact time, but it was after the pandemic that we were just beginning to pick up where we were pre-pandemic, and that is still an ongoing scenario, I'm afraid.
Q. Now, in your statement you talk -- you do go through some of the contact you have with Scottish Government. I won't take you through it. For those who would like to look at it, it's from paragraph 51 onwards to 101/102. All of those -- although the contact with Scottish Government obviously had fallen away and you felt there was less influence, is it fair to say, is it your evidence that despite the fact that you'd -- that Inclusion Scotland prior to the pandemic had been closely involved, and despite the offers and the attempts to engage with Scottish Government throughout the pandemic, even in all those circumstances the outcomes were just -- didn't reflect the efforts that Inclusion Scotland had put into improving that -- improving Scottish Government knowledge about the particular challenges facing the disabled community?
A. If I may, My Lady, answer that in more broad terms, rather philosophical terms, there is the procedure of engagement whereby the engagement is started and ended by authority, it is up to the authority to decide whether they want to engage or not. We can press them to

do it, to talk to us but it is their decision to start and it's their decision to end. So there's the process whereby the initiation and conclusion is in the hands of powerful people. Then when the engagement starts, at the beginning of the process and ends is upon them. It is important that we are involved at the beginning and not the end. Then there is the resourcing of us. We need resources in order to engage with the other party. Then there is the audit of their -- what is the outcome of our involvement, and that process is very difficult to assess.
Q. And --
A. Does that answer your question?
Q. It does.
Do you think that the Scottish Government should have turned more rapidly to the DPOs and Inclusion Scotland when it was clear that the virus was going to change lives and allow you to influence and give your advice and information to Scottish Government?
A. My Lady, we gave them ample opportunity, we gave them ample information, which they could use earlier than when they did, and if they wanted engagement to flourish we need to be involved right at the outset, not at the end of the decision-making process.
Q. You say in your statement, "We would have informed their

draft decision-making about the likely impacts for disabled people and the specific support that would be required before the negative impacts took effect". Do you say they missed that opportunity?
A. Absolutely.
Q. You also say at paragraph 108 of your statement:
"The equality unit disability roundtable and the Social Renewal Advisory Board were helpful in this regard but could be classed as too little, too late. Even so, our input was not always addressed to the extent and with the haste required by disabled people."
A. Yes, that's why I talk about the audit, there were no audits of our involvement.
Q. And to the extent that there was engagement, it was too late and it was too --
A. The engagement was too late, and we never knew what impact our involvement was. So we couldn't ascertain the outcome which could be attributed to our engagement.
Q. So you never were able to find out whether you were able to -- you didn't see the input that Inclusion Scotland were putting into things reflected in the output of Scottish Government?
A. Well, that's true generally. There were one or two instances, my Lady, when we could see the outcome, and that was in the £100 million to restart care packages,

but there was no audit of where that money went to, there was no transparency about where that money went to, because we didn't see any care packages being reopened. So although the government were listening to us, the local authority delivery of service was not.

Q. Turning just finally to the future recommendations that Inclusion Scotland have suggested, they're at paragraph 111 to 116 of your statement, and do you say that DPOs should be involved in emergency planning?

A. Yes. "There should be nothing about us without us". That, my Lady, is our motto, "There should be nothing about us without us".

Q. And there are a series of other recommendations, I won't take you through them, but I've just given the reference for the transcript.

Dr Elder-Woodward, is there anything else you would like to say?

A. Just a couple of things.

First of all, my Lady, there would have been more resilience to Covid if our socioeconomic rights had been delivered. The fact was that we were bereft of social and economic rights, that made us more, err -- I don't like the term "vulnerable" -- more susceptible to the Covid pandemic.

The other thing I wanted to talk about was the DNR.

On the DNR, we felt, people felt, that they were not wanted, that society didn't want them, because they put them on DNRs. That could have been a utilitarian approach to coping with Covid, but we would rather the Commandos' motto, "Leave no one behind". If that motto is true of army people under fire, it should also be true of society in dealing with pandemics, "Leave no one behind".

Thanks, my Lady.

LADY HALLETT: Very good motto.

THE WITNESS: Thank you, counsel.

MS ARLIDGE: My Lady, there are no CP questions. I do have the reference for the supplementary statement to be read into the record, with your leave. That's INQ000397354.

LADY HALLETT: Thank you very much.

Thank you very much indeed, Dr Elder-Woodward. I'm really sorry to hear some of what you've had to say, obviously, but you've been really helpful and I'm very grateful to you. Don't worry if on the journey home you think of something that you wish you'd said. A) I've got the written statement, and I take into account all the written material, not just what I hear here in the oral hearings; and also you have the advantage of being represented by very experienced King's Counsel, Mr Friedman, so he'll make sure that anything you want

to be put before the Inquiry will be put before the Inquiry.

So thank you very much indeed for your help.

THE WITNESS: My Lady, could I thank you for giving me the opportunity to come and give evidence.

LADY HALLETT: Not at all. Thank you.

(The witness withdrew)

LADY HALLETT: Right, I think I have to rise now for five minutes. I think everybody else stays, if they want to stay, and I go for five minutes. I shall return.

(12.15 pm)

(A short break)

(12.19 pm)

LADY HALLETT: Mr Dawson.

MR DAWSON: Good afternoon, my Lady. The next witness, there will be two witnesses giving evidence today, Mr Roger Halliday and Mr Scott Heald.

MR ROGER HALLIDAY (affirmed)

MR SCOTT HEALD (sworn)

Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 2A

MR DAWSON: You are Scott Heald?

MR HEALD: I am.

MR DAWSON: And you are David -- Roger Halliday?

MR HALLIDAY: Roger Halliday.

MR DAWSON: Could I just ask you, first of all, to try to speak into the microphones, but as you're giving evidence together, we'll try to avoid you speaking over each other -- I know you've got a lot of interesting things to tell us -- I'll try to direct my questions to each of you individually, but if you both have things to contribute in certain areas, I'd very much like to hear from both of you on those matters to the extent appropriate, thank you.

Mr Heald, you have provided a witness statement dated 11 October of this year to the Inquiry; is that right?

MR HEALD: That's right.

MR DAWSON: The Inquiry reference is INQ000335154. A copy has just come up.

If we could just go to the page 28. It's a couple of pages before that, I think. Yeah, that one there.

There you have signed the statement; is that correct?

MR HEALD: That's correct.

MR DAWSON: As far as you're concerned does the content of that statement remain true and accurate?

MR HEALD: It does.

MR DAWSON: Mr Halliday, similarly you have provided a statement to the Inquiry dated 15 November of this

year; is that correct?
MR HALLIDAY: Correct.
MR DAWSON: That's the statement there, it's under reference INQ000274011.
And again if we could go to the final page?
You see there you've signed the statement, is that correct?
MR HALLIDAY: Absolutely.
MR DAWSON: Does this statement remain true and accurate as far as you're concerned?
MR HALLIDAY: It does.
MR DAWSON: May I also ask my Lady simply to read into the record, we'll come later to some slides which have been put together relating to statistical matters, the reference for that being INQ000274150, and that's simply so that others can look at that if they consider it appropriate.
Could I start with you, Mr Halliday, just to get some details. You were the Chief Statistician for Scotland from 2011 to 25 April 2022 when you left the Scottish Government to become the chief executive of Research Data Scotland; is that correct?
MR HALLIDAY: Correct.
MR DAWSON: During the pandemic you held a number of roles in addition to being Chief Statistician. Perhaps most

relevantly for our Inquiry, you were the joint head of the Covid analytical team. Is that correct?
MR HALLIDAY: Correct.
MR DAWSON: I understand that the joint head of that team was a lady named Audrey MacDougall?
MR HALLIDAY: That's right.
MR DAWSON: And you were responsible for the quality and accuracy of the data that was published by the Scottish Government; is that correct?
MR HALLIDAY: That's absolutely correct.
MR DAWSON: And as part of your role, I understand that you were a member of a group that we've heard a little bit about already, the Scottish Government Covid Advisory Group; is that correct?
MR HALLIDAY: Yeah, from, until January 2021.
MR DAWSON: And you were a member of some other groups, something called the Scottish Covid chiefs group, until April 2022?
MR HALLIDAY: That's right.
MR DAWSON: And something called the Scottish Covid Data and Intelligence Network delivery group; is that correct?
MR HALLIDAY: That's right.
MR DAWSON: You also attended meetings of a group that we've heard of called SGoRR?
MR HALLIDAY: From time to time. I wasn't a standing

member.
MR DAWSON: Thank you. And you also attended Cabinet meetings.
MR HALLIDAY: Again, from time to time.
MR DAWSON: How was it determined when you would attend SGoRR or Cabinet meetings?
MR HALLIDAY: When there was relevant evidence or data that I or my team collated that was relevant to the agenda of those meetings.
MR DAWSON: Thank you.
Mr Heald, if I could just run through a similar background to you. Over the course of the period on which this module is focused, you were the associate director and head of profession for statistics at the Information Statistics (sic) Division, which was incorporated into PHS when it became operational in April 2020; is that correct?
MR HEALD: That's correct.
MR DAWSON: You continued when PHS was formed and became the interim contact tracing director from May 2020 to January 2021?
MR HEALD: That's correct.
MR DAWSON: You were the chief officer from January 2021 to May 2021?
MR HEALD: That's correct.

MR DAWSON: Since June 2021 your title has been director for data and digital information?
MR HEALD: Data and digital innovation.
MR DAWSON: Innovation?
MR HEALD: Yeah.
MR DAWSON: Also, between January 2020 and April 2022 you were the head of profession for statistics at PHS?
MR HEALD: That's correct.
MR DAWSON: You were accountable, as I understand it, for the statistical methods, standards and timing of statistical release from PHS?
MR HEALD: That's correct.
MR DAWSON: And you say in your statement that whilst part of your role involved advising Scottish Government officials, the final decision regarding the publication of PHS statistical material lay with you?
MR HALLIDAY: That's correct.
MR DAWSON: And that was the case throughout the pandemic?
MR HEALD: It was.
MR DAWSON: Thank you very much.
Could I just ask you, I'll direct the question to Mr Halliday first and then Mr Heald will have something to say about this, some questions broadly about, as far as the Scottish Government response to the pandemic was concerned, the purposes for which the various datasets

that you were involved in collating and analysing and presenting, what the purposes of those might be.

Could you tell me whether the purposes for which data was being collected during the course of the pandemic changed as the pandemic progressed and if so in what ways? Mr Halliday.

MR HALLIDAY: Well, I would say yes, that did happen. So to -- I would say initially it was -- the data that we had around infections, hospitalisations and deaths were used partly to communicate to the public. They were partly used for decision-making as part of modelling. And I would say that -- and other reasons for, in terms of managing the business and decisions of the government.

I would say as we went on, the nature of those decisions would need to change. So, for example, some of those datasets formed part of the decision-making or the evidence for decision-making as part of the levels approach, for example.

So I guess, yeah, I would start off by saying that.

MR DAWSON: So as far as the levels approach was concerned, about which we heard a little yesterday, would it be fair to presume that the data that you required became more localised, given the fact that the levels approach involved local area levels being applied?

MR HALLIDAY: Indeed, and I guess the interest from members of the public as the Covid pandemic sort of went on, again, became more intense, and the demand for local area data by the public certainly increased during that time as well.

MR DAWSON: In the very early stages of the pandemic, would it be fair to say that there was a limited amount of data that was available?

MR HALLIDAY: It certainly developed the amount of data we had. You know, in a large area, particularly for Public Health Scotland, they had existing data systems that served us well, but in many areas what we did was we adjusted either the data collected so that it was looking, for example, at schools and looking at the impact on staff and students at schools, and attendance and absence, or at the frequency of the data that was collected. So the nature of the data collection changed in response to the need for government information and to support decisions.

MR DAWSON: Mr Heald, was there any perspective you have to add to that?

MR HEALD: Yeah, I would agree with the points that Roger has made. I think what I would reflect is that the data that we held, and the data that we published -- so Public Health Scotland had a role to make the data

public -- changed over the course of the pandemic. So, as Roger says, infections and hospitalisations, deaths, very much the focus at the start, but as the pandemic and the approach to the pandemic changed, so things like vaccinations became really important, that we released data on vaccinations into the public domain. We also released data on aspects of the Test & Protect system, just so people could understand how that was operating. So I would say that we adapted what we published as the pandemic progressed.

Your point about data at local level being important, so one of the key differences between the data that was published by Scottish Government, which tended to be headline Scotland numbers, and the data published by Public Health Scotland each day was that we provided more granular data at a more local level, and I think one of the successes for us was the Public Health Scotland Covid dashboard, which had data to, I guess, locality levels or very low levels of geography, that allowed users to log in and see kind of how the pandemic was affecting their local areas.

MR DAWSON: We will come back to it in a bit more detail, but could you remind us, because I'm sure everyone at one stage was aware, of what the Covid-19 dashboard was?

MR HEALD: Yeah, so the Covid-19 dashboard was basically

a tool that Public Health Scotland updated every day that contained data statistics about the pandemic, so updating for the most up-to-date figures. It presented data at Scotland level, so similar to what was published by Scottish Government, but also published data at the more granular, local level. And that was the key difference between what Public Health Scotland published each day and what government did.

Just to add alongside that, we also published the data in what we call open data format, which was we released the data so that others could pick up the data and use it. And that open data also fed into the UK Covid dashboard, which the UK Health Security Agency also published, so there was a real stream of data going out each day.

MR DAWSON: Do I take it from that then that you were feeding the Scottish data into the UK dashboard as well as publishing it separately as a Scottish entity?

MR HEALD: Yes.

MR DAWSON: Thank you.

You have anticipated the area I wanted to go to next, which was the interplay really between both of your roles, one within the Scottish Government and one within PHS.

Our understanding from the material is that both

Scottish Government and PHS published daily statistical updates throughout the pandemic, and the Scottish Government-published data included some data provided by PHS, as you've already said, Mr Heald, and other sources as well, which we understand to include things like the National Records of Scotland.

Is it correct to say that overall the Scottish Government published a daily update on the internet from March 2020 until April 2022, and that PHS produced a daily dashboard; is that correct?

MR HALLIDAY: That's correct, and what we took was the judgement that actually we wanted to make it as easy as possible for people to access the headline statistics that were of significant interest, and so by bringing that together in a single place, we hoped to achieve that.

MR DAWSON: Thank you.

Do I take it to be the case, then, that the data that was produced by PHS was available to Scottish Government and formed a subset of the overall material that was published by the Scottish Government?

MR HALLIDAY: That's pretty much correct. We didn't -- the distinction is in the local area data, that the Scottish -- the data that was published on the Scottish Government website was national data and then Public

Health Scotland produced the dashboard which showed that local area data.

MR DAWSON: So just to understand that, the position is that Scottish Government were draw on PHS data, it would extract from that for publication purposes certain elements of it but not necessarily with the granularity that Mr Heald referred to; is that correct?

MR HALLIDAY: That's correct.

MR DAWSON: I would just like to separate out two concepts here. One is the question of publication of the data for public information, which you've both referred to, and one is the data that would be available for various people within Scottish Government to be able to process, analyse and ultimately inform high-level decisions with which this module is concerned. So the position is that all of the PHS data would be part of a wider suite of data available for to the Scottish Government for that decision-making purpose; is that correct?

MR HALLIDAY: That's correct.

MR DAWSON: But what you've both spoken about, I think, is that publication was a separate matter because thought was put by both the Scottish Government and PHS into what would be appropriate to release into the public domain, which might not be everything that would be compiled?

MR HALLIDAY: Correct.

MR DAWSON: Thank you.

One of the decision-making bodies with which we are concerned, or bodies which is connected to decision-making, is one we have mentioned already, the Scottish Government Resilience Room. Mr Halliday, you have told us that you would on occasion be asked to provide information to that.

I understand that information, statistical and data related information was fed into that body by a series of documents which were known as the SGoRR sitreps; is that correct?

