

Wednesday, 17 January 2024

1
2 (10.00 am)
3 **LADY HALLETT:** I don't seem to have any papers, or my
4 notebook. I think they're in my room. If we carry on,
5 by the time someone's been upstairs ... can we get
6 a message? Okay, thanks.
7 **MR DAWSON:** Thank you, my Lady.
8 I was simply going to introduce to you this morning
9 that, as I said yesterday, we have a number of witnesses
10 this morning who are giving evidence from a number of
11 impact organisations. The first witness this morning is
12 Mrs Jane Morrison.
13 **LADY HALLETT:** Thank you.
14 **MRS JANE MORRISON (affirmed)**
15 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 2A**
16 **MR DAWSON:** Good morning, Mrs Morrison. If you could try to
17 speak, as best you can, into the microphone so we can
18 hear you nice and clearly, that would be much
19 appreciated, thank you.
20 You are Mrs Jane Morrison?
21 **A.** Correct.
22 **Q.** And you have already given evidence, I think, to
23 the Inquiry in its Module 1?
24 **A.** Correct.
25 **Q.** And you give evidence this morning on behalf of

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1 **Q.** As I understand it from the testimony that you've
2 provided to the Inquiry, she was an inpatient in
3 hospital, having developed jaundice, and she was
4 undergoing some tests.
5 **A.** Correct.
6 **Q.** She had been in hospital for two weeks when she caught
7 Covid, catching it on the 15th day of her stay in
8 hospital?
9 **A.** Correct.
10 **Q.** I understand that the tests for her underlying health
11 condition had taken much longer than would have been the
12 case before the pandemic?
13 **A.** That's correct, yes.
14 **Q.** Why was that?
15 **A.** There are things like scans -- every time someone went
16 in the scan it had to be thoroughly disinfected
17 afterwards, and then they had to wait at least
18 20 minutes before they could let another patient come in
19 and use the scanners, so it was tending to be three days
20 between tests rather than just following one after the
21 other.
22 **Q.** I see, so this prolonged her stay in hospital?
23 **A.** Very much so.
24 **Q.** As I understand it, she had been in hospital for 14 days
25 and she caught Covid within the hospital, and that's --

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1 an organisation to which you're affiliated called
2 Scottish Covid Bereaved; is that correct?
3 **A.** Correct.
4 **Q.** And you provided a witness statement to the Inquiry
5 dated 20 March 2023 under reference INQ000144794. That
6 was your witness statement in the first module, to which
7 you speak to an extent already, and Scottish Covid
8 Bereaved has also provided a response to the Inquiry's
9 impact questionnaire which can be found at reference
10 INQ000099718. Is that a document with which you're
11 familiar?
12 **A.** Yes.
13 **Q.** I think you must at the very least have had
14 a significant part in its creation, if not you're
15 actually its creator?
16 **A.** Well, a wee bit.
17 **Q.** Yes, there are some references in it, I think, to your
18 personal situation?
19 **A.** Yes.
20 **Q.** If I could just ask you some questions about that,
21 Mrs Morrison. I understand that in October 2020 your
22 wife, Jacky Morrison-Hart, died from Covid?
23 **A.** Correct, yes.
24 **Q.** And she caught Covid in hospital, as I understand it?
25 **A.** Correct.

2

1 a term which is often applied to that, which I see in
2 some of your testimony, is a nosocomial infection?
3 **A.** That's correct, yes.
4 **Q.** Meaning one which is caught within a hospital
5 environment?
6 **A.** Mm-hm.
7 **Q.** I understand that her condition deteriorated quickly and
8 sadly she died only five days after the onset of her
9 infection?
10 **A.** Yes, it was very quick, because in the five days the
11 Covid, which -- many people still think of it as
12 a respiratory condition, but it has a very big vascular
13 element and it destroys the lining of the blood vessels,
14 and in those five days it had clogged up her lungs, her
15 kidneys had failed, her pancreas had failed and her
16 liver had failed, all because of the Covid, and they
17 tried to do dialysis and they couldn't do it because her
18 blood was so sticky because of the Covid it actually
19 broke the machine.
20 **Q.** May I pass on the Inquiry's condolences for your loss.
21 **A.** Thank you.
22 **Q.** Were you given an opportunity to say goodbye to her?
23 **A.** I was. I was very lucky, because I didn't think I was
24 going to be given the opportunity, because Jacky had
25 been told because of the liver failure in particular,

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

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

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

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

5 **A.** Yes.

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

9 **A.** Yes.

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

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

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

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

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

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

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

5 **A.** March 2021 was when we met Nicola Sturgeon.

6 **Q.** Right.

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

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

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

25 Could I just ask you a few questions then about the

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1 experiences upon whom it can draw --

2 **A.** Yes.

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

5 **A.** Yes.

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

7 **A.** Yes, yes, all over Scotland.

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

10 **A.** Yes.

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

14 **A.** Yes.

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

25 **A.** Yes.

8

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

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

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

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1 a couple of times. And I think that existed until
 2 13 March.
 3 So we had that, and of course as we now know there
 4 was a lack of testing capacity.
 5 But that also raises its own issues, because when we
 6 get to 25 March, the British Geriatrics Society issued
 7 guidance saying that geriatric patients do not exhibit
 8 the same symptoms, and I believe it's only 20% to 30%
 9 that will actually present with a fever, their other
 10 symptoms are completely different. So there's all
 11 those -- there's an awful lot of stuff, and I'm glad
 12 you're having a separate module on it, my Lady, to do
 13 that. So ...
 14 **Q.** And you were raising these matters with the Scottish
 15 Government in 2021?
 16 **A.** Yes.
 17 **Q.** And you were looking, I suppose, for answers from them
 18 as to how these things had been allowed to happen?
 19 **A.** Yes.
 20 **Q.** Some of which you've managed to find some answers to --
 21 **A.** Yes.
 22 **Q.** What role did you understand that Scottish Government
 23 had played in the period, the early period that you've
 24 referred to, as regards care home --
 25 **A.** Yes, my understanding is that -- I don't know who made

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

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

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

14 **A.** Sorry, yes.

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

18 **A.** Thank you for clarifying that.

19 **Q.** Thank you.

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

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

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

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

12 **A.** Yes.

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

17 **A.** Yes.

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

21 **A.** Correct.

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

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

15

1 period we were discussing?

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

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

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

18 **A.** Yes.

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

23 **A.** Yes.

24 **Q.** Thank you very much.

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

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

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

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

15 **A.** Yes.

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

20 **A.** Yes.

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

24 **A.** They are, yes.

25 **Q.** So what you wondered was whether going along with

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1 a uniform UK approach was something that the Scottish
2 Government might have done otherwise?
3 **A.** Yes, I mean, for example we asked about border controls:
4 why didn't we just shut the borders and keep everybody
5 out? And the -- it was explained to us that, yes, we
6 could shut the border, but the Border Force, the
7 monitoring of it is controlled by Westminster, not by
8 Scotland, so they couldn't have the monitoring done at
9 the border. And also the financial aspects of
10 everything, Scotland does not have its own authority to
11 raise funds such as a UK Government has. So they were
12 very limited what they could do within the financial
13 constraints as well.
14 **Q.** So it sounds like from your obviously extensive analysis
15 of matters, Mrs Morrison, that in the early stages
16 issues arose from the devolution settlement which, given
17 the all encompassing nature of Covid, created
18 difficulties about whether the Scottish Government
19 should go one way or the other, but you wanted to know,
20 I think, issue 8 suggests, why did they not go their own
21 way?
22 **A.** Yes.
23 **Q.** Did you, other than what you've said, give -- did they
24 give you what you consider to be a satisfactory answer
25 to this, either at your meeting with the First Minister

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1 So I had understood this was your story, but it
2 bears a number of familiar hallmarks from your story.
3 **A.** Yes.
4 **Q.** Could you explain, therefore, what this story emanates
5 from and, to the extent that you're able within the
6 group, explain the significance of nosocomial infection
7 and the efforts made to prevent it within the group's
8 concerns?
9 **A.** Yeah, just as it says later down in the statement, as
10 a group, 25% of our members have lost someone to
11 nosocomial infection, and that has stayed a fairly
12 consistent figure as we've grown as a group. And this
13 particular issue had a number of points into it. This
14 gentleman's wife was shielding, and then the shielding
15 stopped and she was told to go back to work. She got
16 Covid, went into the hospital, but they thought she was
17 well enough to send home. But they said to her to just
18 go, and she was able to walk through the whole hospital
19 without wearing a mask, whilst having tested positive
20 for Covid on that -- and this is what the situation was.
21 And she subsequently passed away with Covid.
22 **Q.** And is the issue of the extent to which infection was
23 controlled within hospitals a wider issue for the
24 members, the 25% of the SCB?
25 **A.** Yes, there's a number of elements to it. I mean, I've

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1 or subsequently? Does this remain an issue for you?
2 **A.** It does remain an issue, and hopefully we can identify
3 some of that in this module.
4 **Q.** I very much hope so.
5 There's another issue which I wanted to ask you
6 about, in particular because it relates to your own
7 situation. Again if we could go over the page, please,
8 to issue 13. You say there:
9 "There is real concern around hospital acquired
10 Covid-19 and hospital transmission and yet my wife
11 [which was the reference earlier I think why you must
12 have written this] was allowed to walk through the
13 corridors of Hairmyers Hospital having tested positive
14 for covid 19 at her leisure without so much as
15 a facemask on."
16 **A.** Sorry to stop you there, that's not --
17 **Q.** Oh, that's not your story? I'm sorry.
18 **A.** No, it's -- these bits are from the five of us who were
19 there, just a little bit of stories. This was another
20 member's wife.
21 **Q.** I understand.
22 **A.** But I can --
23 **Q.** I'll just finish the quote and then ask you to explain:
24 "At this time the hospitals were not particularly
25 busy why were you sending covid patients home[?]"

18

1 read quite a few infection control plans -- one of my
2 ways of coping with everything was to do a lot of
3 research -- and they focused solely on the nursing
4 medical staff and what they have to do. The only
5 reference I've seen in relation to patients or visitors
6 is they're invited to use an alcohol hand gel, and
7 I have not seen any procedures for visiting tradesmen or
8 repair people, porters -- sorry, porters are covered --
9 on that. So there's some gaps.
10 But to us, one of the biggest gaps is when Covid
11 started, certainly in the hospital that Jacky was in,
12 they set up a system you could only have one named
13 visitor for the duration of that patient's stay, this
14 was before she got Covid, and they had to make
15 an appointment so they didn't have too many people on
16 the ward at once, and wear hospital face masks, gloves
17 and a pinny -- sorry, apron. Which we were doing, every
18 time I went to visit Jacky. Outside of the hospital you
19 had patients who had come outside and they were meeting
20 friends and families in the car parks, with no masks, no
21 social distancing and in groups of up to half a dozen,
22 and then, and I saw it with my own eyes, when they
23 finished they walked back into the hospital and they
24 wouldn't even use the hand gel. So, you know, it makes
25 a mockery of much of the infection control, because it's

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1 like putting down a portcullis to stop a swarm of bees.
 2 **Q.** As we did with the care homes, can you give me some idea
 3 of the timeframe over which these concerns about I think
 4 the guidance but also the enforcement of any guidance
 5 caused concerns to the members of the SCB?
 6 **A.** It's throughout the duration of the whole pandemic.
 7 **Q.** Thank you.

8 There's another issue I'd like to touch on, two
 9 other issues I'd like to touch on with you, if
 10 I possibly could. It's issue 11.

11 So if we could go back a page, please, Lawrence.

12 Issue 11 relates to shielding, which is something
 13 that I think we will touch upon in this module, and
 14 a particular issue relating to Scotland which I wanted
 15 to raise with you on behalf of the members:

16 "Why did the shielding end at the start of August
 17 when people were being allowed to go on holiday and no
 18 doubt bring variants back into the country, the eat out
 19 to help out scheme was started, the schools were
 20 returning mid August and the universities shortly after?
 21 Surely if there was modelling being carried out it would
 22 show this was probably the most dangerous time to stop
 23 shielding."

24 Again, could you explain this? There's a lot in
 25 that about factual information, some of which I'd

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1 between the fact that there were releases happening on
 2 the restrictions but also the most vulnerable re-exposed
 3 to that?

4 **A.** Yes.

5 **Q.** Is that a common issue, that particular issue, amongst
 6 the membership?

7 **A.** Yes, there's quite a few -- quite a few members who are
 8 affected like that. I understand, and again it's one we
 9 need to understand what was the UK decision that started
 10 off, because of course it happened in the whole of the
 11 UK and how much autonomy did the Scottish Government
 12 have.

13 **Q.** That would be one of the questions that you would like
 14 an answer to?

15 **A.** Yes. Yes.

16 **Q.** Another issue that I wanted to touch on briefly with you
 17 is issue 15.

18 So if we go back over the page again, please,
 19 Lawrence. Issue 15, which is something that comes up on
 20 a number of occasions in the SCB materials, is that you
 21 say there:

22 "Symptoms are poorly understood and are not well
 23 publicised outside of the usual three: fever, persistent
 24 cough and loss of taste and/or smell. More symptoms
 25 need to be listed and a good education campaign

23

1 summarised yesterday, but I think this relates to
 2 a decision in August to stop the shielding scheme; is
 3 that right?