MR HALLIDAY: That's right.

MR DAWSON: I understand that these were documents which were provided in connection with SGoRR meetings where decisions might at least be discussed and that the data that was provided in the sitrep was assimilated and put together to try and assist with that decision-making process?

MR HALLIDAY: The data was provided on a daily basis, or updated on a daily basis -- well, some of the elements of the report were updated on a daily basis, some of it was weekly or less frequent, but updates were given every day to make sure that the information that -- was available to the meetings, and more broadly that there

was a clear definitive set of data for government to make decisions upon.

MR DAWSON: If I could have up, please, a document under INQ000214776, thank you very much, this is an example of one of the SGoRR sitreps; is that correct, Mr Halliday?

MR HALLIDAY: That's right.

MR DAWSON: And we see from the top corner that this is from June 2020. Could we -- I wonder whether we might look through this document to a certain extent, and you might be able to tell us a little bit -- for example, if we were able to go to page 3 of the document, there is a colourful arrangement there with a lot of information on a single page under the title "Key indicators", which appears to be split into four separate boxes; is that correct, Mr Halliday?

MR HALLIDAY: That's right.

MR DAWSON: Could you explain to us broadly what the information is that's contained within that, not looking at the detail but the sort of thing that you were trying to convey when putting these things together.

MR HALLIDAY: Yeah, so in April, if I recall, the Scottish Government published the -- a paper about the handling of the pandemic under the theme of the four harms, which are, here: the -- Covid direct, directly from Covid; harm because of the effect of Covid on the health

service; on society; and on the economy.

And what our role was as analysts in government was to bring the range of evidence together under each one of those harms, and what the picture shows here are some -- five key indicators for each of the -- the harms, with a picture of what -- the value of the indicator and how that's changed -- how that compares to the status for the pandemic. And it's red, amber and green to mark -- to highlight areas of potential concern.

MR DAWSON: Would it be fair to say in this four harms strategy that where a box was marked red, which would be the highest category, that would be an indicator for the fact that there was a particular strain in that area that was increasing that harm potentially?

MR HALLIDAY: It's an indicator of that, yes.

MR DAWSON: Yes. And the colour-coding is in order to try to catch the reader's eye and attract them to the things that are perhaps more stable and things that are perhaps less stable, based on the statistics?

MR HALLIDAY: Indeed so. And later on in the report, as then -- a lot of the detail that goes behind these headline numbers.

MR DAWSON: And as you say they're split into four harms. One of the questions I wondered if you might help us

with, Mr Heald, is obviously the four harms are -- as we've heard already: the first relates to the direct threat to health from Covid; the second, broader health harms; the third, society; and the fourth, economic.

Which of the harms would data be fed into this machine which would emanate from PHS?

MR HEALD: Yeah, so looking at that report, data from harm 1, so Covid direct health, there are a number of indicators there that would have come from Public Health Scotland, and broader health, harm 2, would be the other area where data from Public Health Scotland would have fed in.

MR DAWSON: Because those are the two health-related harms?

MR HEALD: Yeah.

MR DAWSON: And who fixed what the indicators were in each box?

MR HALLIDAY: So this was a decision of the analytical and also sort of the -- the leads within Scottish Government on each harm, so we'd be -- my team would work with the Chief Medical Officer on harm 1 and harm 2. On harm 3 the Chief Social Policy Adviser would take the decisions on which indicators are, and on harm 4, on the economy, it's the Chief Economist at Scottish Government.

MR DAWSON: So they would fix what the indicators were they wanted information about, and it would be provided, it

may emanate from PHS or some other source. Were you involved in the actual fixing of the indicators to any extent?

MR HALLIDAY: So I would just clarify --

MR DAWSON: Thank you.

MR HALLIDAY: -- the fact that what would happen is a discussion between the analysts and those people that I've mentioned, because not necessarily -- the data might not necessarily be available for the exact concept that they'd be looking for, and I guess the role of my team was to collate this information -- so the information would be put together by different statistical and analytical teams from around Scottish Government or from other places, and we've mentioned Public Health Scotland and National Records of Scotland as well, and it would be up to my team to commission updates from the various statisticians and to put it together and put it into the format that we can see presented here.

MR DAWSON: And what was done to try to make the information not just contained on this page but throughout this quite lengthy document, which you say was produced regularly, to try to make the information digestible and comprehensible to those who would need to take decisions on the basis of it?

MR HALLIDAY: Yes, well, I guess that what we have is a group of quite senior analytical staff with significant experience of doing exactly as you've described, presenting complex information, multifactorial information in ways that can be digested by politicians and by senior officials, and so the people putting this together are well trained in exactly that task.

MR DAWSON: Is the risk by using, for example, a single page like this, and by using the colour-coding, that someone might, looking at this, simply look at which area is more or less red, think "That's the thing we need to deal with now", and not interrogate the detail?

MR HALLIDAY: I think that would be up to them, but as -- we've used similar kind of presentations when we're looking at overall performance of government in the past, so I think it's something that ministers and other senior officials are relatively used to, the risks that you presented there.

MR DAWSON: Did you, from your perspective, get feedback from ministers or senior officials about the comprehensibility of this obviously very significant and broad database?

MR HALLIDAY: We certainly got questions about some of the detail.

MR DAWSON: Yes, but as far as the overall system of presentation was concerned in these quite lengthy documents with this key indicator element to it, was that something that they fed back saying, yes, they had a good handle on it, or was that something that they struggled with?
MR HALLIDAY: I certainly can't recall any feedback about them struggling with the presentation of the information. It was more that we would get questions that looked very much like they had understood and were reflecting upon and asking for further detail on some of the evidence that's provided.
MR DAWSON: And this may, I have to be clear, be indicative of the timing of this, but we're not going to go through every page of the document, but having done that myself, I wondered whether it might be fair to say that the majority of the document contains information, much of which I suspect may have emanated from PHS, about what's described as the first harm, tracking the ebb and flow of the pandemic; is that correct?
MR HALLIDAY: Yeah, I suppose we wanted to make sure that it wasn't a document that was focused just on the first harm, that it was -- reflected indicators across all four. What was unique about the first harm was that data was updated for at least a couple of the indicators

on a daily basis, so it was much more frequent and it changed much more frequently than -- in terms of what the numbers were actually saying, than some of the other harms. So it was unique in that respect.
MR DAWSON: And as far as -- there is, I should say, some information about the economic side which is contained later, but was it difficult to try to either find data or find data that would assist in particular with harms 2 and 3, which might be slightly more difficult to encapsulate in a format such as this?
MR HALLIDAY: I think that it actually was -- I thought it would be more difficult than it actually turned out, in that some of the data available for the economy was actually available on a fortnightly basis where previously it had been available on a less frequent basis.
MR DAWSON: Because one might say, for example, in harm 3 there's information about vulnerable children attending school, people describing themselves as lonely, people who trust the Scottish Government to work in Scotland's best interests, applications to the Scottish Welfare Fund and the total coronavirus interventions by Police Scotland. One might say that there are a very large number of categories that aren't taken into account which would fall into the area of societal harm.

MR HALLIDAY: That's absolutely right. Some of the -- as you'll have read later on in the document, go into that, but we had to take a judgement on what information to present to make it digestible.
MR DAWSON: Thank you.
Perhaps I might ask you probably my final question, Mr Heald, just in relation to harm 2, where PHS had a significant input, if we could just have a look at that.
Again, there are a number of criteria that are there relating to hospitalisations and in particular cancer.
MR HEALD: Yeah.
MR DAWSON: There are, I think, a number -- one might quite reasonably say there are a number of non-Covid harms that aren't reflected there. Were similar issues experienced as Mr Halliday has described it in that regard?
MR HEALD: Yeah, I mean, I think again, as Mr Halliday's said, a judgement call about what's available, and I guess this is a snapshot of the support at a particular point of time, so again I'm unfamiliar with whether indicators changed throughout the course of the pandemic.
I think the other thing I would say is while this is a document that was shared within government, Public

Health Scotland did still publish, continue to publish data on a whole range of health and care statistics that we had in place prior to the pandemic that continued beyond that, so other data about other areas of health were still available throughout the pandemic.
MR DAWSON: So, for example, mental health obviously --
MR HEALD: Yeah.
MR DAWSON: -- as we know and we've heard was a very significant non-Covid-related harm. It doesn't feature there, but aren't you suggesting that that would be something that PHS would have been compiling throughout the pandemic?
MR HEALD: And we still published statistics on mental health throughout the pandemic, yes.
MR DAWSON: Thank you very much indeed.
If that's a convenient moment, my Lady.
LADY HALLETT: It is, certainly. I shall return at 1.45.
MR DAWSON: Thank you very much.
(12.46 pm)
(The short adjournment)
(1.45 pm)
LADY HALLETT: Mr Dawson.
MR DAWSON: Thank you, my Lady.
I'd like to return to a subject that we touched on briefly near the beginning of your evidence, and that's

to do with publication of data.

I understand from the statements that both the Scottish Government and PHS published data, so there were two sources from which data came.

Perhaps Mr Halliday first, why was it that it was thought useful for data to be published by both sources?

MR HALLIDAY: Well, I would say that it was important to have a very clear place to have data brought together, and the data that we did bring together in Scottish Government, yes, it included Public Health Scotland data, but it also included data from other sources, and I guess that we had that central role of co-ordinating sources of data and Public Health Scotland could focus on the excellent publication of its own data.

MR DAWSON: In terms of what I think you accepted earlier was the ultimate aim of the publication of the data, which was try to keep the public informed in a way that was effective, was the publication of data from both sources potentially confusing, given that the PHS data was a subset of the Scottish Government data?

MR HALLIDAY: I'd like to suggest that it wasn't, I mean, and the Office for Statistics Regulations in fact, who were the organisation that comment on the quality, trustworthiness and value of statistics said exactly that, that these two things worked well together.

MR DAWSON: And you mentioned a moment ago that the Scottish Government data included data obviously over and above the PHS data. What were the other sources, the main other sources that were included within that extra data?

MR HALLIDAY: Are you referring specifically to the direct effects of Covid or --

MR DAWSON: Really --

MR HALLIDAY: -- is it much wider? Because I would say that in Scottish Government we had portfolios of around -- well, more than 100 regular statistical publications that adapted themselves to describing the effects of society, economy and environment during the pandemic.

MR DAWSON: That's what I was interested in, really, the broad range of sources which you called upon. As far as the Covid-related information is concerned, you also published, I think, National Records of Scotland data.

MR HALLIDAY: Indeed.

MR DAWSON: As far as that data was concerned, to what extent did that differ from the PHS data? If that's the right way of putting it.

MR HALLIDAY: Yeah, well, there's a difference in the definition. There we're talking about mortality data from Covid, so there was a different definition that was used for the National Records of Scotland data and the Public Health Scotland data, and in broad terms the

National Records of Scotland data referred to situations where a death was -- Covid was recorded on somebody's death certificate, and Public Health Scotland where somebody had died within 28 days of a positive test. And after the spring of 2020 those two things were very, very similar indeed but during the early part of the pandemic the death certificate data was higher than the Public Health Scotland data, and that's -- I guess reflected the development of testing during that time, because the Public Health Scotland data required a link between a positive test and somebody dying.

MR DAWSON: Right. And as far as the mortality data was concerned, was there a possibility that the discrepancies in those two data sources might be confusing as regards the level of mortality?

MR HALLIDAY: There is -- there's the potential of that, and what us statisticians did to avoid that was to have very clear descriptions of what each statistic was representing, and the differences between the two, and when to use one set of data versus when to use another set of data.

MR DAWSON: Okay, thank you.

I'd like to ask you a few questions about accessibility of data, please. How did you -- I think this is for both of you -- both factor communication

needs and the issue of digital exclusion for members of the public into your decision-making about how you would go about publishing data?

MR HALLIDAY: I guess this is -- you know, we had established processes that are under the -- a code of practice for official statistics and which we were working, which essentially ...

Essentially communication and making sure that people could access and understand was an important part of how statistics are compiled and how they're made available, yeah, to -- as part of our standard processes.

MR DAWSON: Would that be the same for PHS?

MR HEALD: Yeah. I think another important point, particularly as we developed our Covid dashboard, that we got a lot of feedback from users about what was helpful and what was not helpful so that we could adapt the outputs based on the feedback we were getting.

I mean, I think an important point to stress is at the time the data and the outputs was being produced at great pace, and therefore it was really important that we got the data out into the public domain, but I would say we learnt over the course of the pandemic the most effective ways of getting that into the public domain so that people could understand what was happening.

MR DAWSON: What about consideration being given to people with particular needs, in the sense of perhaps disabled people who would have difficulty accessing the information, was that something that featured in the thinking behind publication in either the Scottish Government or PHS?
MR HALLIDAY: I would say that the thing that comes to mind when you've posed that question is about the accessibility of data via the Scottish Government website, but all the presentation of our information was specifically designed to be as accessible as possible, to high accessibility standards.
MR DAWSON: Would that apply to the PHS --
MR HEALD: (overspeaking) -- Scotland, yeah.
MR DAWSON: One of the themes that we've heard from evidence that's been collated by the module and indeed in other parts of the United Kingdom is the theme of digital exclusion. I think it's the case that the data was all simply published through the internet, the dashboard, for example, that we've discussed.
Was any consideration given to the fact that there were sectors of society who, for various reasons, suffered from digital exclusion and how that might be addressed?
MR HALLIDAY: I would say perhaps not directly but I was --

you've looked at yourselves, is that the most vulnerable in society were the most likely to be the most vulnerable to Covid, or the most likely to suffer from digital exclusion, the most likely to have particular difficulties accessing the information. So would it be fair to say that efforts were necessary in order to get the information to the people that were most affected and those efforts might have been done better?
MR HEALD: I think that that would be fair. I think there's always learning with these things. I think the key thing was that we were doing our utmost best to get the data out to the public in as easy accessible formats as possible on a daily basis, and this was running every day with data asked adapting to different stages of the pandemic. So there's always learning from these approaches, but I think we did our utmost best to present the data in a way that people could access it and use it and understand it.
MR DAWSON: Thank you.
From a Scottish Government perspective, Mr Halliday?
MR HALLIDAY: I think I would agree with Mr Heald's assessment of the situation.
MR DAWSON: Thank you.
I'd like to ask you a few questions, as you've helpfully included information about this in your

you know, an important route for making a lot of the information available was not just directly through the statistical publications but in things like the First Minister's daily address where the statistics featured heavily as part of that.
MR DAWSON: I think we'd said earlier that the daily address was headline figures.
MR HALLIDAY: Indeed.
MR DAWSON: So that would be a means of communicating that. There would, of course, be people who would struggle to be able to understand that information. Was any consideration given in that regard about how information would be communicated better through that forum, that involved you?
MR HALLIDAY: That involved me? Not directly.
MR DAWSON: Thank you.
MR HEALD: Likewise for me: not directly. But as far as I recall people could contact Public Health Scotland. If they, for example, were requesting particular pages, we could print them out, make them more accessible. So that was certainly an option. But you are correct the majority of the outputs that came out from Public Health Scotland were in digital means.
MR DAWSON: What the evidence tends to show, and you may be aware of this from a lot of the statistical material

statement -- it's particularly you, Mr Halliday, on this topic -- it's about data sharing on a UK basis.
One of the general questions I was interested in asking you was the extent to which, as far as informing key decision-making is concerned, local data is preferable, important, part of the picture? What would your view be on that?
MR HALLIDAY: I think that that depended on the stage of the pandemic that was being discussed, and the kind of decisions that were being taken.
As I alluded to earlier on, that when the levels approach was being developed and operated, that used local area data to a much more overt kind of -- yeah, used that data much more overtly than at other stages, for example, when national -- at the start of the pandemic, national modelling was what was a vital piece -- vital piece of data rather than a lot of the local effects.
MR DAWSON: So would it be fair to say you've made a time distinction there at the beginning of the pandemic: because there was a limitation on information one had to try to use whatever information one could get, and therefore a more national reliance was prevalent and perhaps that became more local as the pandemic went on?
MR HALLIDAY: I would say that it was more that the scale at

which the -- you know, the numbers that were involved weren't of a scale where there was a local -- a significant local dimension to it. So the national -- and therefore the focus on the national impact.

MR DAWSON: A scale that was statistically apparent based on what testing was available, for example?

MR HALLIDAY: Indeed.

MR DAWSON: So the flip side of that, I suppose, is to ask the question: what -- beyond what we've discussed about the early stage of the pandemic, what was the use to the Scottish system, ultimately Scottish decision-making, of data which came from other parts of the United Kingdom? What sort of data was helpful or important?

MR HALLIDAY: So I put together -- you'll have seen in the situation report and -- I put together a report called the "state of the epidemic", and what that did was put -- we used data from other nations of the UK or other nations internationally to put Scotland's position in context, and that kind of helped frame some of the Scottish data.

MR DAWSON: When you say you used data from other places, to what extent was that data available to you? Did you have problems accessing data, in particular from the UK or more widely from these international sources?

MR HALLIDAY: So I would say that there's two parts to this.

So in terms of the aggregate data that might be about the number of cases in a particular country or a region of a country, that flowed very well through the central Cabinet, Cabinet Office arrangements that we had, and we fed data into that, and that was a reciprocal arrangement, so that worked really quite nicely.

I think that it's fair to say that data at an individual -- around an individual person that could be used for research was more difficult.

MR DAWSON: So to set the Cabinet Office to one side, you mention in your statement at paragraph 12(d) that there were issues in obtaining data from UK Government departments and you cite at least an example of getting data from the DWP in June 2020. First of all, what was the significance of that data, why were you interested in that data?

MR HALLIDAY: So we were interested in that data to try to understand the effect of the pandemic on people's finances and welfare, and the data I'm talking about is of individual case -- individual people level data rather than aggregate data, and we found it quite difficult to come to an arrangement with the Department for Work and Pensions for sharing that data, which is a bit disappointing.

MR DAWSON: And did that continue throughout the pandemic or

was that ever resolved? You mentioned the date, June 2020 --

MR HALLIDAY: That's not yet been resolved.

MR DAWSON: That would be something, would it not, where you've identified, and you've explained why, that data which comes from the DWP for particular purposes would be useful, and this is the sort of thing that an inquiry might look into as suggesting would make a pandemic response more effective in future?

MR HALLIDAY: I think it would.

MR DAWSON: Thank you.

Were there any other such UK Government departments with which you had difficulty?

MR HALLIDAY: Not that I can recall, but I don't think I particularly asked for the similar -- made a similar ask to the -- that I did to DWP to other UK Government --

MR DAWSON: That's the one that sticks in your mind?

MR HALLIDAY: Indeed.

MR DAWSON: You mentioned also preparing some analyses of data on an international basis. Could you tell us a little bit more about that and how that was used to try to assist Scotland's pandemic response?

MR HALLIDAY: Yeah, I can point to a couple of -- a couple of times. So the first one was in our modelling, and

our model inputted data from a range of different countries where there was some easing of restrictions -- this was during the first wave of the pandemic, that we were looking at different options for easing restrictions, and we were able to get some evidence about the effect of different interventions in different countries through our modelling. So we were able to use data from other nations in order to be able to estimate what the effect of different policy interventions might be on things like the R number, or the number of people infected with Covid. So that was the first one.

The second one was --

MR DAWSON: Sorry, just on that one, was that something that continued throughout the pandemic or was specific to a particular time period?

MR HALLIDAY: That was predominantly during the first wave of the pandemic, but to some extent that did continue.

The second one was around foreign travel, and at that time we used a combination of modelling that was done by the London School of Hygiene and Tropical Medicine, and some data from internationally -- internationally comparative data from a European agency to look at the incidence of Covid and the point -- prevalence of Covid, ie the number of infective people or the rates of infective people in different nations,

in order to make decisions about travel corridors to different nations.

MR DAWSON: On the very subject that you mentioned there, the international information, first of all, was that sourced then through the UK Government or did you have independent sources of that information?

MR HALLIDAY: For international travel, there are two routes for that. The first is that the UK Government did some analytical work to bring a set of data together for us, data and modelling together, and that we also looked at some websites that had comparative data on them, where we needed additional granularity in that data or we wanted to make sure that we understood that data properly.

MR DAWSON: To what extent was the data compiled at the end of the day which would have been used by ministers or other advisers to make decisions about border controls as you discussed, would that have been different for Scotland than, for example, at the UK Government level, or would the figures have been --

MR HALLIDAY: The figures were from the same source.

MR DAWSON: Thank you.

I had some other questions about something quite specific from your statement this time. You noted that you worked closely with the ONS, I think you've

mentioned them already, and were briefed by them in respect of various nationwide surveys they were undertaking.

The ONS, we know from other evidence, commenced the Covid Infection Survey in England in May 2020, and is it correct to say that Scotland was the last of the four nations to be admitted to that?

MR HALLIDAY: It's the last -- the last nation for the survey to start in, yes.

MR DAWSON: Yes, and that was around 3 October 2020.

MR HALLIDAY: It started recruiting participants at the beginning of September and the first report was for 3 October, yeah.

MR DAWSON: And my understanding is that that is rather looked at as the gold standard of statistical evidence in certain areas of mapping the pandemic; is that correct?

MR HALLIDAY: It is for particular -- particular things. For understanding the level of prevalence across a nation of the UK -- a region of England level, that's absolutely right. For understanding the pandemic within Scotland, then it's not appropriate because it's of a -- while it went to quite a lot of people, there's still a lot of uncertainty in the estimates for Scotland and for other nations.

MR DAWSON: So my understanding broadly, please correct me if I've got this wrong, was that the approach taken by the ONS was that they looked at sectors of society, looked at prevalence and therefore extrapolated out numbers that would tell you things about infection and mortality; is that broadly right?

MR HALLIDAY: About infection rates, certainly.

MR DAWSON: Yes.

MR HALLIDAY: Not about mortality.

MR DAWSON: Okay, so would that approach generally be deemed to be the gold standard?

MR HALLIDAY: Having a survey that was -- that used consistent methodology in questions across the whole of the UK is the gold standard in terms of the ability to compare data between nations.

MR DAWSON: Is that because, at least in part, the data you might otherwise arrive at or based on, for example, positive tests, would not necessarily reflect the number of people who were actually infected?

MR HALLIDAY: There's the potential for that to be the case. I think when you actually look at the charts, they track each other very, very closely and so actually that's -- the data on positive tests is a good proxy and therefore we were confident to use the data at a local level as well as a national level, which the Covid Infection

Survey couldn't do.

MR DAWSON: I think, Mr Heald, as I understand it, the data on positive tests that you were providing, that was the PHS data --

MR HEALD: It was.

MR DAWSON: -- test positivity?

MR HEALD: Yeah.

MR DAWSON: And you mentioned a moment ago that the potential problem of using what you describe as English prevalence data but you needed to apply to that Scottish local data, is the idea that it would have been better for Scotland to have been involved in that type of approach at an earlier stage, to provide this additional source of information?

MR HALLIDAY: I think that would be useful. I think what we did was we took the time to make sure that that methodology would give us the most useful data from making decisions in Scotland, and once we were confident that the survey would go to enough people here to provide that estimate, then that's when we adopted the survey.

MR DAWSON: Okay.

I understand that in your statement you talk about having requested case level survey responses from the ONS in the summer of 2020. What were they about, what

did they tell you?
MR HALLIDAY: So this recognised that the individual survey responses can be particularly useful for research by enabling the linkage of the results from the survey to other routinely collected health data, say, for example, on vaccinations, and that that would be particularly welcome from the research community, which -- and it was -- we were aware that this was particularly helpful already in the UK context and what we were looking for was the Scottish data so that we could conduct some of that useful research for Scotland too.
MR DAWSON: Okay.
One of the themes again that emerges from evidence that we've heard from a number of groups, in particular representing vulnerable or at-risk individuals, is that they found, when they tried to influence or plead their case for different decisions being taken within Scottish Government, that there was a lack of base data relating to these groups. One particular group, for example, which I referred to in the opening yesterday, had complained about the fact that what this meant was that they had to plead their case more anecdotally and it was difficult to be able to prove the effects that they asserted, in their case in the ethnic communities of Scotland, using statistics or data.

Is it correct to say that there was a lack of data at the beginning and during the pandemic relating to at-risk and vulnerable groups such that this was the result?
It's really for both of you.
MR HEALD: So I think it's definitely fair to say that at the start of the pandemic, but as the pandemic progressed, and recognising the importance of data for those groups that you've talked about, we did take steps to address that.
I would still say that's work in progress, so there's currently a -- for example, a data group that I'm chairing that's looking at, you know, how do we improve the recording of ethnicity and the datasets that we have for health and care. So that's important. But where we could we did publish data.
And one source that we've not touched on during the hearing so far is that Public Health Scotland as well as having the daily dashboard also had a weekly report which allowed us to kind of deep dive into more detail into particular topics. So we did throughout the pandemic have particular chapters that majored on the impacts of different aspects of it on ethnic minorities as the group that you've -- highlight in particular the impact of vaccinations. So it definitely was recognised

and we took steps as best we could to address it, and we're still working now to make sure we've got systems in place to improve that going forward.
MR DAWSON: So that's a work in progress. I've focused on ethnicity because it's one particular example, but across what one might call "protected characteristics" generally would you say, Mr Heald, that that is a work in progress?
MR HEALD: I would say that's a work in progress. And when I, you know, give an example of ethnic groups, you know, we're doing work at the moment on all the protected characteristics, and that's a really important aspect of what we do and it's really, really important to the work that Public Health Scotland does more broadly, so not just for the work we do in Covid.
MR DAWSON: I think actually we heard yesterday that it was one of the purposes of the formation of Public Health Scotland to try to address health inequalities more effectively.
MR HEALD: Yes.
MR DAWSON: And this would be an example of trying to do --
MR HEALD: Yeah.
MR DAWSON: I'd like to ask you a few questions about some other data areas.
You gave evidence, I think, Mr Heald, to the

Scottish Parliament Health, Social Care and Sport Committee at a hearing on 23 November 2021.
MR HEALD: I did.
MR DAWSON: There are a number of aspects. For the sake of the transcript is reference is INQ000286854.
If we could just have that up.
There are a number of reflections, I think, in this similar to the one that you've just made, Mr Heald, which are very interesting to us, about issues that were experienced with data access within PHS and efforts, indeed, that are being made to try to look at that issue.
If I could look, for example, at page 2, I think these are four pages -- oh, no, that's not quite the same as the version I have.
I think here you say that it is in your response -- this is a few lines down in the first paragraph, you refer to -- yes, you refer to:
"We have a lot of data that we can use to good effect, and we have the ability to link the data in order to understand pathways of care. It is important to recognise that we are building on strong foundations. There are a couple of areas that we need to focus -- and are focusing -- on: social care in particular, and primary care. Those are the two big areas to which we

need to direct our attention."

Now, just to be clear, that was you speaking in November 2021, so we were still in the pandemic, but the later stages of the pandemic. Roughly, in context, about the time that Omicron was about to strike or had just struck.

So you were saying at that time that you had identified these problems based on the prior experience with the pandemic.

MR HEALD: Yeah.

MR DAWSON: I'd be interested in particular in understanding more about the difficulties you faced accessing data from social care, and I'll ask you about primary care in a moment.

MR HEALD: Okay, so, yes -- so as I've outlined there, we have got good, well established data systems and processes around collecting a flow of what I would call health service data. One area where there is a gap is social care, as you've alluded to, and that is an area that's still work in progress. So although identifying it back in November 2021, it's still work that we're doing at the moment. And in fact across Scotland, I can't remember the date of the strategy being launched, but we did have a health and care data strategy joint between Scottish Government and local

government, and one of the key aspects of that is the desire to address issues with social care data.

So Public Health Scotland does collect data from social care, we have a system called Source which collects data about individuals who are receiving care at home. One of the challenges though is that the frequency of that data is currently collected on a kind of ongoing basis but is made available quarterly and is used in annual reporting. So we didn't have the set-up that we had for the other health service data that would have allowed us to do more granular reporting on a more regular basis.

And part of that is, you know, we need to have things in place within Public Health Scotland to receive the data, but there is also -- investment is required in infrastructure or locally, in local government, around being able to collect or maintain that data in the first place. So we do need to be thoughtful about the burden on the data providers but it was recognised as a gap.

It's work in progress, we do have some data and we've currently got, as I say through the data strategy, a group looking actively at this as an area of particular focus is data on care homes, in particular what's happening --

MR DAWSON: That's one of the areas I'd like to ask you

about, Mr Heald, because obviously in this module we're interested in infections in care homes across the pandemic but particularly during the first wave when a high proportion of deaths occurred in care homes, and we'll look into the details of that with other witnesses.

But there would be a number -- I think it would be fair to say there would be a number of datasets, if you like, that would be useful to have in analysing and strategising for the types of issues that might arise in a serious infectious disease which might affect predominantly older people, would that be fair?

MR HEALD: Correct.

MR DAWSON: So, for example, data about the number of people in care homes might well be a useful starting point.

MR HEALD: Yes.

MR DAWSON: It might be useful to know, in the context of the Covid pandemic, the number of people that would be likely to be transferred between hospitals and care homes, for example; would that be right?

MR HEALD: Yes.

MR DAWSON: It would be useful I think also to know in this sphere the numbers that might be transferring between the community and care homes.

MR HEALD: Yeah.

MR DAWSON: And it might be useful to know the number of people that are receiving care at home who are in that vulnerable group.

MR HEALD: Yes.

MR DAWSON: Were, in the early stages of the pandemic, these datasets available?

MR HEALD: So they weren't. So that was a definite gap. Although one way -- how would I best describe this -- it is possible from other datasets to triangulate to inform some of those particular questions that you are asking about. So, for example, the Care Inspectorate maintain a register of care homes, that register has the address of the care home, much of the data that we get coming into Public Health Scotland's at an individual level, so we're able to map the postcode as best we can to care homes to understand where people are. But I would agree this is still an area that needs further development.

MR DAWSON: One of the factors you mentioned earlier, which is of course very pertinent to any data provision in the Covid pandemic, was the need for data to be provided quickly because decisions needed to be made quickly and therefore the data backing them up needed to be provided quickly. Even where the data you've referred to might have been available, can I take it from what you're

saying, because they would have had to have been sourced from other places, they wouldn't have been available, certainly, quickly?

MR HEALD: Partly true, I guess it depends -- depended on the analysis that we were doing. I think one thing we pride ourselves on in Scotland is our ability to link the data quickly. So the data on testing is available every day, we've touched on that. The register of care homes, for example, that's held by the Care Inspectorate doesn't change that frequently, but we would be able to link to those data on a regular basis, so it really depended on the analysis that we were doing.

MR DAWSON: You mention in the paper -- it's actually at page 6, I won't go to the direct quote -- but one concept that you mention as being relevant to this is the fragmentation of the system. I was interested in exploring that word, but perhaps you've already told us what that means in the way that you've explained things.

MR HEALD: Yes, so just -- again, to just refresh my memory, which paragraph?

(Pause)

MR DAWSON: I've got the quote here --

MR HEALD: Okay -- oh, I can see it now, it's at the top --

MR DAWSON: Yes, it's the fragmentation of the system that I was interested in exploring with you -- yes, that's

it, thank you very much indeed.

Is that something -- you've already, I think, alluded to something about that because you wanted to talk about the Care Inspectorate, is that why you've already told us or is there another aspect that --

MR HEALD: So I guess in the context of that, the other aspect of that is that -- so data particularly -- this is particularly in relation to local government -- is held by -- by large local authorities, and that landscape is quite -- well, at the time and still is quite fragmented. So what I mean by that is that there is no kind of standard way of collecting or then extracting data. So one of the challenges you have then is that you've got different approaches in 32 different local authorities and standardising that would take time and then, therefore, affect that ability to get data more quickly.