4 **A.** That's correct, yes.

5 **Q.** Was it on 1 August, I think?

6 **A.** I'm not sure of the exact date, sorry.

7 **Q.** Yes (inaudible).

8 **A.** But it seemed that -- I'll come back to the shielding,
 9 if I may, but it would seem that when you've got your
 10 numbers down that you should gradually release the
 11 controls, and what was happening was everything was
 12 being released at once, plus additional things like the
 13 Eat Out to Help Out scheme was introduced. So people
 14 going from social distancing, minimal contact, suddenly
 15 they were let out and everybody went a bit wild, and
 16 that coincided with stopping shielding. So where you
 17 would have been in a position where the person who had
 18 stopped shielding would have gradually readjusted, it
 19 meant that if they were told they had to go back to work
 20 by their employer, for example, they were just exposed
 21 to every possible source of contamination with the
 22 virus.

23 **Q.** So at that point, and at that point these decisions were
 24 being made by the Scottish Government, what you wanted
 25 to point out was that there seemed to be an incongruity

22

1 launched."

2 And you wanted to ask Nicola Sturgeon and others
 3 would they commit to that.

4 To what extent is this a concern? What are the
 5 sorts of symptoms, for example, you would like to see
 6 added either at the time you were having this meeting in
 7 March 2021 or indeed now?

8 **A.** To go back to this just before, I know that Mr Yousaf
 9 wrote to UKHSA, because they are the owners of the
 10 symptoms, so to speak, to ask if it could be extended
 11 and they declined to do that. The issue is, for us,
 12 we've got an awful lot of people who have been bereaved
 13 by Covid and those symptoms were not the primary
 14 symptoms, particularly in the early days when it only
 15 went with fever and persistent cough, before they added
 16 loss of taste or smell, and, as I mentioned earlier,
 17 particularly with older patients who didn't present with
 18 those symptoms as well. So it was a big concern.

19 I suspect that a lot of it, again, was down to lack
 20 of testing capacity, but we should have had -- even if
 21 we couldn't test for it, we should have had more
 22 education given to the public saying "These are the main
 23 symptoms, but you might also experience gastric
 24 symptoms, you might experience lethargy, confusion and
 25 things like that".

24

1 **Q.** So would the result of such an approach have been more
 2 precautionary in the way that it would have perhaps
 3 prompted more people to take a test or more people to
 4 regulate their conduct such to minimise the risk that
 5 they might spread of the virus if they had it?
 6 **A.** Yes, yes.
 7 **Q.** Rather than being restrictive, a wider definition may
 8 have had that effect?
 9 **A.** Yeah. And it also had the effect that we do have
 10 some -- a few people who lost someone where they thought
 11 they had Covid but because they didn't have those three
 12 symptoms -- well, this is particularly in the beginning
 13 when it was just the two, they were told "You don't have
 14 Covid", they were denied a test because they didn't meet
 15 the criteria, and it was very difficult for them to get
 16 help, because they were told through 111 or the testing
 17 system "Well, you haven't got these symptoms so it's not
 18 Covid".
 19 **Q.** Thank you.
 20 I understand from the materials that you've
 21 provided, your own statements and those on behalf of the
 22 group, that there were a number of meetings, not just
 23 the one we've mentioned with Ms Sturgeon, but a number
 24 of meetings with others, including Mr Swinney and
 25 Mr Yourself, subsequently and you've referred to an
 25

1 we've prepared this module and indeed others. I have no
 2 further questions for you, but I would like to offer you
 3 the opportunity to say what you would like, and if
 4 there's anything else you'd like to add, please do so.
 5 **A.** Thank you.
 6 Yes, it's -- we all want the same thing, which is we
 7 all want answers, to make sure that this does not happen
 8 again, and it will only work if everyone speaking to
 9 the Inquiry, particularly the politicians and the
 10 decision-makers, are completely candid and they don't
 11 have selective amnesia, which seems to have been
 12 apparent in some of the previous issues.
 13 That's -- we need the truth and we need people to be
 14 honest, and if they made a mistake, be big enough to
 15 admit you made a mistake.
 16 **MR DAWSON:** Thank you very much, Mrs Morrison. I have no
 17 further questions for you.
 18 My Lady.
 19 **LADY HALLETT:** Are there any core participant questions?
 20 **MR DAWSON:** There are no core participant questions, as
 21 I understand.
 22 **LADY HALLETT:** No, I have no other questions, Mrs Morrison.
 23 Thank you so much for all your help. You mentioned
 24 earlier that you carried out the research to cope with
 25 your grief. Have you found it any comfort?
 27

1 extent to a reply that Mr Yousaf was able to get you on
 2 that particular issue about symptoms.
 3 Broadly speaking, having looked at the materials for
 4 this, it seems to be our impression that the focus of
 5 these meetings, as far as the Scottish Government was
 6 concerned, was really about securing a Scottish Inquiry?
 7 **A.** Yes.
 8 **Q.** But that other than that particular issue about
 9 symptoms, you didn't seem to get very many answers to
 10 the many legitimate issues that you've listed. Would
 11 that be a fair summary?
 12 **A.** Yes, I think that would be, yes.
 13 **Q.** So what that means, in effect, is that these questions
 14 still remain questions for the group?
 15 **A.** Yes.
 16 **Q.** And you are turning to this Inquiry and the
 17 Scottish Inquiry to try to find them out?
 18 **A.** Yes.
 19 **Q.** Although you had been trying to get these answers for
 20 a long time, at least -- certainly at least since
 21 March 2021?
 22 **A.** Yes.
 23 **Q.** There are a number of other areas that are covered in
 24 the statements, all of which have been taken into
 25 account, I can assure you, Mrs Morrison, in the way that
 26

1 **THE WITNESS:** I have, my Lady, thank you, yes.
 2 **LADY HALLETT:** Well, it's really helpful to the rest of us,
 3 obviously, because you raise some really important
 4 points, and between us I hope the Scottish Inquiry and
 5 this Inquiry can answer as many of them as possible so
 6 with the help of people -- what I find really
 7 interesting about the way you've described your
 8 experience and the loss of your wife Jacky is that you
 9 have been constructive, you haven't just been critical,
 10 you have been trying to ask questions to which there
 11 might be an answer, so I'm really grateful to you.
 12 **THE WITNESS:** Thank you, my Lady.
 13 **LADY HALLETT:** And this cough is not Covid, I promise.
 14 I have tested so many times I've run out of tests. But
 15 as those who have been following me in this Inquiry will
 16 know, I do get coughs every so often.
 17 So thank you very much for your help.
 18 **THE WITNESS:** Thank you, my Lady.
 19 **(The witness withdrew)**
 20 **MR DAWSON:** My Lady, the next witness will be Roz Foyer from
 21 the Scottish TUC, which my colleague Mr Tariq will be
 22 conducting. So we require a little changing around, but
 23 it will only take a few seconds.
 24 **LADY HALLETT:** That's fine, thank you.
 25 **(Pause)**
 28

1 **MR TARIQ:** May I please call Rozanne Foyer.
 2 **MS ROZANNE FOYER (affirmed)**
 3 **Questions from COUNSEL TO THE INQUIRY**
 4 **MR TARIQ:** Ms Foyer, thank you for your assistance to
 5 the Inquiry to date. There are a few preliminary
 6 matters I want to talk about before we get to your
 7 evidence. Could you please keep your voice up and speak
 8 into the microphone so that the stenographer can hear
 9 you for the purpose of the transcript. If any of my
 10 questions are unclear, please say so and I will rephrase
 11 and ask the question again.

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

15 Can we please have this onscreen.

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

- 19 **A.** That is correct.
 20 **Q.** If we turn to the final page, which is page 33, there is
 21 a signature that is hidden behind the personal data, but
 22 it would be your signature on this statement; is that
 23 correct?
 24 **A.** Yes, that's correct.
 25 **Q.** Are the contents of this statement true to the best of

29

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

- 5 **Q.** You personally attended a large number of these
 6 meetings; is that right?
 7 **A.** Yes, I would say the vast majority of those meetings.
 8 **Q.** In general terms, what is the STUC's position on the
 9 Scottish Government's engagement with the STUC during
 10 the pandemic? For example, did you find that the
 11 Scottish Government was willing to listen to your
 12 concerns raised on behalf of your members?
 13 **A.** Yeah, I would say that in general terms I would describe
 14 the engagement that we had as intense and constructive.
 15 There was an established relationship there already.
 16 The Scottish Government do see trade unions as a key
 17 social partner, and they have a collaborative working
 18 approach, so we had an established relationship there
 19 already, but that relationship intensified during the
 20 pandemic because I think the Scottish Government
 21 recognised that we could be very helpful in giving them
 22 a real picture of what was happening in workplaces, and
 23 particularly in workplaces where key workers were
 24 working, delivering essential services across the
 25 economy.

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1 your knowledge and belief?

- 2 **A.** Yes, they are.
 3 **Q.** I now want to turn to the STUC's role during the
 4 pandemic.
 5 You are the general secretary of the STUC; is that
 6 right?
 7 **A.** Yes, I am.
 8 **Q.** The STUC is a national lobbying, campaigning and
 9 co-ordinating body for trade unions in Scotland; is that
 10 correct?
 11 **A.** That is correct.
 12 **Q.** It represents over 540,000 members in Scotland; is that
 13 correct?
 14 **A.** Yes, that's right.
 15 **Q.** The organisation's campaigning and lobbying continued
 16 during the pandemic and covered a whole range of
 17 workers' rights, issues and interests; is that correct?
 18 **A.** Yes, it is.
 19 **Q.** I want to discuss the issue of the Scottish Government's
 20 engagement with the STUC during the pandemic.
 21 Is it right that the STUC frequently had meetings
 22 with the Scottish Government throughout the pandemic?
 23 **A.** Yes, we had a forum of engagement and we met the
 24 Scottish Government twice weekly, specifically to bring
 25 the views and concerns of trade unions to the table.

30

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

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

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

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

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

32

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

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

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

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

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

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

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

35

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

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

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

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

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

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

25 Other areas that we were concerned about was just

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 that in the evidence is that you raised concerns with
2 the Scottish Government in relation to aviation workers,
3 and the STUC has produced a note of a meeting it had
4 with representatives of the Scottish Government on
5 10 July 2020.

6 That note can be found at INQ000107203.

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

12 In relation to aviation workers, the note says:

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

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

23 **A.** Yeah.

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

40

1 in England. Do you recall around that time what the
2 concerns were of aviation workers?
3 **A.** Yes. There was a real concern about, frankly,
4 a collapse in the industry and that -- you know, many of
5 these workers -- aviation had virtually, you know,
6 closed down, it was in a very precarious position, so
7 there was a real concern that, you know, those jobs
8 would be required in the re-opening of the economy, they
9 were vital jobs when things went back to normal;
10 however, the companies involved in delivering those very
11 important services were in real trouble and there was
12 a potential retention issue that could happen in that
13 sector.

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

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

5 I think the overriding concern for a lot of workers
6 in that sector was that there was about to be a complete
7 collapse in, you know, their jobs. So there was a lot
8 of concern about the security of their jobs at that
9 point, and I think that underlines the issue that we're
10 dealing with here, that, you know, we have people who --
11 you know, it's important to be able to have money and
12 not be in financial constraints and to have a job. So
13 there was -- a campaigning approach that we had was that
14 we were campaigning to save lives but also to save jobs.
15 **Q.** You touched earlier upon the issue of funding between
16 the Scottish Government and the UK Government, and the
17 STUC's position in its statement is that there was
18 frustration that some actions that the Scottish
19 Government agreed with the STUC as being essential could
20 not be implemented by the Scottish Government due to the
21 limits of devolution or a lack of funding or financial
22 support from the UK Government. Can you provide
23 examples of key actions that the STUC agreed with the
24 Scottish Government but which could not be implemented
25 because of devolution or the funding arrangements?

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1 about what was needed.

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

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

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

25 **A.** The workers in the aviation sector were primarily

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

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

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1 that something should be done to improve statutory sick
 2 pay, but we didn't get any shift on that, unfortunately.
 3 **Q.** That's an area that the Inquiry will explore in more
 4 detail with other witnesses, but did you ever have the
 5 impression that the Scottish Government could have done
 6 more on some of the matters that you were pushing but it
 7 was easier to attribute blame to the UK Government for
 8 not being able to take some of these actions forwards?
 9 **A.** I -- I often get that impression, in all sorts of areas.
 10 The STUC is very active in pushing the Scottish
 11 Government just generally to use all of its devolved
 12 powers, particularly its fiscal powers, in terms of more
 13 progressive taxation, to allow them the budgets to do
 14 more, but I also have to acknowledge that it's difficult
 15 to do that and that the powers they have fiscally are
 16 limited and, you know, you -- it's very hard for the
 17 Scottish Government to overcome ten years of austerity
 18 and budget cuts to public services. It's very hard for
 19 the Scottish Government to go beyond their devolved
 20 responsibilities.

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

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

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

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

21 **A.** Yes, it is.