MR DAWSON: You go on just after this to raise, in the same area, the issue of differing information governance procedures. Is that part of what you've just described?

MR HEALD: Partly. I mean, the information governance really is about that ability to share the data so that local authorities or the data controllers -- so they have a say in what happens to the data.

MR DAWSON: Yes.

MR HEALD: So we have to have the dialogue about kind of what Public Health Scotland's use would be. So that's one aspect. But even if that was resolved and was straightforward, you would still have the issue that the data's fragmented locally and would still need to be --

MR DAWSON: Yes.

MR HEALD: -- addressed.

MR DAWSON: These are separate problems?

MR HEALD: Separate problems.

MR DAWSON: I understand.

MR HEALD: (inaudible).

MR DAWSON: Thank you.

One other aspect I wanted to just touch on, as you've mentioned it before, was difficulties in accessing primary care. What would the value have been of being able to access primary care better than it appeared actually happened?

MR HEALD: Yes, so one of the key values of primary care data is that it tells you a lot about what's happening in the general population, so the reasons why people would go to a general practitioner can be quite different to the reasons why people ended up in hospital, so a lot of the established datasets that we've got are from the hospital acute sector. That data's good, is robust. That ability to understand more

locally what's happening within general practice would have been a really helpful additional dataset to have.

MR DAWSON: Because of the difficulties in accessing hospitals during the pandemic, would that have made primary care data perhaps even more revealing?

MR HEALD: Yes, potentially. And I can talk about steps we took to address some of the shortfalls in primary care data, but --

MR DAWSON: I'd very much like to hear --

MR HEALD: Yeah. So, I mean, it's worth saying. So I've mentioned the Scottish Government data strategy. A key aspects of that is also work we're doing around primary care data. I'll just explain what -- some of the challenges with the primary care data. One is that each of the general practices or the GPs within the general practices are the data controllers, so they have a say in what happens to the data, and so we've been working closely with kind of partners across Scotland to talk through the types of uses we can make of the data.

So there's a couple of things to highlight that we have done. One is around data at what I'm going to call aggregate level. So it's at a reasonably high level, it's not at an individual level. We had a lot of engagement with GP bodies about that and that enabled us to start reporting on activity, effectively face-to-face

activity, or telephone calls in general practice.
MR DAWSON: At what stage was that something you were able to institute?
MR HEALD: So forgive me around the exact dates but my memory is from --
MR DAWSON: Broadly.
MR HEALD: From reading, it was broadly shortly after my appearance at the committee in 2021, so --
MR DAWSON: Pretty much the end of the period we're interested in.
MR HEALD: The period that you're interested in. But we were able to get the data for that.
The other important area which, again, has been touched on, and was touched on in the opening statement that Public Health Scotland gave, was the EAVE II study. You'll forgive me, I can't remember what EAVE II --
MR DAWSON: Well, could we come back --
MR HEALD: Oh you can't --
MR DAWSON: -- questions to go through -- (overspeaking) -- research access.
MR HEALD: But an important aspect of that, and for the surveillance work that was done by Public Health Scotland, we did get agreement to get data at a more individual level from primary care to assist with the surveillance, and we managed to achieve essentially

using the emergency powers that Covid brought, and we're currently in conversations again with the GP community about continuing with that essentially beyond this Covid period, because the emergency powers we had then are no longer in place.
MR DAWSON: Would one of the things that primary data would have been of assistance in would be informing you about what we called the second harm, the extent to which people are suffering other health harms that may not come to the attention of hospitals?
MR HEALD: I think that's fair. I mean, I think it's also worth highlighting. A bit like in Scottish Government, you know, we've got many other data sets within Public Health Scotland that address other harms. So, for example, we used the example earlier of mental health, you know, we've got a lot of other datasets that look at different aspects of mental health, so not having the primary care data didn't completely exclude us from being able to look at other aspects, but it's an important gap, I would say, in our data estate and it's an important gap that I would say we're making good steps with at the moment to address.
MR DAWSON: I had another PHS-specific question. Another thing that was mentioned in the opening about PHS yesterday was the reorganisation that went on within

PHS.
MR HEALD: Yes.
MR DAWSON: That, as I understand it, was a pre-planned organisation -- reorganisation, PHS having been formed as a corporate entity late in 2019 but was only going to become operational on 1 April 2020. And that of course happened at a time when we were in the middle of the first lockdown.
Counsel for PHS accepted that there had been a number of issues, including staff changes and the need institutionally to bed in the new organisation, which are understandable when any large organisation forms like that.
I was interested in the specific element of the extent to which that reorganisation caused difficulties in data provision such as, or perhaps others, the ones that you have frankly pointed out.
MR HEALD: So I think in terms of challenges around data provision, you know, I would say that it didn't cause problems. I think the important point was, as counsel mentioned yesterday, there were three different bodies that came together essentially to form Public Health Scotland and in essence those bodies had, you know, the existing data streams already in place, and those carried on into Public Health Scotland, so data that we

routinely collected and had access to prior to Public Health Scotland we still had that as part of Public Health Scotland.
One of the areas that I would say we did make good strides and there was a real benefit of Public Health Scotland being there was the fact that we have the expertise on the kind of data, the data capture aspects of it and the analytical work from one of the previous organisations, ISD, the Information Services Division, that I was part of that could work more closely with our health protection colleagues to make sure that we kind of had our processes as automated and streamlined as possible. So actually I would say a benefit was we were able to bring additional capacity into the Covid space than might otherwise have been more challenging had Public Health Scotland not --
MR DAWSON: Presumably that amalgamation was part of the (unclear) --
MR HEALD: That's right.
MR DAWSON: -- reason we discussed earlier, trying to improve public health delivery --
MR HEALD: Yeah --
MR DAWSON: -- was bringing together these two organisations?
MR HEALD: Yeah, and important that we didn't want each of

the organisations to continue as the previous organisations; that would defeat the object of Public Health Scotland coming together, so that ability to work together. Obviously at the time of the formation of Public Health Scotland we weren't anticipating the pandemic hitting on day one but I think, certainly from a data analytical perspective, we rose to the challenge well.

MR DAWSON: Another matter that was mentioned yesterday was, as I understood it, difficulties with getting access to data from the original source. A computer system called ECOSS was mentioned.

MR HEALD: Yes.

MR DAWSON: What were the issues around that?

MR HEALD: Yes, so not so much about getting -- problems with getting access to ECOSS -- so just to explain how that works. So essentially data about testing is run through the lab system until Scotland and, latterly, through some of the UK labs that were set up during the pandemic, and those data flow into a system in Public Health Scotland called ECOSS.

What I would highlight is that ECOSS is what we would call a legacy system, it's old, serves its purpose and prior to the pandemic a lot of the surveillance work that we were doing would have been about instances of

disease that were a lot smaller in case than what we ended up seeing in Covid, so one of the challenges quickly became the sheer volume of data that was coming through. Not so much in the very early stages of the pandemic because case numbers each day, although rising, were still relatively small, but we needed to kind of take steps to address that. And in essence what we did do was, without getting too technical, we established what we call a data warehouse, which is on newer technology, that allowed us to feed the testing data into that new platform on a daily basis, and that allowed us to run the analyses, automate what we were producing a lot quicker, which would ease the burden essentially on a lot of our staff in terms of what they were having to do more manually in the early stages of the pandemic.

MR DAWSON: Thank you.

If we could have a document up, please, INQ000366002.

Now, this, as I understand it, is a National Records of Scotland document from 24 March 2021, which sets out statistics in particular relating to various indicators during the previous week but it also includes an overall aggregate total of various things that have happened in the past. There is one particular aspect, which I think

is page 10, that I'd like to ask you about.

So this sets out at that time a number of specific aspects based on a number of specific things, and at the bottom we see that there is reference to data being included about disability, and although a number of the other sources of evidence and types of evidence seem to have been introduced into this type of analysis at quite an early stage, the disability information was only introduced on 24 March 2021.

Is there a reason -- I think it's for you, Mr Halliday -- is there a reason why the disability information hadn't been factored into this very useful document earlier than that?

MR HALLIDAY: Yeah, I would say that in general it's because the data on disability came from -- wasn't recorded as part of the standard information on some of these death certificates and as such we had to bring that information in from the 2011 population census. Now, getting those two sources of data together, the deaths data and the census data and the -- developing a method in order to provide some useful statistics and ensure that we could explain that in a useful way so that people understood the strengths and weaknesses of that analysis, that took a bit of time.

MR DAWSON: Did that mean that information, important

information about people with disability was not available for decision-makers as it might have been in the earlier part of the pandemic?

MR HALLIDAY: Certainly information on disability relating to mortality was not available before that time.

MR DAWSON: Thank you.

In paragraph 36 of your statement you refer to a project to use data linkage to pull data from various sources which may hold different datasets with a view to improving the available data on protected equality characteristics. What's the current progress of that project?

MR HALLIDAY: That dataset's now together and available for research in the public good, and it's held very securely in a -- in the Edinburgh -- the University of Edinburgh National Data Safe Haven.

MR DAWSON: Does that project allow intersectional analysis to be carried out?

MR HALLIDAY: Indeed, that's exactly what it will allow.

MR DAWSON: It will allow that?

MR HALLIDAY: Yes.

MR DAWSON: Thank you.

A general topic which I'd like to touch upon, about which there are a lot of documents that I won't get into, but I'm sure it's one we've touched upon already,

it's the extent to which data was made available to research, research organisations outwith the organisations where you were working, the PHS or the Scottish Government.

There are a number of places where we have indications that for some time there had been concerns raised by academics, for example, about access to research.

Just for the sake of a transcript I'll give some examples. INQ000149111 is an exchange between Professor Mark Woolhouse and the then Chief Medical Officer, Catherine Calderwood, Dr Catherine Calderwood, from May 2018, where concerns are brought up about researchers like Professor Woolhouse being able to access information and data.

Similarly, in the statement of Professor Andrew Morris, who played a prominent role as you'll recall, as chairman of the Scottish Covid Advisory Group, his statement being INQ000346264, at paragraph 16, they raise concerns about the way in which data was provided to researchers.

I'd be interested to hear your perspective on that, in particular whether you feel greater efforts could have been made, but my ultimate objective really is to ask you the extent to which that -- had data been made

available to these individuals and institutions, their work with that data would have better informed Scottish Government decision-making.

MR HALLIDAY: I'm happy to cover this.

MR DAWSON: Mr Halliday.

MR HALLIDAY: So this is, yeah, clearly a known problem before the pandemic, and in fact the Scottish Government decided to set up an organisation to deal with this, which is Research Data Scotland, which is the job that -- I'm now leading that organisation, and that was announced in 2019 in the Scottish Government's programme for government as an organisation to enable data access and data to be brought together around a person, place or business. That -- this is a -- quite a tricky problem and a problem that isn't unique to Scotland, isn't unique to the United Kingdom, is much more -- broader than that, and I guess goes back to the sort of concerns, on balance, of the owners of data wanting to make sure that they protect the privacy of individuals with the fact that there's a lot of utility in the data.

So to answer your question, if we'd made this data available, would this significantly have improved the research base and potentially the evidence base in Covid, I think absolutely it would. And I would say that the government, the Scottish Government, recognised

that that was the case. That's why they announced the set-up of Research Data Scotland in 2019, and that's where, why they decided to fund the organisation up to £25 million in -- from 2021, and I'm delighted to be able to make a contribution to addressing this particular challenge.

MR DAWSON: Thank you.

As we touched upon Professor Morris, just one aspect, we talked earlier about the way in which data was provided to SGoRR, and we looked at one of the sitreps. As we found out yesterday, the Scottish Government set up its own Covid Advisory Group set up in the end of March 2020, started really working in April 2020. As far as data provision to it was concerned, I was interested in exploring how that worked.

Was it possible for that group, for example, to commission or at least ask for specific data either from the Scottish Government or PHS to assist with its work?

MR HALLIDAY: The -- so my team provided data and evidence to that group partly on modelling and partly on other things, and I recall quite a number of cases where members of the group would ask me analytical evidence-related questions that I was able to respond to.

MR DAWSON: And would they be able to do that, would they be able to request it specifically about things they were interested in or would you just provide it and they would have to use what you provided?

MR HALLIDAY: Well, both of those things. So ...

MR DAWSON: Yes, okay.

I would just like to ask you a few questions about matters that have arisen elsewhere around specific incidents of data presentation, which you've addressed in your statements. One for you, Mr Halliday, and one for you, Mr Heald.

Could I go, please, to INQ000239682.

This is a witness statement, I'm hoping, of Ed Humpherson, the Director General for Regulation at the Office for Statistics Regulation, and if I could go to paragraph 35, please, in that it states that:

"In September 2020 concerns were raised with me about a claim made by the First Minister of Scotland that around 40% of care homes in Scotland allowed and enabled indoor visiting. An FOI published on 5 November set out the source of this statement and made clear that the 40% figure was a loose approximation based on incomplete data. We advised the Scottish Government's Head of Covid-19 Analysis that the uncertainty in this data should have been more clearly reflected in the FOI

response and the associated published material. We also stated that it should not have been necessary to wait for the information to be published as part an FOI. It would have been more appropriate to share the data publicly through an ad-hoc release shortly after the statement was made."

I think, Mr Halliday, you will recall that there was some correspondence with you about this. There is a letter INQ000092824. This is a letter, I think, where Mr Humpherson is writing to you about this particular issue.

I'm more interested in the generality of rather than this specific incident, but what's being highlighted here is that there was a piece of information, important statistical piece of information that was relied upon by the First Minister and then it turned out that there were concerns about its accuracy and reliability.

Can you explain the process about how information like the care home indoor visiting statistic would have been provided to the First Minister?

MR HALLIDAY: My suspicions, though I don't know, I guess, in this specific instance, but in general I would say that there are two classes of information, there's statistical information and management information that are collected by professional statisticians and there

are also a range of other management information that are collected by other Scottish Government officials. And with specialist statisticians we all work to the code of practice and that is -- has a proactive publication approach, and what we would do is ahead of that or at the time of publication we'd be -- provide written briefing to the First Minister on the contents of that data, and I think that goes for official statistics and management information. And so I don't know in this particular instance but I would have thought that the First Minister will have received this information by a written submission and made the decision to use this information. And I don't know what particular advice was given at that time to the First Minister on its use.

MR DAWSON: As I said, I'm not necessarily focusing on this particular instance but just how it may illustrate the generality of the process which you've just set out.

It seems that this case illustrates that there will, I think, inevitably, be times, especially when you're dealing with a lot of data that might be complex where data is presented simply in that way: this is a -- here is a figure. And there might, as I think Mr Humpherson was pointing out, be nuance or approximation about it, that it might be misleading for someone to rely on

a figure like that, where perhaps they know the figure but they don't know about the loose approximation aspect to it or perhaps aspects of its reliability.

What facility was there in the system for ministers or their senior advisers to be able to understand more fully in particular statistical information upon which they intended to rely in this fashion?

MR HALLIDAY: Yes, we would be -- by "we", statisticians would be very clear about the status of that data, when it would be put into the public domain, because, as I said, our default position was to make all management information, statistical information available publicly. So I think that's how they would be told.

MR DAWSON: Thank you.

Mr Heald, there was one similar thing coming out of this statement which I was going to ask you about, which is on page 3. I'm not going to go to this document but it concerns an October 2020 PHS report which was related to the discharge of patients from hospitals into care homes. It can be found at INQ000147514 but I am still sticking with the Humpherson statement, INQ000239682.

At page 3, please -- excuse me one second.

(Pause)

In any event -- I'm sorry, I can't lay my hand on

the exact document, but you'll be aware, as you've addressed I think in your statement, Mr Heald, that there was a specific quite subtle, I think, observation made by Mr Humpherson in connection with this information. In particular there was an aspect of the part of the report which related to the extent to which the discharge of patients from hospitals to care homes had led to specific outbreaks.

MR HEALD: Yeah.

MR DAWSON: And what was being pointed out on that very important piece of information in this very important report, that there were certain confidence intervals that had been used, which -- I don't think ultimately there was a criticism about the fact that that had not been mentioned, but that it was mentioned by Mr Humpherson in his important capacity that that was something that was certainly relevant to a complete understanding of the data.

On that subject, again to try to use this as a means of understanding the generality but on this very important topic with which we are concerned, to what extent would information like those confidence levels have been communicated to Ms Freeman, for example, who was the recipient of that information at the time, who was the Cabinet Secretary?

MR HEALD: Yeah, so some important points, I was one of the authors of that report, so I was involved in doing it --

MR DAWSON: Absolutely.

MR HEALD: -- so I know it well.

So that report was a stats report produced by Public Health Scotland that followed all the same processes that other reports had. It was pre-announced. Pre-release access to the report was given to Scottish Government, which is our standard practice. And then the report was published as you say.

I was involved personally in briefing Ms Freeman in the contents of the report but she did not have access to the report prior to that pre-release access period that I am referring to.

MR DAWSON: Okay.

So in that particular instance -- the reference I was looking for earlier was INQ000286856. I think it's actually a letter that Mr -- or some form of contact between you and -- from Mr Humpherson relating to this issue.

MR HEALD: Okay.

MR DAWSON: And he point out -- I think it's page 3 in this document that I'm looking in. Yes, at the bottom:

"When looking at the different types of discharge, we see adjusted hazard ratios of 1.00 for tested

negative, 1.27 for untested and 1.45 for tested positive. Although the confidence intervals again suggest these findings are not significant, the observed 'dose-response' pattern in the adjusted hazard ratios is consistent with a causal relationship between positivity and outbreak. Given the sensitivity of the care home setting during this pandemic, and the likely uses of the evidence from this analysis, some users may have benefited from additional discussion of this in the report."

So I think what he's trying to say is along the lines I suggested earlier, that it may not have been a point that he raised at all, but for the fact that this was a very important matter, as you know as an author of the report. Did you -- do you think that you would have explained these sorts of things to Ms Freeman at the time?

MR HEALD: No, so we did explain this type of thing to Ms Freeman at the time, and I think the important point about this particular report was, given the importance as you rightly highlight of this particular topic, this was being produced at pace to get the results out into the public domain, and what Mr Humpherson essentially was pointing out in his letter is that there are, I guess, some nuances in terms of the analysis that was

undertaken and the results that we could have made clearer in the report in terms of that communication. So it was more about the communication of the results rather than the results per se. And we did take that on board and we did an update to the report the following April where we went into a lot more detail with a lot more visuals to help people understand what we were saying.

MR DAWSON: So am I correct in understanding your evidence that there is a distinction to be made between the criticism, if we can call it that, by Mr Humpherson, which is about communication of this aspect of the data to the public, whereas what you're saying is that that aspect would have been communicated to the decision-maker?

MR HEALD: It would have been, yes.

MR DAWSON: Yes. Thank you.

I'd like to move on now to deal with a completely different part of your evidence with which you have very helpfully agreed to give us some assistance, which is to look at some of the slides that have been put together.

These are at INQ000274150, and you have very helpfully looked through these.

These were originally compiled, my Lady, by the Inquiry team but they were based on publicly

available information, and Mr Halliday and Mr Heald have very helpfully looked through this in order to confirm that this is in fact accurate data, and there are certain graphs and statistics within them that emanate indeed from, for example, PHS or sources to which PHS have contributed. And the purpose of looking at this is to try to understand some of the overall features of the pandemic in Scotland and indeed try to understand some of the statistical basis, which at times gets a little tricky.

So if I might take you, first of all, to slide 6. Although, as I said at the beginning, I'd be very happy for either of you to contribute, I had a slight idea as to who might lead on each one. If I'm getting it wrong, please tell me.

I wonder whether, Mr Heald, you might lead on this one.

MR HEALD: I would.

MR DAWSON: This comes from the UKHSA Covid dashboard. I think you told us earlier that that would be a dashboard to which PHS would contribute Scottish data.

MR HEALD: Yes.

MR DAWSON: And so this reports daily number of reported Covid-19 cases by specimen date from March 2020 to April 2022, ie the period that we're primarily

interested in in this module.

The slide I think suggests possibly, if one were to look at it, it tells us about the number of cases plotted over a period of time. It might suggest at the beginning that there were relatively few cases. Would that be an accurate interpretation of it?

MR HEALD: It would be in terms of cases reported. And I think a really important context on looking at this graph though is understanding the volumes of tests that were going on at the same time in the wider community. So the volume of testing, which is covered in some of the earlier slides, did change dramatically over the course of the pandemic. More testing, you're more likely to find more positive cases.

MR DAWSON: So if we were to look near the beginning of the period and it might suggest there was a low number of cases, that would be because there would be a low number of tests because this particular graph is based on testing?

MR HEALD: Yes.

MR DAWSON: Thank you.

As we go along, I think we can see that there are a number of peaks in the graph, and I think, for example, we can see that there are a number of different ones, for example, cases starting to rise

around about the -- around about October time; would that be right?

MR HEALD: October '20 you mean?

MR DAWSON: 2020.

MR HEALD: Yes.

MR DAWSON: And then there are various other peaks. The fact that we can see these peaks may be indicative of the fact that there's more testing, would that be right?

MR HEALD: Yes.

MR DAWSON: Yes. And do we see that there is potentially a -- so we see some level of rise around about that time, and then we see perhaps another peak, which seems to occur -- would it be around December/January 2021?

MR HEALD: Yes.

MR DAWSON: And I think you have confirmed with us through other sources that in that peak, from PHS data we know that its peak was 29 December 2020, do you recall that from the PHS data?

MR HEALD: Yeah.

MR DAWSON: Then I think, although I won't hold you to the exact number, that what you've told us is that there were 3,137 confirmed cases on that day, so that was the peak of that particular wave.

MR HEALD: Yeah.

MR DAWSON: Yes. Then I think there's a further wave which

one can see, which seems to start around about May 2021, as we go along the line. Would it be correct to say that that was thought to be primarily associated with the Delta variant?

MR HEALD: It was, that's correct.

MR DAWSON: And again I think that you have provided us with helpful other data to suggest that the peak of that is 2 September 2021, when there were 7,622 cases.

MR HEALD: I think if I may, the other important point around those dates is the easing of restrictions at different points in Scotland, and corresponding with that there was also increased testing, so you're absolutely correct the Delta wave -- or Delta variant was present at that time, but there was also increased testing, which also then leads to an increase in overall numbers.

MR DAWSON: Indeed. So you have to take into account both of those figures.

MR HEALD: Yes.

MR DAWSON: The figures are very much higher, but that's due to a combination of a greater number of infections and a --

MR HEALD: Absolutely.

MR DAWSON: Thank you.

I think as we go along the graph we see a very large

peak in December of 2021, and I think you told us that that peak peaked on 29 December, which was 23,539 cases; is that what --

MR HEALD: That's correct, yeah.

MR DAWSON: Then there is a fall in mid-January 2022. Cases remain at a level consistently above however even the September 2021 peak, and there's a further peak which rises to about 15,000 cases I think in around about March 2022; is that right?

MR HEALD: That's right.

MR DAWSON: Are those later peaks attributed to the Omicron --

MR HEALD: They are.

MR DAWSON: Is that correct?

MR HEALD: Yes.

MR DAWSON: Is it correct to say that lateral flow tests were used from December 2020 but until January 2022 positive lateral flow tests required a confirmatory PCR test?

MR HEALD: That's correct.

MR DAWSON: Would that be another reason why earlier figures may appear lower than they actually were?

MR HEALD: No, because if somebody had a lateral flow test and was positive, they would --

MR DAWSON: It would appear.

MR HEALD: -- have had then a confirmatory PCR test which would've appeared in the numbers, so --
MR DAWSON: I see, so that factor --
MR HEALD: -- that factor doesn't feature. It's -- primarily the main reason for the change in January is that you did not require to have a confirmatory PCR, and so we went with the LFD positive data from that point.
MR DAWSON: I see. Thank you very much indeed.
If I might then turn to slide 8, I had thought that this one might be for you, Mr Halliday, but again if you're able to contribute, Mr Heald, please do so.
This is the ONS Infection Survey, is that correct?
MR HALLIDAY: That's correct.
MR DAWSON: We touched upon that briefly earlier, it was the one that started in May 2020 and in Scotland was October 2020 and we discussed the reasons for that. And to what extent does -- what does this illustrate?
I think it's fair to say that this plots the four nations of the United Kingdom against each other; is that correct?
MR HALLIDAY: That's correct.
MR DAWSON: And just to reflect again on the basis upon which these figures are calculated, this is the prevalence basis, I think, that you described earlier; is that correct?

MR HALLIDAY: That's right.
MR DAWSON: So that was a -- it's not a test based but based on proportions of the population and extrapolating out to a total?
MR HALLIDAY: Yeah, a random sample of the population. But it was using testing in the same -- similar sort of PCR testing, but it's not just on who comes forward, it's a deliberately chosen random set of the population.
MR DAWSON: And can you -- you helpfully have marked on the graph that it begins on -- the Scottish line, the dark blue line, beginning in October for the reasons we've discussed, could you please just take us through the periods that represent particularly significant Scottish peaks, in particular how they sit against the UK, the position in the other UK nations.
MR HALLIDAY: I suppose the first thing to say is actually if you were to look at just the Scottish peak, the Scottish line by itself, then it would show something in broad terms similar to the chart that we were just describing before -- that Mr Heald just described and took us through --
MR DAWSON: Could I just ask about that, that was for the reason you said earlier, which is the testing results broadly show the same thing as the prevalence type method; is that correct?

MR HALLIDAY: That's --
MR DAWSON: Thank you.
And so you're going to track the peaks for us against the UK --
MR HALLIDAY: Yeah. So we'll -- you'll see the first area of interest I think is in the winter of 2020, the beginning of 2021, but there ... there's a peak in Scotland but it's generally over the periods of December, January, February that Scotland had a lower prevalence than England and Wales, and a lower peak than Northern Ireland.
MR DAWSON: Just to put that into its context, what we've been looking at there -- because this is a percentage of population basis, so we can plot them against each other, it's not numbers where England would come up the highest number?
MR HEALD: Indeed.
MR DAWSON: So what we're looking at here is that Scotland has a lower prevalence over that period, which is the Alpha variant period; would that be correct?
MR HALLIDAY: That's right.
MR DAWSON: Thank you.
And if we were to go through it further, we might see that certainly there's a -- the lines in around March 2021 all seem to be roughly the same for a period;

would that be right?
MR HALLIDAY: Yes, absolutely.
MR DAWSON: Then we see Scotland starting to rise perhaps in around about July, June 2020 to a certain extent, but then there is a peak maybe somewhere slightly before September, maybe August 2021, where Scotland is certainly representing the highest figure.
MR HALLIDAY: That's right.
MR DAWSON: Okay. And then as we follow the line further across we see as we get into the latter part of -- very latter part of 2020 and through into the end of the slide, would that period roughly be the Omicron period?
MR HALLIDAY: Yes.
MR DAWSON: Would it be fair to say that overall there Scotland plots certainly at its peak the highest but generally pretty high against the other nations?
MR HALLIDAY: I would say that in the peak in October -- in autumn 2021 and in winter -- early in 2022 that the peaks happened at different times for the different nations, with Northern Ireland followed by Scotland followed by England and Wales at broadly the same time. And while Scotland is a little bit higher in the winter -- in the spring of early 2022, whether that's a significant difference or not, certainly there's a level of confidence in the statistics that comes from

the uncertainty of not sampling everybody that -- it was certainly higher -- statistically higher than England but not so for Wales or for Northern Ireland.

MR DAWSON: Okay. And if we just look at the Scottish line alone, one thing which is potentially significant to our overall understanding is that whereas at around the time of the Alpha variant around 1% of the Scotland population appears to have been infected, by the time of the Omicron variant in early 2022 the peak reaches over 8% of the population infected.

MR HALLIDAY: Yes.

MR DAWSON: So that is linked to the fact that Omicron was a more transmissible variant.

MR HALLIDAY: Absolutely. And also that the restrictions that were in place at the time meant there was a lot more mixing between people than there was during the Alpha variant.

MR DAWSON: Okay. There were lesser restrictions at the period when the peak was, as compared to late -- the late 2020 --

MR HALLIDAY: Correct.

MR DAWSON: Thank you. That's -- thank you.

MR HALLIDAY: Also worth just flagging at that period there's also the impact of the vaccination, so obviously a key development in December 2020 was the start of the

vaccination programme, so in terms of, yes, case numbers higher but I guess the sickness of people lower because of the impact of the vaccination.

MR DAWSON: That's a very important observation, thank you.

Would that be how you would characterise really the impact of vaccination, in the sense that it doesn't stop people becoming infected, but it does perhaps in some people stop the worse effects? Is that your interpretation?

MR HALLIDAY: My understanding is that there's a limited impact upon transmission; the much bigger impact is upon the impact in terms of sickness and mortality, yeah.

MR DAWSON: Okay, thank you.

If that would be an appropriate point to break, that would be --

LADY HALLETT: Yes, certainly.

MR DAWSON: Thank you very much, my Lady.

LADY HALLETT: I shall return at 3.15.

(3.00 pm)

(A short break)

(3.15 pm)

LADY HALLETT: Mr Dawson.

MR DAWSON: Thank you, my Lady.

If we could just move on to the next of the slides, thank you, I'm wanting to look at slide 15, please.

Does this slide, which is entitled "Per capita Rates of Covid-19 patients in hospital" -- perhaps we could try you, Mr Heald, this time, and again if there's anything that could be contributed -- or would it be easier --

MR HALLIDAY: I'm happy to surrender, thank you.

MR DAWSON: This is entitled "Rates of Covid-19 patients in hospital", March 2020 to April 2022, and shows I think a comparison between the UK and Scotland in respect of the proportion of patients in hospital with Covid-19 over a similar time to the one we looked at in the ONS study.

MR HALLIDAY: That's correct, though the ONS study started in -- had data from October 2020 on a consistent basis.

MR DAWSON: Right, that's right, thank you.

And there is an indication on this one around about October 2020 that, as far as the Scottish blue line is concerned, there was some change in methodology. Could you just explain briefly what that is and in particular what effect that had on the data before and after it.

MR HALLIDAY: Yeah, of course, but we noticed that the pattern for Scotland and the United Kingdom was -- or other parts of the UK was slightly different and did a clinical audit to investigate what the reason was, and that was done in July 2020, and there was -- that found

that there were actually quite a number of people in Scotland who were in hospital that had at some point been -- tested positive for Covid but Covid had resolved itself and they were still in hospital, and that -- that we made the decision to exclude those people once the -- beyond two weeks from when they were admitted or when they tested positive for Covid -- when they were in hospital, they were excluded from the figures, and that brought us onto a consistent basis with other parts of the --

MR DAWSON: So what that means, I think, is that up to a certain point there were a number of people that were being included as being in hospital with Covid who were in hospital who had had Covid but were no longer suffering from Covid.

MR HALLIDAY: Correct.

MR DAWSON: They were in for other --

MR HALLIDAY: For other reasons.

MR DAWSON: Yes.

So would that mean that before the change of methodology kicks in that we are getting perhaps a slightly inflated number for Scotland and that maybe the true line lies something nearer the UK number?

MR HALLIDAY: I think so.

MR DAWSON: Yes, okay, thank you.

So as we go on one can see again there are peaks, there's a significant peak which I think represents the Alpha variant where the number of hospitalisations with Covid in the UK is above Scotland; does that reflect the figures we saw before related to the numbers of infections perhaps?