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

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

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

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

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

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

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

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

22 **A.** Yes.

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

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

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

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

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

25 I think that what we've seen is that cuts to
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1 So that was something I think we need to think about
2 and think about, you know, how our devolution works and
3 the responsibilities of Scottish Government.

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

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

20 A. Yes, thank you.

21 I would just want to say that for the STUC the
22 people whose story most deserves to be heard in this
23 Inquiry is the key workers who put themselves and their
24 families at risk to provide essential services at a time
25 of real crisis. Many of those workers were on poverty
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1 essential services, that that prolonged period of cuts
2 and that austerity that was implemented by the Scottish
3 Government -- it may have been caused by
4 the UK Government but it was certainly followed and
5 implemented by the Scottish Government -- it left
6 services with no resilience and very ill equipped to
7 meet the needs of the pandemic at a time of crisis.

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

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

16 So, for example, the Health and Safety Executive,
17 which is a UK body, I feel did not engage appropriately
18 with the workplace guidance, safety guidance that was
19 issued by the Scottish Government under its public
20 health responsibilities, and I think that was a missed
21 opportunity to disseminate this information effectively
22 to employers and workers. What tended to happen was it
23 was union reps in areas that were well organised that
24 were using these tools, but what about areas where there
25 isn't a trade union?
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1 pay rates, the majority were women, and
2 disproportionately they came from black and ethnic
3 minority backgrounds, and the sad reality is that too
4 many of those workers lost their lives protecting us.
5 But I don't think we protected them enough.

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

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

25 MR TARIQ: Ms Foyer, thank you for your evidence.
52

1 There's no further questions, my Lady, from me.
 2 **LADY HALLETT:** No, I have no further questions.
 3 Thank you very much indeed, Ms Foyer, very grateful
 4 to you.
 5 **(The witness withdrew)**
 6 **LADY HALLETT:** We'll break now, because I think we need to
 7 make arrangements for the next witness. So I shall
 8 return at 11.30.
 9 **MR TARIQ:** I'm obliged.
 10 **(11.13 am)**
 11 **(A short break)**
 12 **(11.30 am)**
 13 **LADY HALLETT:** Ms Arlidge.
 14 **MS ARLIDGE:** My Lady, may I please call
 15 Dr Jim Elder-Woodward OBE.
 16 **DR JIM ELDER-WOODWARD (sworn)**
 17 **MS PATRYCJA PASTERNAK (sworn)**
 18 **LADY HALLETT:** I'll just explain to people, we have asked
 19 for Dr Elder-Woodward's assistant to be sworn in, just
 20 in case she has to help in any way with any
 21 communication issues.
 22 **THE WITNESS:** Thank you, my Lady.
 23 **LADY HALLETT:** Not at all.
 24 **Questions from COUNSEL TO THE INQUIRY**
 25 **MS ARLIDGE:** Thank you very much.
 53

1 pandemic, if we may. You suffer from -- sorry, you
 2 were, until 1999, a senior social work officer at
 3 Glasgow City Council; that's right, isn't it?
 4 **A.** Yes.
 5 **Q.** During your time with local government, were you
 6 involved in establishing indirect and direct payments
 7 into --
 8 **A.** Yes, I was.
 9 **Q.** Did you also assist in the development of the Glasgow
 10 Centre for Inclusive Living?
 11 **A.** Yes, I did. Yes.
 12 **Q.** So you therefore had quite the experience of dealing
 13 with bureaucracy and accessing services, because you'd
 14 been your own -- you'd done that for other people as
 15 well, hadn't you?
 16 **A.** Yes.
 17 **Q.** You retired, of course, long before the pandemic
 18 started, but you, as part of your needs, had a package
 19 in place for support; is that right?
 20 **A.** Yes, it was a 24-hour package.
 21 **Q.** 24-hour --
 22 **A.** Day and night.
 23 **Q.** With personal assistants assisting you for the whole
 24 24 hours a day?
 25 **A.** Yes. I've got a team of five part-time personal
 55

1 Dr Elder-Woodward, you have provided two statements
 2 to the Inquiry, one in your capacity as co-convenor of
 3 Inclusion Scotland and a supplementary personal
 4 statement. The reference for the Inclusion Scotland
 5 statement is INQ000371664. Hopefully you will see that
 6 on your screen in front of you, and it will be
 7 a familiar document to you.
 8 **A.** Yes.
 9 **Q.** On page 23 of that, you've signed that statement on
 10 behalf of yourself and Inclusion Scotland, haven't you?
 11 **A.** Yes.
 12 **Q.** You have also provided a supplementary statement. The
 13 INQ reference, I'm afraid I do not have to hand
 14 immediately but we'll have it in a moment, and that is
 15 a personal statement in which you exhibit a number of
 16 documents setting out your own personal lived experience
 17 of the pandemic; is that right?
 18 **A.** Yes, that's right.
 19 **Q.** We'll be looking at both aspects of that in the course
 20 of your evidence today. In the course of your evidence
 21 if there's anything that I say that is not clear, please
 22 do just ask me to repeat myself. Of course if there's
 23 any elements that you would like your assistant to help
 24 you with, please do so.
 25 If we turn first to your personal experiences of the
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1 assistants who I manage myself.
 2 **Q.** Effectively you're given a sort of budget to employ
 3 assistants to cover your needs within that budget?
 4 **A.** Yes, and Patty's one of them.
 5 **Q.** Yes. When lockdown came, two of your personal
 6 assistants were unable to continue assisting you, due to
 7 their own personal circumstances; is that correct?
 8 **A.** Yes, that's right.
 9 **Q.** In terms of having control of the budget for employing
 10 those personal assistants, how did that cause
 11 difficulties for you?
 12 **A.** Well, to begin with, I didn't know where the money would
 13 come from to pay for their self-isolation, because I had
 14 to find additional support. I also cut the hours of
 15 support because there was insufficient support
 16 available.
 17 **Q.** So --
 18 **A.** I was fortunate enough to receive support from the
 19 Independent Living Fund. I don't know if you've heard
 20 about that but it's a fund whereby people receiving
 21 money from their local authority can go to the Fund for
 22 additional money. And although I wasn't receiving much,
 23 I did receive support from my local authority, the Fund
 24 was able to give me more money to pay for the furlough
 25 of the people taking self-isolation. Did that answer
 56

1 the point?

2 **Q.** So when you, having reduced your own personal assistant
3 support, you effectively had to seek assistance
4 elsewhere to try and maintain some level of support that
5 would keep you safe --

6 **A.** Yes.

7 **Q.** -- and keep you as healthy as you could be?

8 **A.** Yes.

9 **Q.** In circumstances where you were responsible for
10 employing your own carers -- sorry, personal assistants,
11 and having to put two on furlough or statutory sick pay,
12 did that in itself cause you stress and concern and
13 extra workload at quite the time when you didn't need
14 it?

15 **A.** Yes. I'm afraid the person that came in to help, she
16 stole money from me and jewellery from the house, so
17 I was under extreme stress because the police couldn't
18 help me and I had a bit of a collapse, at which time my
19 nephew took control of my support package.

20 **Q.** And you suffered both sort of mentally and physically as
21 a result of this stress, didn't you?

22 **A.** Yes, I did.

23 **Q.** You were able, as a result of your previous knowledge
24 and your previous role at Glasgow City Council, and as
25 a result of your knowledge and experience through

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1 **Q.** And you have been in that post since November 2023, so
2 after the pandemic, but you have been a board member
3 since 2005?

4 **A.** Yes.

5 **Q.** And in that role, you are responsible for various
6 things, including overseeing the governance of the
7 organisation and representing the board at meetings,
8 including with Scottish Government and others; is that
9 right?

10 **A.** Yes.

11 **Q.** Just to assist the Inquiry and my Lady and those
12 listening, Inclusion Scotland is a registered charity,
13 it's a disabled people's organisation, and it is led
14 therefore by people who have -- are disabled themselves
15 or deaf or hard of hearing; is that right?

16 **A.** Yes, that's right.

17 **Q.** So it's a -- is it right to say that it is both
18 a support network for people and an advocacy network
19 seeking to achieve change in government and to represent
20 individuals' rights?

21 **A.** It's in support of all local disabled people's
22 organisations. We don't support individuals.

23 **Q.** No.

24 **A.** We support local and national organisations, but we do
25 have two programmes funded by the Scottish Government to

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1 Inclusion Scotland, you're a very adept, knowledgeable
2 expert in accessing services and advocating for not only
3 your own rights but for those other people who require
4 assistance?

5 **A.** Yes, but even so I found it very difficult living with
6 Covid, because everything was locked down, so even
7 I couldn't find the support I needed. With all my
8 professional and academic contacts, I still couldn't get
9 the support I needed.

10 **Q.** If I may read from a document you've produced for this
11 Inquiry, you say:

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

17 **A.** Yes, that's been a long campaign on behalf of the
18 movement that we need more peer support, because peer
19 support is much more effective than non-peer support.
20 With peer support there's empathy and knowledge of the
21 situation of the person.

22 **Q.** If we move, therefore, in that very vein, on to your
23 work with Inclusion Scotland, is it right that you're
24 the co-convenor of Inclusion Scotland?

25 **A.** Yes, I am.

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1 support people in employment and to support people to
2 enter the political system when they join political
3 parties or they stand for local or national elections we
4 offer support to people to stand for elections.

5 **Q.** And the focus of the groups within Inclusion Scotland,
6 the operational focus of Inclusion Scotland is disabled
7 people within the community rather than, for example, in
8 residential care homes and the like?

9 **A.** In the majority, yes.

10 **Q.** Inclusion Scotland, would you say, worked closely with
11 Scottish Government and others throughout, prior to the
12 pandemic, as an advocacy service and a representative
13 service seeking to influence policy in government?

14 **A.** We found the engagement very open.

15 **Q.** And you found that there was a level of proper access
16 and two-way dialogues; is that fair?

17 **A.** On the whole. The government isn't one entity, it's
18 different departments and several people within the
19 departments, but we had some good relations and some not
20 so good relations within the government, if that's
21 understood.

22 **Q.** It's no doubt part and parcel of the enormous machinery
23 of government that's --

24 **A.** Exactly.

25 **Q.** And as part of the engagement with government --

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

8 **A.** Yes.

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

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

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

21 **A.** Yes.

22 **Q.** -- matters.

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

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

5 **Q.** Even before the pandemic?

6 **A.** Even before the pandemic.

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

9 **A.** Absolutely.

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

12 **A.** Yes.

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

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

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1 out:

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

10 **A.** Yes.

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

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

19 **Q.** And those, that crisis was multifactorial, wasn't it?

20 So there would be issues about access to suitable
 21 housing, accessible housing?

22 **A.** Yes.

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

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

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1 imposition of Do Not Attempt Cardiopulmonary
 2 Resuscitation."

3 **A.** Yes.

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

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

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

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

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

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1 statement:

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

12 So this is a sort of two-fold element to lockdown
13 and schools closing and support being withdrawn, that
14 you say hit those with disabled children particularly
15 hard because they lost both the schooling and the
16 special educational needs support that is inherent in
17 schooling itself?

18 A. Yes. The lack of schooling, and the lack of support,
19 especially for children with complex needs, particularly
20 psychological needs, that added to the stress of parents
21 because they had to deal with very difficult children
22 24 hours a day and there was no respite for them.

23 Q. Would you say that that was therefore compounded as
24 well, particularly in the physical circumstances of
25 lockdown where --

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

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1 A. Absolutely.

2 Q. -- much closer?

3 You also talk in your statement about the impact of
4 reasonable adjustments on those in the disabled
5 community. For instance, in terms of face coverings,
6 for those people with difficulties -- with communication
7 difficulties, if someone was deaf, and relied upon
8 lip-reading, for instance, the presence of face masks
9 of course would cause them greater difficulty in
10 accessing society?

11 A. That is true, very few people use the plastic masks
12 which were see-through. Those windows in the masks help
13 people who were deaf, and very, very few people even
14 those working with deaf people didn't use that
15 accommodation.

16 Q. You say some frontline service providers refused to step
17 back and remove their mask or to use an alternative
18 means of communication like pens and paper?