MR HALLIDAY: That's exactly how I see it.

MR DAWSON: As we go on, I think there's a slight peak around July but possibly around about August 2021 again there seems to be a significant rise of Scotland for a period above the UK average; is that right?

MR HALLIDAY: That's right.

MR DAWSON: And again I think that roughly coincides with the period that we had identified as being one where Scotland's infections went up significantly due to Delta; is that right?

MR HALLIDAY: That's right.

MR DAWSON: And again beyond that, when we get in towards the end of 2021 and the Omicron wave, you see the lines mirroring each other almost exactly for a period, but then towards the end of the period that we're interested in, this takes us up to April 2022, there's a significant jump in Scotland as compared to the rest of the UK. Would that tend to suggest that at the very end of the period in which we are interested there is

a statistically significantly higher number of people in Scottish hospitals with Covid than in the UK? Is that what it shows?

MR HALLIDAY: It shows that -- so statistical significance with administrative data is a slightly more complicated phrase --

MR DAWSON: I wouldn't want --

MR HALLIDAY: Certainly the Scotland number is of an order higher than the rest of the UK. Which is -- I'm not quite sure as to the reason given that at the time -- when we referred back to the Covid Infection Survey, whilst the Scottish peak was a little bit higher, it certainly wasn't higher to the magnitudes that the hospital --

MR DAWSON: If one were to assume that one would be in hospital with Covid if one were iller with Covid, would that tend to suggest that there was a higher proportion of people in Scotland who were iller with Covid at that time at the severe end, that would make you go into hospital, than in the rest of the UK by way of average?

MR HALLIDAY: That's right. And again from the vaccinations data, it just -- the numbers are broadly comparable in Scotland and the rest of the United Kingdom, so it's -- I'm struggling to explain exactly what that is using the other data that's available to us around Covid.

LADY HALLETT: Mr Dawson, just going back to the Delta peak, autumn 2021, the whole of the UK suffered from the Delta variant, didn't it, so is there any explanation for that peak or is that not statistically significant?

MR HALLIDAY: I think there is a noticeable difference between -- I think that's a -- I'd put that in the same group as what happened in April 2022, that the levels of infection are slightly higher in Scotland, the levels of vaccination are broadly the same, and so I -- beyond that it's difficult to quite understand this. I guess one factor in this may be something to do with the underlying health conditions of people in Scotland relative to other parts of the United Kingdom.

LADY HALLETT: I think that's the point that Mr Dawson was then making.

MR DAWSON: Thank you, my Lady.

If I could take you on to the next slide, which is slide 27. This is one of the dashboards, so perhaps you, Mr Heald, on this one, "Cumulative Covid-19 deaths for Scotland". The graph shows the cumulative number of deaths in which Covid-19 is mentioned on the death certificate rather than excess deaths; isn't that right?

MR HEALD: That's right.

MR DAWSON: So would these have been the figures that PHS would have been releasing or were the PHS figures based

on some other statistic at the time?

MR HEALD: So my understanding is that these cumulative deaths are the deaths published by NRS, National Records of Scotland, and as we've talked about before, the figures from Public Health Scotland, once testing really ramped up, mirrored the figures that we saw in NRS. But these are the National Records of Scotland figures rather than the Public Health Scotland ones.

MR DAWSON: Just to be clear, we all remember that the headline statistics that would be given, for example, in daily briefings would include statistics for the previous 24 hours' infections and mortality.

MR HEALD: Yeah.

MR DAWSON: Those would have been provided by PHS, isn't that right?

MR HALLIDAY: Yeah.

MR DAWSON: And those PHS numbers for the most recent time period, I think it varied when it was a weekend for a slightly longer period or something, but would they -- what would the source about the information about the mortality have been in that?

MR HEALD: So for the daily reporting that was done, the source of the data would have been Public Health Scotland. And what we did in essence was link the positive confirmed cases to very fast data we were

getting from National Records of Scotland about death registrations, but those death registrations didn't have the detail, so we only knew about people who died and we matched them to the Covid data that we had --

MR DAWSON: Because I was wondering whether I could explore with you the possibility that that, in real time, creates a statistic which says "this is the number of deaths that have been recorded" --

MR HEALD: Yeah.

MR DAWSON: -- but it may be that, for example, certain circumstances of deaths would result in quicker certification, for example perhaps patients who are in hospital, than perhaps people who have died in the community where possibly whether it's a Covid death might not be entirely clear, does that statistically change things very much or are you basically reporting the deaths --

MR HEALD: It's the same -- so it's the same -- it's based on the registration, so it's the same time period. What I'm highlighting is that the level of detail available when the registration first comes through --

MR DAWSON: Yes.

MR HEALD: -- is not as detailed essentially as we were using the raw data about people who'd died.

MR DAWSON: Yes.

MR HEALD: NRS would then use the full record when it became available and --

MR DAWSON: I see, and I suppose overall it's possible that the overall numbers we see here might suffer from the fact that death certification might not be entirely accurate and there might be some Covid deaths missed.

MR HEALD: I think if you look at slide 25, it's in the pack, kind of shows the difference between what was recorded on the death certificate and what we found in Public Health Scotland. So we've already touched about on the kind of early period when there was a higher number --

MR DAWSON: Yes.

MR HEALD: -- from NRS, and that's down to the fact there was less testing at that time.

MR DAWSON: Yes.

MR HEALD: But you can see from the kind of July 2020 period all the way through, I would say that the Public Health Scotland and NRS figures matched pretty consistently --

MR DAWSON: I see.

MR HEALD: -- so that would suggest then that the recording of Covid, when it became available on the death record, was pretty consistent with what we got by matching --

MR DAWSON: Thank you.

MR HEALD: -- the deaths to the test data.

MR DAWSON: As far as 27 is concerned, we see a rise and then a plateau, if you like. Would that be roughly telling us the number of deaths that were in the first wave?

MR HEALD: Yes, so that March to --

MR DAWSON: It's March. It plateaus at around about June 2020 and that lasts till around about November 2020.

MR HALLIDAY: That's exactly right.

MR DAWSON: Yes, and I'm wondering, it might be overly simplistic, but it rather looks like you see a similar pattern in the second and what you might call the third waves, is that there's roughly 5,000 deaths in the first wave maybe slightly more than that but around about the same in the second wave; is that right?

MR HALLIDAY: That's right. It's over -- the second wave is over a slightly longer period of time but it's broadly similar.

MR DAWSON: Yes. And then we see a rise again from around about July 2021 through to the end of the period. Again, that's a more gradual line rather than a steep line that we saw before, but that would be a combination of Delta and Omicron, would that be correct, over that period? And again if one combines those two in that later period you see, broadly speaking, roughly the same

number of deaths, it comes to somewhere around 15,000 deaths, around about slightly under 5,000 in the first part, slightly over 5,000 in the second and slightly under 5,000 in the third; is that right?

MR HALLIDAY: That's right, but again it's over a longer period of time --

MR DAWSON: Yes.

MR HALLIDAY: -- the first to the second to the third.

MR DAWSON: Hence the lines are more or less steep.

MR HALLIDAY: That's exactly it, yes.

MR DAWSON: Thank you very much.

Could I take you on now to slide 28, please. I won't dwell too long on this one because it's quite complicated this one, as far as I can make out.

This is reflecting something different from the previous slide, which is excess deaths rather than deaths on certificates; is that correct?

MR HALLIDAY: That's correct.

MR DAWSON: And what this traces is the certification with the light blue line and excess deaths with the dark blue line, and very deliberately inviting you to try to keep your explanation as simple as possible I wondered if you could explain to us broadly why it is that the lines appear as they do.

MR HALLIDAY: Okay. So these two things are measuring

related but different, distinctly different things.
So the deaths with Covid-19 on the death certificate are the figures from the National Records of Scotland that we've discussed before. Excess deaths is a measure of all deaths whether that's related to Covid or not, and the chart here compares what happened during 2020 up to 2022 with what happened in the five years, month by month, and the numbers are above zero where there are more deaths than there would be expected at that time of the year, and it would be below zero, for example in spring 2021 and spring 2022, where there are fewer deaths than would be expected at the time of the year.
So what it shows is that there's a high peak both in excess deaths and deaths from Covid in wave 1, and the two lines match up pretty well, and that there is then -- the relationship between these -- the deaths from Covid-19 and excess deaths is relatively sort of -- there's a -- you know, those two things are relatively well aligned in wave 2 but then it becomes less clear cut the relationship between those two things.
MR DAWSON: Because excess deaths, as I understand it, doesn't mean just Covid deaths, it's the number of deaths more than would have been experienced -- had been experienced in a previous time period at a given moment.
MR HALLIDAY: That's right.

MR DAWSON: Would that give us some indication about deaths that occurred over this period that weren't due to Covid?
MR HALLIDAY: Yes, it would do.
MR DAWSON: Thank you. There's a couple more slides I'd like to take you to quickly. The next one is slide 34.
This is Covid mortality rates by self-reported disability category. These are, I think, age adjusted; is that correct?
MR HALLIDAY: That's right.
MR DAWSON: So it would be wrong to say, for example, that disability can be equated to old age, these figures were designed to strip out that aspect of the analysis, is that right?
MR HALLIDAY: That's right.
MR DAWSON: And this slide shows that, adjusted for age, those members of society who self-report as disabled had a significantly higher rate of Covid mortality when compared with non-disabled members of society; is that right?
MR HALLIDAY: That's right.
MR DAWSON: Thank you.
One further slide that I wanted to go to, which is slide 35. What this slide, which is based on Scotland again, tells us, I think, are the ethnic minority

communities, and those which suffered the greatest numbers of mortality in Scotland; is that correct?
MR HALLIDAY: Yeah.
MR DAWSON: From which we can see that the community that suffered the greatest number of deaths is the Pakistani community; is that right?
MR HALLIDAY: What this chart does show -- I mean, that's broadly correct. There is also a confidence interval here that says it was significantly higher also amongst the other Asian --
MR DAWSON: Yes, I see that. So the fact there's a broad horizon line indicates the confidence interval, I think. So I suppose it's possible that the second category is slightly more, but relatively speaking it seems to be that the Pakistani or other Asian communities suffered the greatest likelihood of death.
MR HALLIDAY: Absolutely.
MR DAWSON: Thank you.
Those are the questions that I have for you, thank you very much. If you just bear with me one moment.
There is nothing from the core participants, my Lady.
LADY HALLETT: Thank you very much indeed. I followed nearly everything that you've said, which is a miracle, given my self-confessed difficulty with graphs.

I'm very grateful for your help and I hope that you found having the two of you together worked quite well. It did for us. So thank you for everything you've done.
MR HALLIDAY: Thank you.
MR HEALD: Thank you very much indeed.
(The witnesses withdrew)
MR DAWSON: I think that the next witness will be Dr Audrey MacDougall. My colleague Ms Arlidge will be dealing with her.
MS ARLIDGE: My Lady, may I call Dr Audrey MacDougall.
DR AUDREY MacDOUGALL (affirmed)
Questions from COUNSEL TO THE INQUIRY
LADY HALLETT: Ms Arlidge.
MS ARLIDGE: Thank you very much, my Lady.
Dr MacDougall, you have -- thank you for your assistance in providing your evidence to this Inquiry. We see a witness statement from you, reference INQ000346964. It's just been brought up on the screen. I hope it's familiar with you. I believe on page 23, it will be redacted in this version, but you have signed that statement.
A. That's correct.
Q. And you're happy with the contents of --
A. Yes.
Q. -- the statement, that they're truthful --

A. Yes.
Q. -- to the best of your knowledge and belief.
There are going to be a series of areas I take you through during the course of your evidence. I will try myself to be as slow as I can be for the stenographer, who is doing sterling work in the background. I would ask you also to try and keep your answers nice and slow. I realise we're at the end of the day, and I can only apologise for that.
A. Certainly, that's fine.
Q. You are -- starting from the beginning, you wear a number of hats in Scottish Government in terms of analytical, statistical, research hats. Is that a fair way of putting it as a broad spectrum to start off with?
A. I think to try and just encapsulate the period covered by the Inquiry, at the start of that period I wore two hats, if you like, I was the Scottish Government's chief social researcher, which is a professional role, looking after social researchers within the government and looking after the promotion of social research within the government. I was also head of what was called the communities analysis division, which was a division made up of different types of analysts, researchers, statisticians, economists, who provided analysis covering a range of areas, poverty, social security,

housing, a range of different areas. So when Covid started, those were the two roles that I fulfilled.
I then moved to establish the Covid modelling and analysis hub, to specifically look at doing the same job, if you like, but solely focused on Covid issues, so looking at providing a wide range of evidence and analysis but related to Covid issues.
However, I didn't give up my communities job for about a year, so there was about a year when I held three posts.
Q. And shortly after you commenced working, setting up the modelling and analytical hub -- I'm sure I'll get that wrong multiple times -- MAH, for the --
A. MAH.
Q. MAH. Shortly after you joined that and set it up, you recognised that the scope of the work that was involved no doubt was enormous and you asked Mr Roger Halliday, who has just given evidence, to join you in that hub?
A. That's correct. We felt that we had a very good complementary set of skills that myself as a social researcher and Mr Halliday as a statistician, we knew each other well, we had worked together before, so we felt that that would be a very good combination. And then in practical terms the hours that were being worked by the hub and the need for that senior oversight,

you know, for very many hours every day meant that it was impossible for one person to do the job.
Q. And in due course, early on but in due course, you were also very heavily involved in setting up and the development of the four harms strategy and providing evidence and analysis in that regard?
A. That's correct.
Q. To go to the very sort of genesis of the MAH, my Lady has already heard evidence -- sorry, comments yesterday from Jamie Dawson about the set-up of things like SGoRR, obviously that was pre-pandemic?
A. Yeah.
Q. It was a system that was already in place?
A. Yes.
Q. Is it correct to say that SGoRR, having been activated in light of the pandemic and the need for responding, requested your analytical approach or your evidence and your assistance in the very early stages --
A. Yes.
Q. -- early March to say "We need eyes on things from a statistical and modelling analysis" --
A. Yes, that would be correct, yes.
Q. So you were requested to provide that sort of analysis from about 4 March 2020?
A. So that was when I became involved, but there were other

people who had been providing analysis before then under the auspices, say, of the health analysis colleagues, or there may have been other colleagues in other parts of the office who were starting to get involved as well. The whole organisation was turning itself towards looking at Covid, so I wouldn't want to give the impression that there was nothing happening before then, there certainly was activity going on. But when SGoRR invited me to become involved, it was really recognising that this was a step change to any crisis that had been dealt with before and would benefit from having a central co-ordinating and specialist division. That would then draw in work that was happening in other parts of the office as well.
Q. So you were therefore to able to provide a sort of central focal point --
A. Yes.
Q. -- and leadership role in respect of multiple areas --
A. That's right.
Q. -- of information and modelling --
A. Yes.
Q. -- coming to your attention and effectively drawing together threads from different departments --
A. Yes.
Q. -- who were presumably all carrying out their own

individual assessments from different, in different, transport looking at one aspect of things --

A. That's correct, absolutely, yes.

Q. When you took leadership of the MAH, how many people were sort of at your disposal, as it were?

A. Well, I think we probably started in week one with about five people, and one of my first tasks was to actually staff the division correctly, so that was the -- indeed my first week or so spent in actually making sure that we had sufficient staff of the right grade and of the right quality and the right skill, and that was undertaken by drawing out the relevant staff from other parts of the Scottish Government.

From my role as head of profession and working with the other heads of profession in Scottish Government, I had a reasonable oversight of the talent that we had available to us, so I went shopping and asked for particular people to come and work with me, and gradually built up, you know, a reasonable sized division.