19 A. Yes, that was true.

20 Q. So simple adjustments that your organisation found were
21 simply not being made; is that right?

22 A. Yes.

23 Q. Then of course for some people who were vulnerable to
24 the infection with Covid, fear about people not
25 following the rules, did that have an impact on social

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1 integration and people being able to access their
 2 community?
 3 **A.** Yes. There were instances where disabled people refused
 4 support for fear of being infected, that is the case.
 5 There is also the case that Professors Shakespeare and
 6 Watson brought up in Module 2, in that people
 7 particularly with learning disabilities were housed in
 8 group accommodation, which facilitated the transfer of
 9 the virus because they were living in close proximity to
 10 one another.
 11 **Q.** We've spoken briefly already about the contact that
 12 Inclusion Scotland had with Scottish Government
 13 ministers and officials. You say at paragraph 53 of
 14 your statement:
 15 "Despite it having been abundantly clear to the
 16 Scottish Government that disabled people would be
 17 gravely and disproportionately affected by Covid-19, and
 18 actions taken to mitigate it, this previously good level
 19 of engagement reduced suddenly as the pandemic took
 20 hold. This was presumably so that the Scottish
 21 Government could reset to deal with the emergency."
 22 **A.** Yes.
 23 **Q.** How long did it take until Inclusion Scotland became
 24 more involved again with Scottish Government?
 25 **A.** I find it difficult to answer, because it didn't until
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1 do it, to talk to us but it is their decision to start
 2 and it's their decision to end. So there's the process
 3 whereby the initiation and conclusion is in the hands of
 4 powerful people. Then when the engagement starts, at the
 5 beginning of the process and ends is upon them. It is
 6 important that we are involved at the beginning and not
 7 the end. Then there is the resourcing of us. We need
 8 resources in order to engage with the other party. Then
 9 there is the audit of their -- what is the outcome of
 10 our involvement, and that process is very difficult to
 11 assess.
 12 **Q.** And --
 13 **A.** Does that answer your question?
 14 **Q.** It does.
 15 Do you think that the Scottish Government should
 16 have turned more rapidly to the DPOs and
 17 Inclusion Scotland when it was clear that the virus was
 18 going to change lives and allow you to influence and
 19 give your advice and information to Scottish Government?
 20 **A.** My Lady, we gave them ample opportunity, we gave them
 21 ample information, which they could use earlier than
 22 when they did, and if they wanted engagement to flourish
 23 we need to be involved right at the outset, not at the
 24 end of the decision-making process.
 25 **Q.** You say in your statement, "We would have informed their
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1 after the pandemic. I can't give an exact time, but it
 2 was after the pandemic that we were just beginning to
 3 pick up where we were pre-pandemic, and that is still an
 4 ongoing scenario, I'm afraid.
 5 **Q.** Now, in your statement you talk -- you do go through
 6 some of the contact you have with Scottish Government.
 7 I won't take you through it. For those who would like
 8 to look at it, it's from paragraph 51 onwards to
 9 101/102. All of those -- although the contact with
 10 Scottish Government obviously had fallen away and you
 11 felt there was less influence, is it fair to say, is it
 12 your evidence that despite the fact that you'd -- that
 13 Inclusion Scotland prior to the pandemic had been
 14 closely involved, and despite the offers and the
 15 attempts to engage with Scottish Government throughout
 16 the pandemic, even in all those circumstances the
 17 outcomes were just -- didn't reflect the efforts that
 18 Inclusion Scotland had put into improving that --
 19 improving Scottish Government knowledge about the
 20 particular challenges facing the disabled community?
 21 **A.** If I may, My Lady, answer that in more broad terms,
 22 rather philosophical terms, there is the procedure of
 23 engagement whereby the engagement is started and ended
 24 by authority, it is up to the authority to decide
 25 whether they want to engage or not. We can press them to
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1 draft decision-making about the likely impacts for
 2 disabled people and the specific support that would be
 3 required before the negative impacts took effect". Do
 4 you say they missed that opportunity?
 5 **A.** Absolutely.
 6 **Q.** You also say at paragraph 108 of your statement:
 7 "The equality unit disability roundtable and the
 8 Social Renewal Advisory Board were helpful in this
 9 regard but could be classed as too little, too late.
 10 Even so, our input was not always addressed to the
 11 extent and with the haste required by disabled people."
 12 **A.** Yes, that's why I talk about the audit, there were no
 13 audits of our involvement.
 14 **Q.** And to the extent that there was engagement, it was too
 15 late and it was too --
 16 **A.** The engagement was too late, and we never knew what
 17 impact our involvement was. So we couldn't ascertain
 18 the outcome which could be attributed to our engagement.
 19 **Q.** So you never were able to find out whether you were able
 20 to -- you didn't see the input that Inclusion Scotland
 21 were putting into things reflected in the output of
 22 Scottish Government?
 23 **A.** Well, that's true generally. There were one or two
 24 instances, my Lady, when we could see the outcome, and
 25 that was in the £100 million to restart care packages,
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1 but there was no audit of where that money went to,
2 there was no transparency about where that money went
3 to, because we didn't see any care packages being
4 reopened. So although the government were listening to
5 us, the local authority delivery of service was not.

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

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

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

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

18 **A.** Just a couple of things.

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

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

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

3 So thank you very much indeed for your help.

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

6 **LADY HALLETT:** Not at all. Thank you.

7 **(The witness withdrew)**

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

12 **(12.15 pm)**

13 **(A short break)**

14 **(12.19 pm)**

15 **LADY HALLETT:** Mr Dawson.

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

19 **MR ROGER HALLIDAY (affirmed)**

20 **MR SCOTT HEALD (sworn)**

21 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 2A**

22 **MR DAWSON:** You are Scott Heald?

23 **MR HEALD:** I am.

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

25 **MR HALLIDAY:** Roger Halliday.

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

9 Thanks, my Lady.

10 **LADY HALLETT:** Very good motto.

11 **THE WITNESS:** Thank you, counsel.

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

15 **LADY HALLETT:** Thank you very much.

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

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

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

13 **MR HEALD:** That's right.

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

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

18 There you have signed the statement; is that
19 correct?

20 **MR HEALD:** That's correct.

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

23 **MR HEALD:** It does.

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

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

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1 member.
 2 **MR DAWSON:** Thank you. And you also attended Cabinet
 3 meetings.
 4 **MR HALLIDAY:** Again, from time to time.
 5 **MR DAWSON:** How was it determined when you would attend
 6 SGoRR or Cabinet meetings?
 7 **MR HALLIDAY:** When there was relevant evidence or data that
 8 I or my team collated that was relevant to the agenda of
 9 those meetings.
 10 **MR DAWSON:** Thank you.
 11 Mr Heald, if I could just run through a similar
 12 background to you. Over the course of the period on
 13 which this module is focused, you were the associate
 14 director and head of profession for statistics at the
 15 Information Statistics (sic) Division, which was
 16 incorporated into PHS when it became operational in
 17 April 2020; is that correct?
 18 **MR HEALD:** That's correct.
 19 **MR DAWSON:** You continued when PHS was formed and became the
 20 interim contact tracing director from May 2020 to
 21 January 2021?
 22 **MR HEALD:** That's correct.
 23 **MR DAWSON:** You were the chief officer from January 2021 to
 24 May 2021?
 25 **MR HEALD:** That's correct.

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1 relevantly for our Inquiry, you were the joint head of
 2 the Covid analytical team. Is that correct?
 3 **MR HALLIDAY:** Correct.
 4 **MR DAWSON:** I understand that the joint head of that team
 5 was a lady named Audrey MacDougall?
 6 **MR HALLIDAY:** That's right.
 7 **MR DAWSON:** And you were responsible for the quality and
 8 accuracy of the data that was published by the Scottish
 9 Government; is that correct?
 10 **MR HALLIDAY:** That's absolutely correct.
 11 **MR DAWSON:** And as part of your role, I understand that you
 12 were a member of a group that we've heard a little bit
 13 about already, the Scottish Government Covid Advisory
 14 Group; is that correct?
 15 **MR HALLIDAY:** Yeah, from, until January 2021.
 16 **MR DAWSON:** And you were a member of some other groups,
 17 something called the Scottish Covid chiefs group, until
 18 April 2022?
 19 **MR HALLIDAY:** That's right.
 20 **MR DAWSON:** And something called the Scottish Covid Data and
 21 Intelligence Network delivery group; is that correct?
 22 **MR HALLIDAY:** That's right.
 23 **MR DAWSON:** You also attended meetings of a group that we've
 24 heard of called SGoRR?
 25 **MR HALLIDAY:** From time to time. I wasn't a standing

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

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1 that you were involved in collating and analysing and
2 presenting, what the purposes of those might be.
3 Could you tell me whether the purposes for which
4 data was being collected during the course of the
5 pandemic changed as the pandemic progressed and if so in
6 what ways? Mr Halliday.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 **MR HEALD:** Yes.

20 **MR DAWSON:** Thank you.

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

25 Our understanding from the material is that both

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

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

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

17 **MR DAWSON:** Thank you.

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

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

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1 **MR HALLIDAY:** Correct.

2 **MR DAWSON:** Thank you.

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

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

13 **MR HALLIDAY:** That's right.

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

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

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

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

8 **MR HALLIDAY:** That's correct.

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

19 **MR HALLIDAY:** That's correct.

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

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

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

6 **MR HALLIDAY:** That's right.

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

16 **MR HALLIDAY:** That's right.

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

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

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1 service; on society; and on the economy.
 2 And what our role was as analysts in government was
 3 to bring the range of evidence together under each one
 4 of those harms, and what the picture shows here are
 5 some -- five key indicators for each of the -- the
 6 harms, with a picture of what -- the value of the
 7 indicator and how that's changed -- how that compares to
 8 the status for the pandemic. And it's red, amber and
 9 green to mark -- to highlight areas of potential
 10 concern.

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

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

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

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

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

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

4 **MR HALLIDAY:** So I would just clarify --

5 **MR DAWSON:** Thank you.

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

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

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

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

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

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

14 **MR HEALD:** Yeah.

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

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

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

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

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

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

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

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

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1 **MR DAWSON:** Yes, but as far as the overall system of
 2 presentation was concerned in these quite lengthy
 3 documents with this key indicator element to it, was
 4 that something that they fed back saying, yes, they had
 5 a good handle on it, or was that something that they
 6 struggled with?

7 **MR HALLIDAY:** I certainly can't recall any feedback about
 8 them struggling with the presentation of the
 9 information. It was more that we would get questions
 10 that looked very much like they had understood and were
 11 reflecting upon and asking for further detail on some of
 12 the evidence that's provided.

13 **MR DAWSON:** And this may, I have to be clear, be indicative
 14 of the timing of this, but we're not going to go through
 15 every page of the document, but having done that myself,
 16 I wondered whether it might be fair to say that the
 17 majority of the document contains information, much of
 18 which I suspect may have emanated from PHS, about what's
 19 described as the first harm, tracking the ebb and flow
 20 of the pandemic; is that correct?

21 **MR HALLIDAY:** Yeah, I suppose we wanted to make sure that it
 22 wasn't a document that was focused just on the first
 23 harm, that it was -- reflected indicators across all
 24 four. What was unique about the first harm was that
 25 data was updated for at least a couple of the indicators

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1 **MR HALLIDAY:** That's absolutely right. Some of the -- as
 2 you'll have read later on in the document, go into that,
 3 but we had to take a judgement on what information to
 4 present to make it digestible.

5 **MR DAWSON:** Thank you.
 6 Perhaps I might ask you probably my final question,
 7 Mr Heald, just in relation to harm 2, where PHS had
 8 a significant input, if we could just have a look at
 9 that.
 10 Again, there are a number of criteria that are there
 11 relating to hospitalisations and in particular cancer.

12 **MR HEALD:** Yeah.

13 **MR DAWSON:** There are, I think, a number -- one might quite
 14 reasonably say there are a number of non-Covid harms
 15 that aren't reflected there. Were similar issues
 16 experienced as Mr Halliday has described it in that
 17 regard?

18 **MR HEALD:** Yeah, I mean, I think again, as Mr Halliday's
 19 said, a judgement call about what's available, and
 20 I guess this is a snapshot of the support at a
 21 particular point of time, so again I'm unfamiliar with
 22 whether indicators changed throughout the course of the
 23 pandemic.
 24 I think the other thing I would say is while this is
 25 a document that was shared within government, Public

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1 on a daily basis, so it was much more frequent and it
 2 changed much more frequently than -- in terms of what
 3 the numbers were actually saying, than some of the other
 4 harms. So it was unique in that respect.

5 **MR DAWSON:** And as far as -- there is, I should say, some
 6 information about the economic side which is contained
 7 later, but was it difficult to try to either find data
 8 or find data that would assist in particular with
 9 harms 2 and 3, which might be slightly more difficult to
 10 encapsulate in a format such as this?

11 **MR HALLIDAY:** I think that it actually was -- I thought it
 12 would be more difficult than it actually turned out, in
 13 that some of the data available for the economy was
 14 actually available on a fortnightly basis where
 15 previously it had been available on a less frequent
 16 basis.

17 **MR DAWSON:** Because one might say, for example, in harm 3
 18 there's information about vulnerable children attending
 19 school, people describing themselves as lonely, people
 20 who trust the Scottish Government to work in Scotland's
 21 best interests, applications to the Scottish Welfare
 22 Fund and the total coronavirus interventions by Police
 23 Scotland. One might say that there are a very large
 24 number of categories that aren't taken into account
 25 which would fall into the area of societal harm.

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1 Health Scotland did still publish, continue to publish
 2 data on a whole range of health and care statistics that
 3 we had in place prior to the pandemic that continued
 4 beyond that, so other data about other areas of health
 5 were still available throughout the pandemic.

6 **MR DAWSON:** So, for example, mental health obviously --
 7 **MR HEALD:** Yeah.
 8 **MR DAWSON:** -- as we know and we've heard was a very
 9 significant non-Covid-related harm. It doesn't feature
 10 there, but aren't you suggesting that that would be
 11 something that PHS would have been compiling throughout
 12 the pandemic?

13 **MR HEALD:** And we still published statistics on mental
 14 health throughout the pandemic, yes.

15 **MR DAWSON:** Thank you very much indeed.
 16 If that's a convenient moment, my Lady.

17 **LADY HALLETT:** It is, certainly. I shall return at 1.45.

18 **MR DAWSON:** Thank you very much.
 19 (12.46 pm)
 20 (The short adjournment)
 21 (1.45 pm)
 22 **LADY HALLETT:** Mr Dawson.
 23 **MR DAWSON:** Thank you, my Lady.
 24 I'd like to return to a subject that we touched on
 25 briefly near the beginning of your evidence, and that's

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1 to do with publication of data.

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

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

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

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

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

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1 National Records of Scotland data referred to situations
2 where a death was -- Covid was recorded on somebody's
3 death certificate, and Public Health Scotland where
4 somebody had died within 28 days of a positive test.

5 And after the spring of 2020 those two things were very,
6 very similar indeed but during the early part of the
7 pandemic the death certificate data was higher than the
8 Public Health Scotland data, and that's -- I guess
9 reflected the development of testing during that time,
10 because the Public Health Scotland data required a link
11 between a positive test and somebody dying.

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

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

22 **MR DAWSON:** Okay, thank you.

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

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

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

7 **MR DAWSON:** Really --

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

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

17 **MR HALLIDAY:** Indeed.

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

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

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

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

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

13 **MR DAWSON:** Would that be the same for PHS?

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

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

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1 **MR DAWSON:** What about consideration being given to people
2 with particular needs, in the sense of perhaps disabled
3 people who would have difficulty accessing the
4 information, was that something that featured in the
5 thinking behind publication in either the Scottish
6 Government or PHS?

7 **MR HALLIDAY:** I would say that the thing that comes to mind
8 when you've posed that question is about the
9 accessibility of data via the Scottish Government
10 website, but all the presentation of our information was
11 specifically designed to be as accessible as possible,
12 to high accessibility standards.

13 **MR DAWSON:** Would that apply to the PHS --

14 **MR HEALD:** (overspeaking) -- Scotland, yeah.

15 **MR DAWSON:** One of the themes that we've heard from evidence
16 that's been collated by the module and indeed in other
17 parts of the United Kingdom is the theme of digital
18 exclusion. I think it's the case that the data was all
19 simply published through the internet, the dashboard,
20 for example, that we've discussed.

21 Was any consideration given to the fact that there
22 were sectors of society who, for various reasons,
23 suffered from digital exclusion and how that might be
24 addressed?

25 **MR HALLIDAY:** I would say perhaps not directly but I was --
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1 you've looked at yourselves, is that the most vulnerable
2 in society were the most likely to be the most
3 vulnerable to Covid, or the most likely to suffer from
4 digital exclusion, the most likely to have particular
5 difficulties accessing the information. So would it be
6 fair to say that efforts were necessary in order to get
7 the information to the people that were most affected
8 and those efforts might have been done better?

9 **MR HEALD:** I think that that would be fair. I think there's
10 always learning with these things. I think the key
11 thing was that we were doing our utmost best to get the
12 data out to the public in as easy accessible formats as
13 possible on a daily basis, and this was running every
14 day with data asked adapting to different stages of the
15 pandemic. So there's always learning from these
16 approaches, but I think we did our utmost best to
17 present the data in a way that people could access it
18 and use it and understand it.

19 **MR DAWSON:** Thank you.

20 From a Scottish Government perspective, Mr Halliday?

21 **MR HALLIDAY:** I think I would agree with Mr Heald's
22 assessment of the situation.

23 **MR DAWSON:** Thank you.

24 I'd like to ask you a few questions, as you've
25 helpfully included information about this in your
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1 you know, an important route for making a lot of the
2 information available was not just directly through the
3 statistical publications but in things like the
4 First Minister's daily address where the statistics
5 featured heavily as part of that.

6 **MR DAWSON:** I think we'd said earlier that the daily address
7 was headline figures.

8 **MR HALLIDAY:** Indeed.

9 **MR DAWSON:** So that would be a means of communicating that.
10 There would, of course, be people who would struggle to
11 be able to understand that information. Was any
12 consideration given in that regard about how information
13 would be communicated better through that forum, that
14 involved you?

15 **MR HALLIDAY:** That involved me? Not directly.

16 **MR DAWSON:** Thank you.

17 **MR HEALD:** Likewise for me: not directly. But as far as
18 I recall people could contact Public Health Scotland.
19 If they, for example, were requesting particular pages,
20 we could print them out, make them more accessible. So
21 that was certainly an option. But you are correct the
22 majority of the outputs that came out from Public Health
23 Scotland were in digital means.

24 **MR DAWSON:** What the evidence tends to show, and you may be
25 aware of this from a lot of the statistical material
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1 statement -- it's particularly you, Mr Halliday, on this
2 topic -- it's about data sharing on a UK basis.

3 One of the general questions I was interested in
4 asking you was the extent to which, as far as informing
5 key decision-making is concerned, local data is
6 preferable, important, part of the picture? What would
7 your view be on that?

8 **MR HALLIDAY:** I think that that depended on the stage of the
9 pandemic that was being discussed, and the kind of
10 decisions that were being taken.

11 As I alluded to earlier on, that when the levels
12 approach was being developed and operated, that used
13 local area data to a much more overt kind of -- yeah,
14 used that data much more overtly than at other stages,
15 for example, when national -- at the start of the
16 pandemic, national modelling was what was a vital
17 piece -- vital piece of data rather than a lot of the
18 local effects.

19 **MR DAWSON:** So would it be fair to say you've made a time
20 distinction there at the beginning of the pandemic:
21 because there was a limitation on information one had to
22 try to use whatever information one could get, and
23 therefore a more national reliance was prevalent and
24 perhaps that became more local as the pandemic went on?

25 **MR HALLIDAY:** I would say that it was more that the scale at
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1 which the -- you know, the numbers that were involved
 2 weren't of a scale where there was a local --
 3 a significant local dimension to it. So the national --
 4 and therefore the focus on the national impact.
 5 **MR DAWSON:** A scale that was statistically apparent based on
 6 what testing was available, for example?
 7 **MR HALLIDAY:** Indeed.
 8 **MR DAWSON:** So the flip side of that, I suppose, is to ask
 9 the question: what -- beyond what we've discussed about
 10 the early stage of the pandemic, what was the use to the
 11 Scottish system, ultimately Scottish decision-making, of
 12 data which came from other parts of the United Kingdom?
 13 What sort of data was helpful or important?
 14 **MR HALLIDAY:** So I put together -- you'll have seen in the
 15 situation report and -- I put together a report called
 16 the "state of the epidemic", and what that did was
 17 put -- we used data from other nations of the UK or
 18 other nations internationally to put Scotland's position
 19 in context, and that kind of helped frame some of the
 20 Scottish data.
 21 **MR DAWSON:** When you say you used data from other places, to
 22 what extent was that data available to you? Did you
 23 have problems accessing data, in particular from the UK
 24 or more widely from these international sources?
 25 **MR HALLIDAY:** So I would say that there's two parts to this.

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1 was that ever resolved? You mentioned the date,
 2 June 2020 --
 3 **MR HALLIDAY:** That's not yet been resolved.
 4 **MR DAWSON:** That would be something, would it not, where
 5 you've identified, and you've explained why, that data
 6 which comes from the DWP for particular purposes would
 7 be useful, and this is the sort of thing that an inquiry
 8 might look into as suggesting would make a pandemic
 9 response more effective in future?
 10 **MR HALLIDAY:** I think it would.
 11 **MR DAWSON:** Thank you.
 12 Were there any other such UK Government departments
 13 with which you had difficulty?
 14 **MR HALLIDAY:** Not that I can recall, but I don't think
 15 I particularly asked for the similar -- made a similar
 16 ask to the -- that I did to DWP to other
 17 UK Government --
 18 **MR DAWSON:** That's the one that sticks in your mind?
 19 **MR HALLIDAY:** Indeed.
 20 **MR DAWSON:** You mentioned also preparing some analyses of
 21 data on an international basis. Could you tell us
 22 a little bit more about that and how that was used to
 23 try to assist Scotland's pandemic response?
 24 **MR HALLIDAY:** Yeah, I can point to a couple of -- a couple
 25 of times. So the first one was in our modelling, and

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1 So in terms of the aggregate data that might be about
 2 the number of cases in a particular country or a region
 3 of a country, that flowed very well through the central
 4 Cabinet, Cabinet Office arrangements that we had, and we
 5 fed data into that, and that was a reciprocal
 6 arrangement, so that worked really quite nicely.
 7 I think that it's fair to say that data at
 8 an individual -- around an individual person that could
 9 be used for research was more difficult.
 10 **MR DAWSON:** So to set the Cabinet Office to one side, you
 11 mention in your statement at paragraph 12(d) that there
 12 were issues in obtaining data from UK Government
 13 departments and you cite at least an example of getting
 14 data from the DWP in June 2020. First of all, what was
 15 the significance of that data, why were you interested
 16 in that data?
 17 **MR HALLIDAY:** So we were interested in that data to try to
 18 understand the effect of the pandemic on people's
 19 finances and welfare, and the data I'm talking about is
 20 of individual case -- individual people level data
 21 rather than aggregate data, and we found it quite
 22 difficult to come to an arrangement with the Department
 23 for Work and Pensions for sharing that data, which is
 24 a bit disappointing.
 25 **MR DAWSON:** And did that continue throughout the pandemic or

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1 our model inputted data from a range of different
 2 countries where there was some easing of restrictions --
 3 this was during the first wave of the pandemic, that we
 4 were looking at different options for easing
 5 restrictions, and we were able to get some evidence
 6 about the effect of different interventions in different
 7 countries through our modelling. So we were able to use
 8 data from other nations in order to be able to estimate
 9 what the effect of different policy interventions might
 10 be on things like the R number, or the number of people
 11 infected with Covid. So that was the first one.
 12 The second one was --
 13 **MR DAWSON:** Sorry, just on that one, was that something that
 14 continued throughout the pandemic or was specific to
 15 a particular time period?
 16 **MR HALLIDAY:** That was predominantly during the first wave
 17 of the pandemic, but to some extent that did continue.
 18 The second one was around foreign travel, and at
 19 that time we used a combination of modelling that was
 20 done by the London School of Hygiene and Tropical
 21 Medicine, and some data from internationally --
 22 internationally comparative data from a European agency
 23 to look at the incidence of Covid and the point --
 24 prevalence of Covid, ie the number of infective people
 25 or the rates of infective people in different nations,

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1 in order to make decisions about travel corridors to
2 different nations.
3 **MR DAWSON:** On the very subject that you mentioned there,
4 the international information, first of all, was that
5 sourced then through the UK Government or did you have
6 independent sources of that information?

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

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

21 **MR HALLIDAY:** The figures were from the same source.

22 **MR DAWSON:** Thank you.

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

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

7 **MR HALLIDAY:** About infection rates, certainly.

8 **MR DAWSON:** Yes.

9 **MR HALLIDAY:** Not about mortality.

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

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

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

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

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

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

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

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

11 **MR HALLIDAY:** It started recruiting participants at the
12 beginning of September and the first report was for
13 3 October, yeah.

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

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

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1 Survey couldn't do.

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

5 **MR HEALD:** It was.

6 **MR DAWSON:** -- test positivity?

7 **MR HEALD:** Yeah.

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

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

22 **MR DAWSON:** Okay.

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

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1 did they tell you?
 2 **MR HALLIDAY:** So this recognised that the individual survey
 3 responses can be particularly useful for research by
 4 enabling the linkage of the results from the survey to
 5 other routinely collected health data, say, for example,
 6 on vaccinations, and that that would be particularly
 7 welcome from the research community, which -- and it
 8 was -- we were aware that this was particularly helpful
 9 already in the UK context and what we were looking for
 10 was the Scottish data so that we could conduct some of
 11 that useful research for Scotland too.

12 **MR DAWSON:** Okay.
 13 One of the themes again that emerges from evidence
 14 that we've heard from a number of groups, in particular
 15 representing vulnerable or at-risk individuals, is that
 16 they found, when they tried to influence or plead their
 17 case for different decisions being taken within Scottish
 18 Government, that there was a lack of base data relating
 19 to these groups. One particular group, for example,
 20 which I referred to in the opening yesterday, had
 21 complained about the fact that what this meant was that
 22 they had to plead their case more anecdotally and it was
 23 difficult to be able to prove the effects that they
 24 asserted, in their case in the ethnic communities of
 25 Scotland, using statistics or data.

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1 and we took steps as best we could to address it, and
 2 we're still working now to make sure we've got systems
 3 in place to improve that going forward.

4 **MR DAWSON:** So that's a work in progress. I've focused on
 5 ethnicity because it's one particular example, but
 6 across what one might call "protected characteristics"
 7 generally would you say, Mr Heald, that that is a work
 8 in progress?

9 **MR HEALD:** I would say that's a work in progress. And when
 10 I, you know, give an example of ethnic groups, you know,
 11 we're doing work at the moment on all the protected
 12 characteristics, and that's a really important aspect of
 13 what we do and it's really, really important to the work
 14 that Public Health Scotland does more broadly, so not
 15 just for the work we do in Covid.