Q. You set out at paragraph 15 of your statement that you agreed effectively a programme of work with your colleague -- with the key --

A. Yes.

Q. -- Scottish Government directors?

A. Yes.

Q. Is it the case effectively you had something of a blank sheet of paper and you had -- there was a discussion that went on between the various directors and yourself saying "This is the sort of thing we can assist with, these are the things that are on our sort of radar"?

A. That's exactly it, I mean, this is the initial programme and, as you will see going through the statement, it changes over time in terms of the actual work we do, but the work always generated either from commissions from ministers or from other colleagues, particularly policy colleagues, or the work could be generated by ourselves where we proactively felt that there was some gaps in the evidence base or gaps in our knowledge, and we initiated work to fill those gaps. So it could go either way, it could be a commission or it could be something that we put forward.

Q. Just looking at those various -- again, like my predecessor in standing up here a moment ago, please don't get too complicated in these answers -- but looking at the initial programme, we've got things -- we've got developing the population base --

A. Mm-hm.

Q. Could you just very briefly explain what a population base --

A. Sure.

Q. Probably saying to you briefly explain something that is an incredibly complicated issue is a bit difficult, but population base models: is that looking at who is a member of the society -- the population that you're looking to model?

A. So I'll just say a little bit which hopefully might help in terms of modelling, and I should preface this by saying I am not a modelling expert, I had some modelling experts in my staff, but broadly speaking there were three types of modelling carried out during Covid. There was epidemiological modelling, which was the modelling that gave us the R number, the growth rate, the infection rate, and that's what SPI-M-O was concerned with, and that was at the core of understanding what was happening with the pandemic.

Then there was what was called operational modelling, and by its very nature -- you can get the idea -- operational modelling was taking that epidemiological modelling, using that to say: well, what does that tell us about cases, what does that tell us about potential hospitalisations, ICU, so you could use it for operations, how many hospital beds might I need.

Then you have policy based modelling, and that's what this refers to, is taking that epidemiological

modelling but then using it to try and say: well, what would happen if we did X or we did Y, if we implemented different types of scenarios, and that might be either things that we're doing, ie things that the government had chosen to do, or it might be just different scenarios. Well, what if we think, instead of 80% of the population getting infected, it would be 60%, what would that mean? So ... does that help?

Q. It does.

Just going through some of the other points there, so leading on responding to commissions from SGoRR, again you say you're not a modeller, but this is where SGoRR, headed by Andrew Morris, comes and says to you "Please can you give us a model about the likely transmission rate in" --

A. So -- indeed, so we could be asked: could you model what might happen if the transmission -- if, you know, 60% of people became infected, 70%, or could you model what might happen if R was 2 or R was 4 or R was 6, you could model on that basis. Commissions from SGoRR that could also consist of work that wasn't modelled, it might be, for example: what do we know? I mean, you know, what's the latest on the science and transmission then? What is it telling us? Or it might be: what do you think people in the street are saying, you know, what's

happening? So it could be a range of different types of evidence.

Q. I'm asked to remind you -- remind myself that I misspoke by saying SGoRR was headed by Andrew Morris. It's SCAG that was headed by Andrew Morris, I apologise.

But nevertheless, the same sort of approach, so SGoRR, because SCAG was subsequently set up and --

A. Yes.

Q. -- were also asking for data and modelling to be carried out and to, on that same sort of basis; is that right?

A. On the same sort of basis, but with SCAG, when it was established, initially Roger was the -- was a member to represent our division, and then when Roger moved on, I became the member of SCAG to represent our division.

So it went -- again, there was a kind of a both-way relationship with SCAG. We would present the work we had done to SCAG -- to look for commentary, critique, discussion -- or SCAG could ask us to produce the particular pieces of work, and we would go and do that.

Q. Then updating, controlling and sharing the central assumptions and parameters that everyone should be working to; is that a sort of proced -- that's not modelling assumptions necessarily, that's much more -- is that more in the sort of "these are the key performance indicator styles" approach?

A. Could be modelling assumptions but, it would be just generally: here's what we're assuming about the pandemic at the moment, based on the current state of what we know in terms of the science, in terms of what SAGE is telling us, in terms of what SPI-M-O is, and ensuring that everybody across the office had that same broad understanding of what was happening.

Q. Was the MAH asked to provide specific advice on specific policy questions from the outset or from early March, or was it more sort of general "Show us where things are going"?

A. So it started off obviously with "Show us where things are going", but as soon as government moved to a position of wanting to introduce NPIs or wanting to, you know, make changes of any sort, then we were asked if we could model through the impact of certain of those changes that were going to be made. So that became a regular -- a regular occurrence throughout the whole of the pandemic.

Q. From -- if I might take some sort of specific examples, were you asked, for instance, to model issues about discharge of patients into care homes and the effect of that?

A. No, we did not model discharge into care homes.

Q. Were you asked, in terms of care -- appreciating that

there was subsequent issues in terms of subgroups about children and education -- before those subgroups came about, were you asked about modelling into or providing evidence in terms of things like education closures and the like?

A. So we were asked to look at what would be the impact, let's say, on R and then the subsequent case numbers of the closure of schools, that would be a valid modelling --

Q. When was that sort of -- I appreciate it's not meant to be a memory --

A. Oh, goodness. It would have been done at various points in time, because schools were opened, closed, and then partially opened, you know, so there was -- it would have taken place at different times, it would've done that kind of modelling.

And that would have been based -- just to clarify, as well, the basis on which it would have been done -- it would have been based on assumptions that would have come from SAGE.

Q. I apologise, Dr MacDougall, I'm being asked if you could just try and slow your responses slightly.

A. I apologise.

Q. I apologise. I know it's very difficult.

At the very beginning, 4 March, 10 March, 12 March,

when SGoRR come and ask you to have greater input?

A. Yes.

Q. Of course you've already given evidence that there was embedded analysis in each different department, for instance.

A. Yes.

Q. The -- I think it's uncontroversial that knowledge of the existence of the threat of Covid was growing.

A. Yes.

Q. And the early COBR meetings in which people were, you know, recognising that there was a need to ascertain whether there was sufficient resilience in the system, what's it going to look like in Scotland, have we got enough beds, have we got --

A. Yes.

Q. Was that sort of analysis being done within the departments before you set up MAH, or were you having to start effectively from not necessarily zero but a very basic level of blank sheets to start?

A. So because I wasn't involved before 4 March, I can't comment on exactly what was happening, but I don't think one could say that nothing was happening.

Q. Could effort -- could MAH have been set up earlier?

A. It's a question that as analysts we will always say we want to be in the room from the beginning, but there's

always a trade-off between people trying to just get it -- try and formulate the question before we get involved, trying to work out what the scale is of the issue before we get involved. So it's always a little bit of a trade-off as to at what point, say, should something like MAH be put in place.

We are, for the future, for future crises, following on from debriefing from Covid, we have written some guidelines about what might happen in the future.

Q. And what do those guidelines say, briefly?

A. And I think, yes, I would look for perhaps an earlier activation of this kind of -- this kind of division.

Q. Because to some extent it's sort of self -- it's a self-fulfilling prophecy or self-evident that the earlier you get involved, to some extent, the more data that you're able to get your hands on, the more data you're able to analyse, the more able you are to think about the questions that need to be asked at an early stage, so you don't have so much of a blank sheet of paper when you start?

A. I think that would be true, but I would like to qualify that by saying although my division wasn't there, there were other people doing work.

Q. When you -- just on that point, then, when you set up the division, were the people that were working in the

various departments, were they people that were bringing into the division or did they remain sort of embedded in their respective directorates?

A. No, I brought people into the division, they moved away from their own directorates, so they weren't trying to do two jobs at once.

Q. So -- but you were utilising their expertise and their particular --

A. Yes.

Q. -- or the knowledge of the work that they'd been doing prior to MAH being --

A. Yes, yes.

Q. Following on, again just in terms of data sharing and how things were set up, if we look at paragraph 19 of your statement -- it should come up on the screen.

A. Yes.

Q. Thank you.

You note there that you need -- I suppose this is the sort of the other end of the telescope. You're getting information and analysing it, but it has to go somewhere --

A. Yes, that's correct.

Q. -- and it has to be shared with the right department?

A. Yes.

Q. So you recognised the importance of effectively not

working in a silo, and using the other end of the telescope to give that information to the relevant people and the relevant decision-makers?

A. That's right, yes.

Q. Now, you say in this statement that initially it was for senior analysts in Scottish Government, but by the end of May it was for all interested parties, it was gradually expanded to include latest data, evidence and research alongside modelling. So it grew --

A. Yes.

Q. -- as it -- from no doubt 12 March when you were setting it all up --

A. Yes.

Q. -- there was less information --

A. That's correct.

Q. -- and you were giving it to fewer people.

A. Yes.

Q. You had a weekly call.

A. Yes.

Q. When did the weekly calls start, the original, the initial weekly calls?

A. The initial weekly calls with a small group of analysts will have started a week after I started in the role.

Q. And by senior analysts, do you mean other modellers, other ... what do you mean?

A. I'll explain to you. So each, you know -- as you have no doubt had a lot of information about the structure of the Scottish Government, so the Scottish Government is made up of directorates, if you think of a DG family, each DG family would have at least one division in it that was made up of analysts, and that division would be headed up by a senior civil servant who was an analyst, so my equivalent in -- and there would be one of those divisions in education, in justice, in health, in ... with specialists in those topic areas as well as particularly specialists in particular skills and methodologies and so on. So initially I was dealing with those SCS analysts.

Pre-Covid, and indeed as a routine, we had a leadership group called the analytical leadership group where all the senior analysts meet about once every six weeks to discuss areas of mutual interest and cross-cutting issues across the government. So this was a ramp-up, if you like, of that.

Q. So, to start off with, it was analyst to analyst, as it were?

A. Yes.

Q. And then those analysts were expected to feed up the --

A. Yes.

Q. -- analysis that you were providing --

A. Yes.
Q. -- to the hub to their respective director general areas?
A. Indeed.
Q. So at that point is it fair to say that you didn't have so much direct contact with the director general or the directorate decision-makers in terms of sharing your modelling?
A. So in terms of sharing modelling, at this point I was engaged primarily with the senior policymakers in the health DG, and was -- and I have to say occasional, because I can't necessarily say I was at every meeting -- but was invited to gold meetings and various other meetings where ministers were present to present on modelling and -- I think Mr Halliday said the same -- we took it in turns to present information at those types of meetings.
Q. You say -- staying with the same paragraph of your statement, you say it became a key -- the weekly Covid --
A. Mm-hmm.
Q. -- became a key communication tool for disseminating the modelling the evidence and the analysis. It was regularly attended by over 100 people, including the Chief Medical Officer, CSA, NCD and senior colleagues.

To be clear, is that the "by the end of May" time, or is that later on? So you say earlier in your statement "By the end of May it was for all interested parties", but did it continue to expand into people like the CMO attending and --
A. Yeah, it was opened up to all interested parties, so quite literally an invite was sent out to anybody in the government who was working on Covid who would find it useful to have a weekly update, and attendance built up as more people got involved, more people got engaged, and as the range of our evidence expanded as well, and that naturally expanded as more evidence became available and more research became available.
Q. So when -- again I don't need a specific date, but approximately when did the CMO start attending those weekly calls?
A. Oh, goodness. I'm not sure. I just can't hazard a guess on that, honestly.
Q. And as they expanded and you had more people joining and an open invitation, presumably the -- with other analysts, they understand the principles about modelling, they understand more readily how the evidence is being assessed, did it -- did your calls have to engage at a level of trying to explain what it all meant and explain the principles --

A. Yes.
Q. -- behind modelling as it went through?
A. Yes.
Q. So how were you able to ensure that those decision-makers and those senior members who were attending were able to, you know, understand what is modelling and the like?
A. I think we tried to present the information in a way that was readily comprehendible, but we also -- the call itself wasn't just my team presenting information, there was also a period of time set aside for questions, and it was made very, very clear that any question could be asked, so it could be what people might think of as a very basic question, that was absolutely fine, or it could be a more complex question, and we had a mix of both, and we used that as feedback. So if we were getting feedback that seemed to indicate that people didn't understand one element of our presentation, then we would change that for the following week.
Q. I'm relieved to hear that no question is too stupid from me at least.
Can we think about -- and appreciating you're not a modeller, but you've already touched on slightly in terms of how modelling, what modelling is and how it works. It's a term that is used sort of

interchangeably, isn't it, to not necessarily reflect those three areas that you were talking about, but if we take them all in stages in slightly more detail, but very slightly more detail, than you spoke to a moment ago: epidemiological modelling, that was done in both in-house in Scottish Government, wasn't it, and also by applying -- by using other external modelling groups, so SPI-M, as you've already spoken to, that fed into SAGE?
A. Yes.
Q. You were working with other universities?
A. Yes.
Q. And Scottish Government had their own --
A. Yes.
Q. -- modelling approach in which, is it right that they were using the Imperial College of London's modelling?
A. Yes.
Q. Like base --
A. Yeah.
Q. -- sort of structure, as it were, and then applying Scottish specific data to it?
A. That's correct. So from a very early stage Imperial College published their modelling code and so it was available to use. We obviously spoke to Imperial College and we made adjustments for Scotland so we could make adjustments for the age profile of the

population, for example. We then ran, if you like, our own model. We wished to build our capacity in-house and run our model in-house, so we ran that. We also, via our CMO, we asked our CMO to request that SPI-M started to model Scotland separately, because to begin with there were only UK models and we felt that the UK models weren't an adequate representation of what we were starting to see happening in Scotland. At that point in time SPI-M-O were starting to run regional models for England so they then agreed that, yes, separate modelling for Scotland would be appropriate.

Q. Just pausing there for a second, when was "at that time"?

A. Oh, it was in March, I mean, it was very early on, so we're a couple of weeks into it when we decide that we really do need to have separate Scottish modelling.

We -- a combination then of our own conversations by our modelling team spoke to some of the modelling groups in the universities to say: would you like to model Scotland? And a number of the groups agreed that, yes, they would model Scotland. So that enabled us to have a number of groups modelling Scotland specifically, including ourselves, and then we could gradually bring those models together to form SPI-M or consensus.

You've probably heard about the consensus approach

being really important, because any one model by itself could be misleading or could be less accurate, if you like, by bringing a number of models together and creating a consensus you get a quality assurance of what's being done.

Q. Because someone could just simply put the wrong assumption in and it would result in an aberrant outcome?

A. Absolutely, yes.

Q. So there's a bit of cross-marking and peer review, effectively?

A. So it's a peer -- indeed, that's exactly what SPI-M-O would be, a peer review process.

Q. And that sort of epidemiological modelling allows for sort of short term analysis, "Look, this is what we think is going to happen, within a certainty level of degrees, over the next couple of weeks, the next month or so", and then longer term modelling with --

A. It's uncertain.

Q. It becomes more and more uncertain?

A. It becomes more and more uncertain, particularly it depends on what assumptions you might want to make about whether you intervene to change the existing situation. Obviously if you assume that what's happening today will continue to happen and I am making no interventions,

you'll project forward and you'll get an idea of what might happen, and I think some of the early Imperial College models, for example, that's what will have happened, because if no action is taken, here's what things might look like. Whereas more useful modelling is to try and say: well, okay, what if we did this type of intervention or that type of intervention, can we do some sort of scenarios or estimates as to what difference that might make?

Q. Just to go through a sort of very basic modelling approach, could we have, please, on screen INQ00029254. I hope this doesn't hurt everyone else's eyes the way it hurts mine, but this is a document produced on 24 March, so the day after lockdown, and it's a -- is it an early attempt to model what is happening and what is likely to happen in the reasonable worst-case scenario in Scotland when assessed in terms of infections, deaths, need for hospital beds and the like?