16 **MR DAWSON:** I think actually we heard yesterday that it was
 17 one of the purposes of the formation of Public Health
 18 Scotland to try to address health inequalities more
 19 effectively.

20 **MR HEALD:** Yes.

21 **MR DAWSON:** And this would be an example of trying to do --

22 **MR HEALD:** Yeah.

23 **MR DAWSON:** I'd like to ask you a few questions about some
 24 other data areas.

25 You gave evidence, I think, Mr Heald, to the

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1 Is it correct to say that there was a lack of data
 2 at the beginning and during the pandemic relating to
 3 at-risk and vulnerable groups such that this was the
 4 result?

5 It's really for both of you.

6 **MR HEALD:** So I think it's definitely fair to say that at
 7 the start of the pandemic, but as the pandemic
 8 progressed, and recognising the importance of data for
 9 those groups that you've talked about, we did take steps
 10 to address that.

11 I would still say that's work in progress, so
 12 there's currently a -- for example, a data group that
 13 I'm chairing that's looking at, you know, how do we
 14 improve the recording of ethnicity and the datasets that
 15 we have for health and care. So that's important. But
 16 where we could we did publish data.

17 And one source that we've not touched on during the
 18 hearing so far is that Public Health Scotland as well as
 19 having the daily dashboard also had a weekly report
 20 which allowed us to kind of deep dive into more detail
 21 into particular topics. So we did throughout the
 22 pandemic have particular chapters that majored on the
 23 impacts of different aspects of it on ethnic minorities
 24 as the group that you've -- highlight in particular the
 25 impact of vaccinations. So it definitely was recognised

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1 Scottish Parliament Health, Social Care and Sport
 2 Committee at a hearing on 23 November 2021.

3 **MR HEALD:** I did.

4 **MR DAWSON:** There are a number of aspects. For the sake of
 5 the transcript is reference is INQ000286854.

6 If we could just have that up.

7 There are a number of reflections, I think, in this
 8 similar to the one that you've just made, Mr Heald,
 9 which are very interesting to us, about issues that were
 10 experienced with data access within PHS and efforts,
 11 indeed, that are being made to try to look at that
 12 issue.

13 If I could look, for example, at page 2, I think
 14 these are four pages -- oh, no, that's not quite the
 15 same as the version I have.

16 I think here you say that it is in your response --
 17 this is a few lines down in the first paragraph, you
 18 refer to -- yes, you refer to:

19 "We have a lot of data that we can use to good
 20 effect, and we have the ability to link the data in
 21 order to understand pathways of care. It is important
 22 to recognise that we are building on strong foundations.
 23 There are a couple of areas that we need to focus -- and
 24 are focusing -- on: social care in particular, and
 25 primary care. Those are the two big areas to which we

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1 need to direct our attention."

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

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

10 **MR HEALD:** Yeah.

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

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

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

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

13 **MR HEALD:** Correct.

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

16 **MR HEALD:** Yes.

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

21 **MR HEALD:** Yes.

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

25 **MR HEALD:** Yeah.

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

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

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

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

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

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

4 **MR HEALD:** Yes.

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

7 **MR HEALD:** So they weren't. So that was a definite gap.

8 Although one way -- how would I best describe this -- it
9 is possible from other datasets to triangulate to inform
10 some of those particular questions that you are asking
11 about. So, for example, the Care Inspectorate maintain
12 a register of care homes, that register has the address
13 of the care home, much of the data that we get coming
14 into Public Health Scotland's at an individual level, so
15 we're able to map the postcode as best we can to
16 care homes to understand where people are. But I would
17 agree this is still an area that needs further
18 development.

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

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

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

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

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

21 (Pause)

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

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

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

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

6 **MR DAWSON:** Yes.

7 **MR HEALD:** -- addressed.

8 **MR DAWSON:** These are separate problems?

9 **MR HEALD:** Separate problems.

10 **MR DAWSON:** I understand.

11 **MR HEALD:** (inaudible).

12 **MR DAWSON:** Thank you.

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

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

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1 it, thank you very much indeed.

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

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

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

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

25 **MR DAWSON:** Yes.

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

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

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

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

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

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

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1 activity, or telephone calls in general practice.

2 **MR DAWSON:** At what stage was that something you were able
3 to institute?

4 **MR HEALD:** So forgive me around the exact dates but my
5 memory is from --

6 **MR DAWSON:** Broadly.

7 **MR HEALD:** From reading, it was broadly shortly after my
8 appearance at the committee in 2021, so --

9 **MR DAWSON:** Pretty much the end of the period we're
10 interested in.

11 **MR HEALD:** The period that you're interested in. But we
12 were able to get the data for that.

13 The other important area which, again, has been
14 touched on, and was touched on in the opening statement
15 that Public Health Scotland gave, was the EAVE II study.
16 You'll forgive me, I can't remember what EAVE II --

17 **MR DAWSON:** Well, could we come back --

18 **MR HEALD:** Oh you can't --

19 **MR DAWSON:** -- questions to go through -- (overspeaking) --
20 research access.

21 **MR HEALD:** But an important aspect of that, and for the
22 surveillance work that was done by Public Health
23 Scotland, we did get agreement to get data at a more
24 individual level from primary care to assist with the
25 surveillance, and we managed to achieve essentially

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1 PHS.

2 **MR HEALD:** Yes.

3 **MR DAWSON:** That, as I understand it, was a pre-planned
4 organisation -- reorganisation, PHS having been formed
5 as a corporate entity late in 2019 but was only going to
6 become operational on 1 April 2020. And that of course
7 happened at a time when we were in the middle of the
8 first lockdown.

9 Counsel for PHS accepted that there had been
10 a number of issues, including staff changes and the need
11 institutionally to bed in the new organisation, which
12 are understandable when any large organisation forms
13 like that.

14 I was interested in the specific element of the
15 extent to which that reorganisation caused difficulties
16 in data provision such as, or perhaps others, the ones
17 that you have frankly pointed out.

18 **MR HEALD:** So I think in terms of challenges around data
19 provision, you know, I would say that it didn't cause
20 problems. I think the important point was, as counsel
21 mentioned yesterday, there were three different bodies
22 that came together essentially to form Public Health
23 Scotland and in essence those bodies had, you know, the
24 existing data streams already in place, and those
25 carried on into Public Health Scotland, so data that we

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1 using the emergency powers that Covid brought, and we're
2 currently in conversations again with the GP community
3 about continuing with that essentially beyond this Covid
4 period, because the emergency powers we had then are no
5 longer in place.

6 **MR DAWSON:** Would one of the things that primary data would
7 have been of assistance in would be informing you about
8 what we called the second harm, the extent to which
9 people are suffering other health harms that may not
10 come to the attention of hospitals?

11 **MR HEALD:** I think that's fair. I mean, I think it's also
12 worth highlighting. A bit like in Scottish Government,
13 you know, we've got many other data sets within Public
14 Health Scotland that address other harms. So, for
15 example, we used the example earlier of mental health,
16 you know, we've got a lot of other datasets that look at
17 different aspects of mental health, so not having the
18 primary care data didn't completely exclude us from
19 being able to look at other aspects, but it's an
20 important gap, I would say, in our data estate and it's
21 an important gap that I would say we're making good
22 steps with at the moment to address.

23 **MR DAWSON:** I had another PHS-specific question. Another
24 thing that was mentioned in the opening about PHS
25 yesterday was the reorganisation that went on within

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1 routinely collected and had access to prior to Public
2 Health Scotland we still had that as part of Public
3 Health Scotland.

4 One of the areas that I would say we did make good
5 strides and there was a real benefit of Public Health
6 Scotland being there was the fact that we have the
7 expertise on the kind of data, the data capture aspects
8 of it and the analytical work from one of the previous
9 organisations, ISD, the Information Services Division,
10 that I was part of that could work more closely with our
11 health protection colleagues to make sure that we kind
12 of had our processes as automated and streamlined as
13 possible. So actually I would say a benefit was we were
14 able to bring additional capacity into the Covid space
15 than might otherwise have been more challenging had
16 Public Health Scotland not --

17 **MR DAWSON:** Presumably that amalgamation was part of the
18 (unclear) --

19 **MR HEALD:** That's right.

20 **MR DAWSON:** -- reason we discussed earlier, trying to
21 improve public health delivery --

22 **MR HEALD:** Yeah --

23 **MR DAWSON:** -- was bringing together these two
24 organisations?

25 **MR HEALD:** Yeah, and important that we didn't want each of

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

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

13 **MR HEALD:** Yes.

14 **MR DAWSON:** What were the issues around that?

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

22 What I would highlight is that ECOSS is what we
 23 would call a legacy system, it's old, serves its purpose
 24 and prior to the pandemic a lot of the surveillance work
 25 that we were doing would have been about instances of
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1 is page 10, that I'd like to ask you about.

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

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

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

25 **MR DAWSON:** Did that mean that information, important
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1 disease that were a lot smaller in case than what we
 2 ended up seeing in Covid, so one of the challenges
 3 quickly became the sheer volume of data that was coming
 4 through. Not so much in the very early stages of the
 5 pandemic because case numbers each day, although rising,
 6 were still relatively small, but we needed to kind of
 7 take steps to address that. And in essence what we did
 8 do was, without getting too technical, we established
 9 what we call a data warehouse, which is on newer
 10 technology, that allowed us to feed the testing data
 11 into that new platform on a daily basis, and that
 12 allowed us to run the analyses, automate what we were
 13 producing a lot quicker, which would ease the burden
 14 essentially on a lot of our staff in terms of what they
 15 were having to do more manually in the early stages of
 16 the pandemic.

17 **MR DAWSON:** Thank you.

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

20 Now, this, as I understand it, is a National Records
 21 of Scotland document from 24 March 2021, which sets out
 22 statistics in particular relating to various indicators
 23 during the previous week but it also includes an overall
 24 aggregate total of various things that have happened in
 25 the past. There is one particular aspect, which I think
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1 information about people with disability was not
 2 available for decision-makers as it might have been in
 3 the earlier part of the pandemic?

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

6 **MR DAWSON:** Thank you.

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

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

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

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

20 **MR DAWSON:** It will allow that?

21 **MR HALLIDAY:** Yes.

22 **MR DAWSON:** Thank you.

23 A general topic which I'd like to touch upon, about
 24 which there are a lot of documents that I won't get
 25 into, but I'm sure it's one we've touched upon already,
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1 it's the extent to which data was made available to
2 research, research organisations outwith the
3 organisations where you were working, the PHS or the
4 Scottish Government.

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

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

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

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

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1 that that was the case. That's why they announced the
2 set-up of Research Data Scotland in 2019, and that's
3 where, why they decided to fund the organisation up to
4 £25 million in -- from 2021, and I'm delighted to be
5 able to make a contribution to addressing this
6 particular challenge.

7 **MR DAWSON:** Thank you.

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

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

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

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

4 **MR HALLIDAY:** I'm happy to cover this.

5 **MR DAWSON:** Mr Halliday.

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

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

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

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

6 **MR DAWSON:** Yes, okay.

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

12 Could I go, please, to INQ000239682.

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

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

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

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

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

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

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

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

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

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

14 **MR DAWSON:** Thank you.

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

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

24 (Pause)

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

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

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

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

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

9 **MR HEALD:** Yeah.

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

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

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

3 **MR DAWSON:** Absolutely.

4 **MR HEALD:** -- so I know it well.

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

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

15 **MR DAWSON:** Okay.

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

21 **MR HEALD:** Okay.

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

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

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

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

16 **MR HEALD:** It would have been, yes.

17 **MR DAWSON:** Yes. Thank you.

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

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

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

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

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

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

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

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

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

18 **MR HEALD:** I would.

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

22 **MR HEALD:** Yes.

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

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1 interested in in this module.

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

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

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

20 **MR HEALD:** Yes.

21 **MR DAWSON:** Thank you.

22 As we go along, I think we can see that there are
23 a number of peaks in the graph, and I think,
24 for example, we can see that there are a number of
25 different ones, for example, cases starting to rise
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1 one can see, which seems to start around about May 2021,
2 as we go along the line. Would it be correct to say
3 that that was thought to be primarily associated with
4 the Delta variant?

5 **MR HEALD:** It was, that's correct.

6 **MR DAWSON:** And again I think that you have provided us with
7 helpful other data to suggest that the peak of that is
8 2 September 2021, when there were 7,622 cases.

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

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

19 **MR HEALD:** Yes.

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

23 **MR HEALD:** Absolutely.

24 **MR DAWSON:** Thank you.

25 I think as we go along the graph we see a very large
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1 around about the -- around about October time; would
2 that be right?

3 **MR HEALD:** October '20 you mean?

4 **MR DAWSON:** 2020.

5 **MR HEALD:** Yes.

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

9 **MR HEALD:** Yes.

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

14 **MR HEALD:** Yes.

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

19 **MR HEALD:** Yeah.

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

24 **MR HEALD:** Yeah.

25 **MR DAWSON:** Yes. Then I think there's a further wave which
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1 peak in December of 2021, and I think you told us that
2 that peak peaked on 29 December, which was 23,539 cases;
3 is that what --

4 **MR HEALD:** That's correct, yeah.

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

10 **MR HEALD:** That's right.

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

13 **MR HEALD:** They are.

14 **MR DAWSON:** Is that correct?

15 **MR HEALD:** Yes.

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

20 **MR HEALD:** That's correct.

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

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

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

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

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

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

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

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

11 **MR HALLIDAY:** Yes.

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

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

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

21 **MR HALLIDAY:** Correct.

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

23 **MR HALLIDAY:** Also worth just flagging at that period
24 there's also the impact of the vaccination, so obviously
25 a key development in December 2020 was the start of the
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1 Does this slide, which is entitled "Per capita Rates
2 of Covid-19 patients in hospital" -- perhaps we could
3 try you, Mr Heald, this time, and again if there's
4 anything that could be contributed -- or would it be
5 easier --

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

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

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

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

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

21 **MR HALLIDAY:** Yeah, of course, but we noticed that the
22 pattern for Scotland and the United Kingdom was -- or
23 other parts of the UK was slightly different and did
24 a clinical audit to investigate what the reason was, and
25 that was done in July 2020, and there was -- that found
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1 vaccination programme, so in terms of, yes, case numbers
2 higher but I guess the sickness of people lower because
3 of the impact of the vaccination.

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

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

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

13 **MR DAWSON:** Okay, thank you.

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

16 **LADY HALLETT:** Yes, certainly.

17 **MR DAWSON:** Thank you very much, my Lady.

18 **LADY HALLETT:** I shall return at 3.15.

19 (3.00 pm)

(A short break)

21 (3.15 pm)

22 **LADY HALLETT:** Mr Dawson.

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

24 If we could just move on to the next of the slides,
25 thank you, I'm wanting to look at slide 15, please.
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1 that there were actually quite a number of people in
2 Scotland who were in hospital that had at some point
3 been -- tested positive for Covid but Covid had resolved
4 itself and they were still in hospital, and that -- that
5 we made the decision to exclude those people once the --
6 beyond two weeks from when they were admitted or when
7 they tested positive for Covid -- when they were in
8 hospital, they were excluded from the figures, and that
9 brought us onto a consistent basis with other parts of
10 the --

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

16 **MR HALLIDAY:** Correct.

17 **MR DAWSON:** They were in for other --

18 **MR HALLIDAY:** For other reasons.

19 **MR DAWSON:** Yes.

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

24 **MR HALLIDAY:** I think so.

25 **MR DAWSON:** Yes, okay, thank you.
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1 So as we go on one can see again there are peaks,
 2 there's a significant peak which I think represents the
 3 Alpha variant where the number of hospitalisations with
 4 Covid in the UK is above Scotland; does that reflect the
 5 figures we saw before related to the numbers of
 6 infections perhaps?
 7 **MR HALLIDAY:** That's exactly how I see it.
 8 **MR DAWSON:** As we go on, I think there's a slight peak
 9 around July but possibly around about August 2021 again
 10 there seems to be a significant rise of Scotland for
 11 a period above the UK average; is that right?
 12 **MR HALLIDAY:** That's right.
 13 **MR DAWSON:** And again I think that roughly coincides with
 14 the period that we had identified as being one where
 15 Scotland's infections went up significantly due to
 16 Delta; is that right?
 17 **MR HALLIDAY:** That's right.
 18 **MR DAWSON:** And again beyond that, when we get in towards
 19 the end of 2021 and the Omicron wave, you see the lines
 20 mirroring each other almost exactly for a period, but
 21 then towards the end of the period that we're interested
 22 in, this takes us up to April 2022, there's
 23 a significant jump in Scotland as compared to the rest
 24 of the UK. Would that tend to suggest that at the very
 25 end of the period in which we are interested there is

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1 **LADY HALLETT:** Mr Dawson, just going back to the Delta peak,
 2 autumn 2021, the whole of the UK suffered from the Delta
 3 variant, didn't it, so is there any explanation for that
 4 peak or is that not statistically significant?
 5 **MR HALLIDAY:** I think there is a noticeable difference
 6 between -- I think that's a -- I'd put that in the same
 7 group as what happened in April 2022, that the levels of
 8 infection are slightly higher in Scotland, the levels of
 9 vaccination are broadly the same, and so I -- beyond
 10 that it's difficult to quite understand this. I guess
 11 one factor in this may be something to do with the
 12 underlying health conditions of people in Scotland
 13 relative to other parts of the United Kingdom.
 14 **LADY HALLETT:** I think that's the point that Mr Dawson was
 15 then making.
 16 **MR DAWSON:** Thank you, my Lady.
 17 If I could take you on to the next slide, which is
 18 slide 27. This is one of the dashboards, so perhaps
 19 you, Mr Heald, on this one, "Cumulative Covid-19 deaths
 20 for Scotland". The graph shows the cumulative number of
 21 deaths in which Covid-19 is mentioned on the death
 22 certificate rather than excess deaths; isn't that right?
 23 **MR HEALD:** That's right.
 24 **MR DAWSON:** So would these have been the figures that PHS
 25 would have been releasing or were the PHS figures based

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1 a statistically significantly higher number of people in
 2 Scottish hospitals with Covid than in the UK? Is that
 3 what it shows?
 4 **MR HALLIDAY:** It shows that -- so statistical significance
 5 with administrative data is a slightly more complicated
 6 phrase --
 7 **MR DAWSON:** I wouldn't want --
 8 **MR HALLIDAY:** Certainly the Scotland number is of an order
 9 higher than the rest of the UK. Which is -- I'm not
 10 quite sure as to the reason given that at the time --
 11 when we referred back to the Covid Infection Survey,
 12 whilst the Scottish peak was a little bit higher, it
 13 certainly wasn't higher to the magnitudes that the
 14 hospital --
 15 **MR DAWSON:** If one were to assume that one would be in
 16 hospital with Covid if one were iller with Covid, would
 17 that tend to suggest that there was a higher proportion
 18 of people in Scotland who were iller with Covid at that
 19 time at the severe end, that would make you go into
 20 hospital, than in the rest of the UK by way of average?
 21 **MR HALLIDAY:** That's right. And again from the vaccinations
 22 data, it just -- the numbers are broadly comparable in
 23 Scotland and the rest of the United Kingdom, so it's --
 24 I'm struggling to explain exactly what that is using the
 25 other data that's available to us around Covid.

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1 on some other statistic at the time?
 2 **MR HEALD:** So my understanding is that these cumulative
 3 deaths are the deaths published by NRS, National Records
 4 of Scotland, and as we've talked about before, the
 5 figures from Public Health Scotland, once testing really
 6 ramped up, mirrored the figures that we saw in NRS. But
 7 these are the National Records of Scotland figures
 8 rather than the Public Health Scotland ones.
 9 **MR DAWSON:** Just to be clear, we all remember that the
 10 headline statistics that would be given, for example, in
 11 daily briefings would include statistics for the
 12 previous 24 hours' infections and mortality.
 13 **MR HEALD:** Yeah.
 14 **MR DAWSON:** Those would have been provided by PHS, isn't
 15 that right?
 16 **MR HALLIDAY:** Yeah.
 17 **MR DAWSON:** And those PHS numbers for the most recent time
 18 period, I think it varied when it was a weekend for
 19 a slightly longer period or something, but would they --
 20 what would the source about the information about the
 21 mortality have been in that?
 22 **MR HEALD:** So for the daily reporting that was done, the
 23 source of the data would have been Public Health
 24 Scotland. And what we did in essence was link the
 25 positive confirmed cases to very fast data we were

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1 getting from National Records of Scotland about death
 2 registrations, but those death registrations didn't have
 3 the detail, so we only knew about people who died and we
 4 matched them to the Covid data that we had --
 5 **MR DAWSON:** Because I was wondering whether I could explore
 6 with you the possibility that that, in real time,
 7 creates a statistic which says "this is the number of
 8 deaths that have been recorded" --
 9 **MR HEALD:** Yeah.
 10 **MR DAWSON:** -- but it may be that, for example, certain
 11 circumstances of deaths would result in quicker
 12 certification, for example perhaps patients who are in
 13 hospital, than perhaps people who have died in the
 14 community where possibly whether it's a Covid death
 15 might not be entirely clear, does that statistically
 16 change things very much or are you basically reporting
 17 the deaths --
 18 **MR HEALD:** It's the same -- so it's the same -- it's based
 19 on the registration, so it's the same time period. What
 20 I'm highlighting is that the level of detail available
 21 when the registration first comes through --
 22 **MR DAWSON:** Yes.
 23 **MR HEALD:** -- is not as detailed essentially as we were
 24 using the raw data about people who'd died.
 25 **MR DAWSON:** Yes.

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1 **MR DAWSON:** As far as 27 is concerned, we see a rise and
 2 then a plateau, if you like. Would that be roughly
 3 telling us the number of deaths that were in the first
 4 wave?
 5 **MR HEALD:** Yes, so that March to --
 6 **MR DAWSON:** It's March. It plateaus at around about
 7 June 2020 and that lasts till around about
 8 November 2020.
 9 **MR HALLIDAY:** That's exactly right.
 10 **MR DAWSON:** Yes, and I'm wondering, it might be overly
 11 simplistic, but it rather looks like you see a similar
 12 pattern in the second and what you might call the third
 13 waves, is that there's roughly 5,000 deaths in the first
 14 wave maybe slightly more than that but around about the
 15 same in the second wave; is that right?
 16 **MR HALLIDAY:** That's right. It's over -- the second wave is
 17 over a slightly longer period of time but it's broadly
 18 similar.
 19 **MR DAWSON:** Yes. And then we see a rise again from around
 20 about July 2021 through to the end of the period.
 21 Again, that's a more gradual line rather than a steep
 22 line that we saw before, but that would be a combination
 23 of Delta and Omicron, would that be correct, over that
 24 period? And again if one combines those two in that
 25 later period you see, broadly speaking, roughly the same

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1 **MR HEALD:** NRS would then use the full record when it became
 2 available and --
 3 **MR DAWSON:** I see, and I suppose overall it's possible that
 4 the overall numbers we see here might suffer from the
 5 fact that death certification might not be entirely
 6 accurate and there might be some Covid deaths missed.
 7 **MR HEALD:** I think if you look at slide 25, it's in the
 8 pack, kind of shows the difference between what was
 9 recorded on the death certificate and what we found in
 10 Public Health Scotland. So we've already touched about
 11 on the kind of early period when there was a higher
 12 number --
 13 **MR DAWSON:** Yes.
 14 **MR HEALD:** -- from NRS, and that's down to the fact there
 15 was less testing at that time.
 16 **MR DAWSON:** Yes.
 17 **MR HEALD:** But you can see from the kind of July 2020 period
 18 all the way through, I would say that the Public Health
 19 Scotland and NRS figures matched pretty consistently --
 20 **MR DAWSON:** I see.
 21 **MR HEALD:** -- so that would suggest then that the recording
 22 of Covid, when it became available on the death record,
 23 was pretty consistent with what we got by matching --
 24 **MR DAWSON:** Thank you.
 25 **MR HEALD:** -- the deaths to the test data.

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1 number of deaths, it comes to somewhere around 15,000
 2 deaths, around about slightly under 5,000 in the first
 3 part, slightly over 5,000 in the second and slightly
 4 under 5,000 in the third; is that right?
 5 **MR HALLIDAY:** That's right, but again it's over a longer
 6 period of time --
 7 **MR DAWSON:** Yes.
 8 **MR HALLIDAY:** -- the first to the second to the third.
 9 **MR DAWSON:** Hence the lines are more or less steep.
 10 **MR HALLIDAY:** That's exactly it, yes.
 11 **MR DAWSON:** Thank you very much.
 12 Could I take you on now to slide 28, please.
 13 I won't dwell too long on this one because it's quite
 14 complicated this one, as far as I can make out.
 15 This is reflecting something different from the
 16 previous slide, which is excess deaths rather than
 17 deaths on certificates; is that correct?
 18 **MR HALLIDAY:** That's correct.
 19 **MR DAWSON:** And what this traces is the certification with
 20 the light blue line and excess deaths with the dark blue
 21 line, and very deliberately inviting you to try to keep
 22 your explanation as simple as possible I wondered if you
 23 could explain to us broadly why it is that the lines
 24 appear as they do.
 25 **MR HALLIDAY:** Okay. So these two things are measuring

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1 related but different, distinctly different things.
 2 So the deaths with Covid-19 on the death certificate
 3 are the figures from the National Records of Scotland
 4 that we've discussed before. Excess deaths is a measure
 5 of all deaths whether that's related to Covid or not,
 6 and the chart here compares what happened during 2020 up
 7 to 2022 with what happened in the five years, month by
 8 month, and the numbers are above zero where there are
 9 more deaths than there would be expected at that time of
 10 the year, and it would be below zero, for example in
 11 spring 2021 and spring 2022, where there are fewer
 12 deaths than would be expected at the time of the year.

13 So what it shows is that there's a high peak both in
 14 excess deaths and deaths from Covid in wave 1, and the
 15 two lines match up pretty well, and that there is
 16 then -- the relationship between these -- the deaths
 17 from Covid-19 and excess deaths is relatively sort of --
 18 there's a -- you know, those two things are relatively
 19 well aligned in wave 2 but then it becomes less clear
 20 cut the relationship between those two things.