A. Yes. Yes, put simply, yes, and it gives you two scenarios, one with no social interventions, one with -- the "do nothing" scenario, if you like -- one with social interventions, and the social interventions are listed out here, the kind of things that you might do. Or if not listed here, they will be listed in --

Q. They're at line 21, the social interventions applied --

A. Oh, that's right, sorry, apologies, there you are. So yeah, that's an initial attempt to --

Q. Just as a sort of worked example, as it were, am I right in reading this that the way this -- that no interventions, when we look at reasonable worst-case scenario, the -- it's anticipated that there will be a peak of infections in Scotland per week of just over 1.1 million?

A. So you would have hit a peak of 1.1 million, so that was based on a range of assumptions about the percentage of the population that was likely to be infected, how quickly the pandemic would spread and how transmissible the pandemic was, and then there was a hospitalisation data, what percentage of those who got sick would need hospitalisation.

Obviously because this was very early days, we didn't know -- obviously we didn't know about vaccines, we didn't know we were going to have vaccines, so this was a kind of very, just native, if we did nothing and, you know, the epidemic just spread --

Q. And the version within -- with those social interventions effectively was based on, was predicated on all of those interventions just being lifted after three months, or whatever the figure was --

A. Yeah.

Q. -- and then in that position the modelling was still saying -- was saying effectively the same thing is going to happen it's just going to be --

A. Shifted.

Q. -- 15 weeks later, 14 weeks later in the piece?

A. That's correct, because what you would do is dampen down but then you would shift.

Q. You'd see the ping back or the bounce back that we hear about.

A. Yes.

Q. This document was then, I think, presented effectively to Scottish Government by way of a sort of slide pack, I think by your colleague Mr Halliday.

A. Yes.

Q. If we can just go to that very briefly, INQ000292555. I think this is an attempt to make the information slightly more accessible to those who ...

(Pause)

A. Yes.

Q. So we can see at this stage, so very early on, but there have been some updates from a previous -- this is I think version 1.8, but it's still early doors.

A. It's very early days, yes.

Q. On page 4, we look at the key assumptions that have been applied in that modelling.

A. Yes.

Q. Who decides on how -- these assumptions and how they're applied?

A. So the assumptions that we were using at that point were assumptions that would have come through SPI-M or SAGE. We weren't certainly creating our own assumptions.

Q. And it may be in those circumstances you can't assist with this question, but it says there at the bottom:

"Assumes care home residents are not moved."

A. Yes. I think the position, and I'm fully appreciating the issue around care home residents, I think in this situation it was rather the other way round: are care home residents going to be moved into hospital, rather than are people being moved from hospital into care homes.

Q. And then if we just turn to the next page, page 5, we see the caveats that are being highlighted as not being factored into things. Were these -- again, are these from SPI-M-O or SPI-M, or are they ...?

A. So --

Q. Are they you and your team saying, "Well, hang on, these are things that we might need to factor in"?

A. It was -- this would have been a little bit of both, because some of these were things that, you know, wouldn't have been factored in by any modelling group

doing modelling, whereas for example number 10 there would have been quite specific to us. And number 7, we haven't adjusted for Scottish geography, so they would have been quite specific to us.

Q. If we move to a slightly separate section of your evidence, please, in terms of the route out, the route map.

A. Yes.

Q. So we know that the Scottish Government published their route map, their framework for decision-making, in April 2020, and is it right that your team were then asked to provide data and evidence in respect of the issues that they were looking -- the metrics?

A. Yes.

Q. Do we see the first -- if we bring up INQ000131026, this further -- you look puzzled.

A. I tell you why I look puzzled. It is true that we were asked to produce information and, if you like, a measurement framework in and around the four harms, but it's not this document. There is another document that was published around about the same time that did that.

Q. Can I -- I'll take you through some of the evidence in this --

A. Apologies.

Q. It deals with metric, I apologise if that's not the direct document, but I think it deals with metrics that we can look at.

A. Certainly.

Q. So if we look at page 9 of this document, we see -- so this is evidence that is being provided in terms of health impacts and --

A. That's correct, yes.

Q. So spread of the virus, our lockdown rules are working, we get various statistics and then if we look at just at the bottom of that page, if we scroll down, the charts show a range of key measures in the pandemic in Scotland, new cases, hospitalisations, numbers. Are those the sorts of data that you were providing from the MAH, even though it might be in a different document and a different approach?

A. So key measures of the pandemic came from different places. I think you've already heard from Mr Heald from PHS, who were actually responsible for a lot of the daily data in terms of cases and hospitalisations, ICU and so on. So actual data was being fed through PHS to ourselves.

Q. And then in an analysis of, in support of or in measuring --

A. Yes.

Q. -- the way the interventions were working --
A. Yes.
Q. -- or whether lockdown needed to continue and the like, that was being fed through your team in the MAH with those sorts of information and being able to model through?
A. So we could use PHS data to model through what might happen. So particularly case data, for example, was a typical input to a model, and we would use PHS case data for that.
Q. Again, given this isn't quite the document, you might not be able to assist, but if we look at page 12, so we see here, this is a document from May 2020, just for clarity, the --
A. Yes.
Q. -- sort of headline figure, headline title, "Limited headroom to change restrictions", and it says:
"While precision on the R number is difficult, it's likely to be 0.7 to 1."
R number something, of course, that the MAH was particularly --
A. Yes.
Q. -- keen and interested in in terms of analysing the ebbs and flows of the pandemic, and the --
A. That's correct.

Q. -- applications.
It says, the second half of that:
"This is an average for all of Scotland. The R number for community transmission in Scotland is estimated to be below R number in care homes and hospitals. This is a matter of critical concern."
A. Yes.
Q. So in other words, general community perhaps closer to 0.7, for example, but because it's an average --
A. Yes.
Q. -- knowing that there were higher -- there was higher R number --
A. Yes.
Q. -- in care and hospital settings was dragging the R number up in the average R number up --
A. Yes.
Q. -- is that right?
A. I'd have to think about the actual proportions to say what exact difference it might make. But, I mean, obviously what you're seeing here is you've got an R number but then you're seeing actual data in terms of what's happening in hospitals and happening in care homes, that's not aligning with the community R number, so you can see that the R number may be higher.

Q. And I think in due course you -- again, it might just be easier to bring it up on screen. INQ000249321, page 7. This is a document, sort of sets out how the pandemic is being modelled in Scotland, broadly, and it says there:
"Estimating R in different settings.
"There are at least three different epidemics in Scotland ..."
A. Yes.
Q. So effectively quite early on you were --
A. We were aware.
Q. You were aware through different --
A. Yes.
Q. Community -- am I right, is it community, hospitals and care?
A. Yes.
Q. Is that the three?
A. Yes.
Q. The communities that you're looking -- the three metrics.
You're looking at the whole population model. It notes other types of models are needed to analyse those three segments of society, as it were, and you're working with academic groups from around the UK to develop modelling for those settings.
Did they ever come about, those models?

A. Care home modelling came about, there was care home modelling done through SPI-M, we didn't do it, it was done through other people, through SPI-M, and --
Q. Was that SPI-M modelling Scottish specific?
A. No, not Scottish specific.
(Pause)
I think we did -- there will have been some analysis done of care homes, because modelling is a very particular tool, when actual data starts to become available one can also be looking at actual data and, you know, getting some better estimation of what's happening rather than trying to model forward.
Q. We heard evidence earlier today about the sort of concerted effort to publish lots of data, to be open and --
A. Yes.
Q. -- produce the data and the modelling.
A. Yes.
Q. Was that something you in the MAH were particularly concerned about?
A. Yes. We were very keen -- we realised our material wasn't for everybody, that some people may not wish to engage with us, but we were very keen to try and get material out when we felt appropriate. So from a very early stage, our Modelling the Epidemic report was

produced, and we produced that on a weekly basis for most of the pandemic, moving to fortnightly nearer the end. And that was put out there to give a degree of transparency about what we were doing, to recognise the caveats, recognise what it could and couldn't do, and to invite comment in the sense of we were very happy if people wanted to get in touch with us and make suggestions for improvement or suchlike, so, you know, that was why we put that out there. And indeed I think it served its purpose in that sense. We did have a lot of people get in touch, ask questions, get in touch, offer advice, offer help.

So, yeah, I was -- I felt that that achieved what I wanted it to achieve. It wasn't a document that I thought everybody, you know, in the general public would be reading, but for what I wanted and for the audience, I felt it was -- it worked.

Q. Is there a risk in publishing so much data that it becomes overwhelming and sort of it's the only show in town, as it were, because it's the most -- it's the thing that's shouting the loudest?

A. Yeah, it is interesting, that, because, I mean, we did publish a lot of other material. There wasn't just modelling. We published a State of the Epidemic report, which we didn't start until slightly later on in the

pandemic, but then we did a weekly round-up, if you like, for the public, we had our four harms website, and we published quite a range of research reports.

Now, it's a really good question whether everybody just really then focused in on this modelling and didn't perhaps pay due attention to some of the other forms of evidence and analysis that were published and available, and that's always a risk, but preferable I think to put as much out as possible.

Q. Because there's always a risk that something like modelling and its extremely difficult concepts run the risk of looking like it's a crystal ball, like you're able to predict --

A. Yes.

Q. -- the future, and therefore some may say that, "Well, the modelling says this", and become fixated simply on the modelling rather than taking it in the round with other, less attractive crystal ball approaches?

A. And that was part of the reason for the four harms approach, to try and provide a framework within which you could wrap up, if you like, or encapsulate quite a range of evidence and analysis looking at the issue from different angles. So it wasn't just looking at modelling, harm 1, that's all. It was trying to take into account a much wider range of approaches, evidence

and perspectives.

Q. And at the other end of the telescope in terms of public interaction, you were carrying out polls and --

A. Yes.

Q. -- studies in terms of --

A. Yes.

Q. -- contacting people?

A. Yes.

Q. (a) to -- and that feeds into the modelling in itself, doesn't it?

A. So the Scottish Contact Survey certainly fed modelling, one could model based on contact survey. What the Scottish Contact Survey did was survey people to find out how many people they'd been in touch with during the week. So it would be quite literally, "Well, you know, I met one person in a shop, I met one person in ..." and by that you build up a picture of the population, of the amount of contact people are having with each other, that has a impact on transmission -- the more people you have contact, the more, you know, high risk for transmission -- and that can feed into a model.

So that was one sort of survey, if you like, interaction with the public, but we were also doing work such as polling to try and find out a little bit more about the public's attitudes, public's level of

compliance, public's sense of wellbeing, a range of different issues.

Q. Because things like compliance will also feed into whether the NPIs are likely to continue working or --

A. Indeed.

Q. -- the effectiveness changing over time. If people are less likely to comply with lockdown rules as time goes by, that feeds into the modelling --

A. That's correct, and that would feed into -- that would be one of the considerations within our four harms approach was that consideration of compliance. Actually "compliance" is really not a very nice word, but adherence. But, you know, the general idea would be one wouldn't put something in place that people would find it impossible to adhere to.

Q. And presumably some of that polling was particularly useful in the context of harm 3?

A. Yes.

Q. And was that a major source of information and data for harm 3? Because it's quite a difficult thing otherwise, I would imagine, to --

A. Yeah, yeah, it was a major source because it was a weekly source so, you know, it was one thing that we could use to get regular information. Other information that fed harm 3 came to a variety of different research

projects or reports, but certainly wouldn't have been available or updated on anything like a weekly basis.
Q. In terms of the polling and the studies that were being undertaken, are you aware of to what extent were Scottish specific polls and studies carried out in respect of minority groups, in respect of the particular effect that -- for instance, that we've heard about this morning -- NPIs having on ability of people in the disabled communities to access care or food or ...?
A. So, I mean, through our own polling we could only split down so far in terms of different groups within the population because the poll simply wasn't large enough to get every group that one would -- underrepresented group that one would like, which was why then in -- individual research projects were launched which involved focus groups, interviews, different types of interactions with people from different groupings, and that would have included ethnic minority groups.

We also drew on the work of representative bodies themselves, so where representative bodies themselves had undertaken their own research and, you know, polling or surveying or whatever, we always invited them to, you know, share that with us and that became part of our evidence base.
Q. Very, very briefly, a whistle stop tour of the four

harms strategy --
A. Okay.
Q. -- which I'm going to apologise in advance for. INQ000131028.
A. Ah, yes.
Q. This is hopefully more familiar in terms of that's what you were expecting to be drawn up. This is the 11th -- it's dated 11 December, I think, setting out the detail of the four harms.

I appreciate lots of evidence will be heard about the four harms and the way it was put, how it was dealt with across government, but just very briefly in terms of your role --
A. Yes.
Q. -- you -- is it true that -- is it true to say that your -- the harm that you probably had in your researcher -- wearing your researcher hat, that was harm 3 in particular, as we've just said?
A. Yes.
Q. If we just look at page 22 of this document, that sets out sort of broad analysis, broad description of those harms.
A. Yes.
Q. Wearing your respective hats, to what extent were you involved in trying to balance different harms, or were

you simply being required to provide evidence in each, under each heading of each harm, as it were?
A. So, I'll try and explain my role here. My division were obviously responsible for a lot of the information that fed harm 1 through our modelling work and through our scientific review work that we undertook, and we provided a lot of input into that, along with our scientific and clinical and medical colleagues. That was harm 1.

Harm 2, the main work was undertaken by my colleagues in health analysis, they undertook that work.

Harm 3 was myself, our Chief Social Policy Adviser, who was ultimately responsible, and our colleagues in areas such as justice, education and so on. Including some of our own work, though, because you'll notice topics here like loneliness, anxiety, trust in government, social capital. These were all subject to -- these were all part of our polling and our own research, so that was a mixture. As you can imagine, because harm 3 was that very broad, so it took a lot of inputs.

Then harm 4, which was the economic analysis, was carried out by my economics colleagues and led by our Chief Economic Adviser.
Q. In terms of your role in MAH, you weren't being asked --

or were you -- to try and undertake that balancing between the various harms as opposed to "Please provide the evidence of harm 3, harm 4"?
A. Well, not as an individual but I was a -- one of the core attendees at the four harms meeting. So that extent, you know, I would have a perspective and I would give my views. But I was also responsible on a regular basis, if you like, for co-ordinating and bringing together all the material that was produced on all the harms and writing it up in a way that was then presented to ministers.
Q. So providing advice in respect of that balancing exercise and --
A. Yes.
Q. -- where there were more red lines, as we were looking at earlier?
A. One of many colleagues who were involved. This was a very collaborative effort.
MS ARLIDGE: My Lady, may I just bend down to check?

(Pause)

I have nothing further for you. Was there anything you would like to add, Dr MacDougall?
THE WITNESS: I -- two things I just want to say, really.

First of all, I really do want to get across the idea, if we can, that this was an incredibly

collaborative effort, and although by the very nature of the Inquiry you're interviewing lots of other individuals, all our activity was terribly collaborative. So you obviously just get partial views from everybody you speak to.

But the other thing that I would like to do is to pay tribute to the analytical staff within the government who were responsible for the production of some really sophisticated and new and, you know, really high quality analysis and the amount of work and effort and the hours that people put in was phenomenal. So I would really like to pay tribute to my colleagues.

MS ARLIDGE: My Lady, do you have any questions?

LADY HALLETT: No, I have no questions, thank you very much.

Thank you very much for your help, Dr MacDougall.

THE WITNESS: Thank you.

LADY HALLETT: Very helpful.

(The witness withdrew)

LADY HALLETT: Right, 10 o'clock?

MS ARLIDGE: My Lady, just before you rise --

LADY HALLETT: Oh, yes, you wanted to ask about publication.

MS ARLIDGE: -- I'm going to need to ask about some -- make an application for publication in terms of all of the witnesses' statements that have been heard.

LADY HALLETT: Certainly, all the documents that you wish to

have published from today shall be published.

MS ARLIDGE: I'm very grateful. Thank you very much, my Lady.

LADY HALLETT: Thank you. 10 o'clock tomorrow, please.

MS ARLIDGE: Thank you.

(4.30 pm)

(The hearing adjourned until 10 am on Thursday, 18 January 2024)

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