21 **MR DAWSON:** Because excess deaths, as I understand it,
 22 doesn't mean just Covid deaths, it's the number of
 23 deaths more than would have been experienced -- had been
 24 experienced in a previous time period at a given moment.

25 **MR HALLIDAY:** That's right.

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1 communities, and those which suffered the greatest
 2 numbers of mortality in Scotland; is that correct?

3 **MR HALLIDAY:** Yeah.

4 **MR DAWSON:** From which we can see that the community that
 5 suffered the greatest number of deaths is the Pakistani
 6 community; is that right?

7 **MR HALLIDAY:** What this chart does show -- I mean, that's
 8 broadly correct. There is also a confidence interval
 9 here that says it was significantly higher also amongst
 10 the other Asian --

11 **MR DAWSON:** Yes, I see that. So the fact there's a broad
 12 horizon line indicates the confidence interval, I think.

13 So I suppose it's possible that the second category is
 14 slightly more, but relatively speaking it seems to be
 15 that the Pakistani or other Asian communities suffered
 16 the greatest likelihood of death.

17 **MR HALLIDAY:** Absolutely.

18 **MR DAWSON:** Thank you.

19 Those are the questions that I have for you, thank
 20 you very much. If you just bear with me one moment.

21 There is nothing from the core participants,
 22 my Lady.

23 **LADY HALLETT:** Thank you very much indeed. I followed
 24 nearly everything that you've said, which is a miracle,
 25 given my self-confessed difficulty with graphs.

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1 **MR DAWSON:** Would that give us some indication about deaths
 2 that occurred over this period that weren't due to
 3 Covid?

4 **MR HALLIDAY:** Yes, it would do.

5 **MR DAWSON:** Thank you. There's a couple more slides I'd
 6 like to take you to quickly. The next one is slide 34.

7 This is Covid mortality rates by self-reported
 8 disability category. These are, I think, age adjusted;
 9 is that correct?

10 **MR HALLIDAY:** That's right.

11 **MR DAWSON:** So it would be wrong to say, for example, that
 12 disability can be equated to old age, these figures were
 13 designed to strip out that aspect of the analysis, is
 14 that right?

15 **MR HALLIDAY:** That's right.

16 **MR DAWSON:** And this slide shows that, adjusted for age,
 17 those members of society who self-report as disabled had
 18 a significantly higher rate of Covid mortality when
 19 compared with non-disabled members of society; is that
 20 right?

21 **MR HALLIDAY:** That's right.

22 **MR DAWSON:** Thank you.

23 One further slide that I wanted to go to, which is
 24 slide 35. What this slide, which is based on Scotland
 25 again, tells us, I think, are the ethnic minority

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1 I'm very grateful for your help and I hope that you
 2 found having the two of you together worked quite well.
 3 It did for us. So thank you for everything you've done.

4 **MR HALLIDAY:** Thank you.

5 **MR HEALD:** Thank you very much indeed.

6 **(The witnesses withdrew)**

7 **MR DAWSON:** I think that the next witness will be
 8 Dr Audrey MacDougall. My colleague Ms Arlidge will be
 9 dealing with her.

10 **MS ARLIDGE:** My Lady, may I call Dr Audrey MacDougall.

11 **DR AUDREY MacDOUGALL (affirmed)**

12 **Questions from COUNSEL TO THE INQUIRY**

13 **LADY HALLETT:** Ms Arlidge.

14 **MS ARLIDGE:** Thank you very much, my Lady.

15 Dr MacDougall, you have -- thank you for your
 16 assistance in providing your evidence to this Inquiry.
 17 We see a witness statement from you, reference
 18 INQ000346964. It's just been brought up on the screen.
 19 I hope it's familiar with you. I believe on page 23, it
 20 will be redacted in this version, but you have signed
 21 that statement.

22 **A.** That's correct.

23 **Q.** And you're happy with the contents of --

24 **A.** Yes.

25 **Q.** -- the statement, that they're truthful --

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1 A. Yes.

2 Q. -- to the best of your knowledge and belief.

3 There are going to be a series of areas I take you

4 through during the course of your evidence. I will try

5 myself to be as slow as I can be for the stenographer,

6 who is doing sterling work in the background. I would

7 ask you also to try and keep your answers nice and slow.

8 I realise we're at the end of the day, and I can only

9 apologise for that.

10 A. Certainly, that's fine.

11 Q. You are -- starting from the beginning, you wear

12 a number of hats in Scottish Government in terms of

13 analytical, statistical, research hats. Is that a fair

14 way of putting it as a broad spectrum to start off with?

15 A. I think to try and just encapsulate the period covered

16 by the Inquiry, at the start of that period I wore two

17 hats, if you like, I was the Scottish Government's chief

18 social researcher, which is a professional role, looking

19 after social researchers within the government and

20 looking after the promotion of social research within

21 the government. I was also head of what was called the

22 communities analysis division, which was a division made

23 up of different types of analysts, researchers,

24 statisticians, economists, who provided analysis

25 covering a range of areas, poverty, social security,

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1 you know, for very many hours every day meant that it

2 was impossible for one person to do the job.

3 Q. And in due course, early on but in due course, you were

4 also very heavily involved in setting up and the

5 development of the four harms strategy and providing

6 evidence and analysis in that regard?

7 A. That's correct.

8 Q. To go to the very sort of genesis of the MAH, my Lady

9 has already heard evidence -- sorry, comments yesterday

10 from Jamie Dawson about the set-up of things like SGoRR,

11 obviously that was pre-pandemic?

12 A. Yeah.

13 Q. It was a system that was already in place?

14 A. Yes.

15 Q. Is it correct to say that SGoRR, having been activated

16 in light of the pandemic and the need for responding,

17 requested your analytical approach or your evidence and

18 your assistance in the very early stages --

19 A. Yes.

20 Q. -- early March to say "We need eyes on things from

21 a statistical and modelling analysis" --

22 A. Yes, that would be correct, yes.

23 Q. So you were requested to provide that sort of analysis

24 from about 4 March 2020?

25 A. So that was when I became involved, but there were other

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1 housing, a range of different areas. So when Covid

2 started, those were the two roles that I fulfilled.

3 I then moved to establish the Covid modelling and

4 analysis hub, to specifically look at doing the same

5 job, if you like, but solely focused on Covid issues, so

6 looking at providing a wide range of evidence and

7 analysis but related to Covid issues.

8 However, I didn't give up my communities job for

9 about a year, so there was about a year when I held

10 three posts.

11 Q. And shortly after you commenced working, setting up the

12 modelling and analytical hub -- I'm sure I'll get that

13 wrong multiple times -- MAH, for the --

14 A. MAH.

15 Q. MAH. Shortly after you joined that and set it up, you

16 recognised that the scope of the work that was involved

17 no doubt was enormous and you asked Mr Roger Halliday,

18 who has just given evidence, to join you in that hub?

19 A. That's correct. We felt that we had a very good

20 complementary set of skills that myself as a social

21 researcher and Mr Halliday as a statistician, we knew

22 each other well, we had worked together before, so we

23 felt that that would be a very good combination. And

24 then in practical terms the hours that were being worked

25 by the hub and the need for that senior oversight,

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1 people who had been providing analysis before then under

2 the auspices, say, of the health analysis colleagues, or

3 there may have been other colleagues in other parts of

4 the office who were starting to get involved as well.

5 The whole organisation was turning itself towards

6 looking at Covid, so I wouldn't want to give the

7 impression that there was nothing happening before then,

8 there certainly was activity going on. But when SGoRR

9 invited me to become involved, it was really recognising

10 that this was a step change to any crisis that had been

11 dealt with before and would benefit from having

12 a central co-ordinating and specialist division. That

13 would then draw in work that was happening in other

14 parts of the office as well.

15 Q. So you were therefore to able to provide a sort of

16 central focal point --

17 A. Yes.

18 Q. -- and leadership role in respect of multiple areas --

19 A. That's right.

20 Q. -- of information and modelling --

21 A. Yes.

22 Q. -- coming to your attention and effectively drawing

23 together threads from different departments --

24 A. Yes.

25 Q. -- who were presumably all carrying out their own

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- 1 individual assessments from different, in different,
2 transport looking at one aspect of things --
- 3 **A.** That's correct, absolutely, yes.
- 4 **Q.** When you took leadership of the MAH, how many people
5 were sort of at your disposal, as it were?
- 6 **A.** Well, I think we probably started in week one with about
7 five people, and one of my first tasks was to actually
8 staff the division correctly, so that was the -- indeed
9 my first week or so spent in actually making sure that
10 we had sufficient staff of the right grade and of the
11 right quality and the right skill, and that was
12 undertaken by drawing out the relevant staff from other
13 parts of the Scottish Government.
- 14 From my role as head of profession and working with
15 the other heads of profession in Scottish Government,
16 I had a reasonable oversight of the talent that we had
17 available to us, so I went shopping and asked for
18 particular people to come and work with me, and
19 gradually built up, you know, a reasonable sized
20 division.
- 21 **Q.** You set out at paragraph 15 of your statement that you
22 agreed effectively a programme of work with your
23 colleague -- with the key --
- 24 **A.** Yes.
- 25 **Q.** -- Scottish Government directors?

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- 1 **A.** Sure.
- 2 **Q.** Probably saying to you briefly explain something that is
3 an incredibly complicated issue is a bit difficult, but
4 population base models: is that looking at who is
5 a member of the society -- the population that you're
6 looking to model?
- 7 **A.** So I'll just say a little bit which hopefully might help
8 in terms of modelling, and I should preface this by
9 saying I am not a modelling expert, I had some modelling
10 experts in my staff, but broadly speaking there were
11 three types of modelling carried out during Covid.
12 There was epidemiological modelling, which was the
13 modelling that gave us the R number, the growth rate,
14 the infection rate, and that's what SPI-M-O was
15 concerned with, and that was at the core of
16 understanding what was happening with the pandemic.
- 17 Then there was what was called operational
18 modelling, and by its very nature -- you can get the
19 idea -- operational modelling was taking that
20 epidemiological modelling, using that to say: well, what
21 does that tell us about cases, what does that tell us
22 about potential hospitalisations, ICU, so you could use
23 it for operations, how many hospital beds might I need.
- 24 Then you have policy based modelling, and that's
25 what this refers to, is taking that epidemiological

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- 1 **A.** Yes.
- 2 **Q.** Is it the case effectively you had something of a blank
3 sheet of paper and you had -- there was a discussion
4 that went on between the various directors and yourself
5 saying "This is the sort of thing we can assist with,
6 these are the things that are on our sort of radar"?
- 7 **A.** That's exactly it, I mean, this is the initial programme
8 and, as you will see going through the statement, it
9 changes over time in terms of the actual work we do, but
10 the work always generated either from commissions from
11 ministers or from other colleagues, particularly policy
12 colleagues, or the work could be generated by ourselves
13 where we proactively felt that there was some gaps in
14 the evidence base or gaps in our knowledge, and we
15 initiated work to fill those gaps. So it could go
16 either way, it could be a commission or it could be
17 something that we put forward.
- 18 **Q.** Just looking at those various -- again, like my
19 predecessor in standing up here a moment ago, please
20 don't get too complicated in these answers -- but
21 looking at the initial programme, we've got things --
22 we've got developing the population base --
- 23 **A.** Mm-hm.
- 24 **Q.** Could you just very briefly explain what a population
25 base --

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- 1 modelling but then using it to try and say: well, what
2 would happen if we did X or we did Y, if we implemented
3 different types of scenarios, and that might be either
4 things that we're doing, ie things that the government
5 had chosen to do, or it might be just different
6 scenarios. Well, what if we think, instead of 80% of
7 the population getting infected, it would be 60%, what
8 would that mean? So ... does that help?
- 9 **Q.** It does.
- 10 Just going through some of the other points there,
11 so leading on responding to commissions from SGoRR,
12 again you say you're not a modeller, but this is where
13 SGoRR, headed by Andrew Morris, comes and says to you
14 "Please can you give us a model about the likely
15 transmission rate in" --
- 16 **A.** So -- indeed, so we could be asked: could you model what
17 might happen if the transmission -- if, you know, 60% of
18 people became infected, 70%, or could you model what
19 might happen if R was 2 or R was 4 or R was 6, you could
20 model on that basis. Commissions from SGoRR that could
21 also consist of work that wasn't modelled, it might be,
22 for example: what do we know? I mean, you know, what's
23 the latest on the science and transmission then? What
24 is it telling us? Or it might be: what do you think
25 people in the street are saying, you know, what's

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1 happening? So it could be a range of different types of
 2 evidence.
 3 **Q.** I'm asked to remind you -- remind myself that I misspoke
 4 by saying SGoRR was headed by Andrew Morris. It's SCAG
 5 that was headed by Andrew Morris, I apologise.
 6 But nevertheless, the same sort of approach, so
 7 SGoRR, because SCAG was subsequently set up and --
 8 **A.** Yes.
 9 **Q.** -- were also asking for data and modelling to be carried
 10 out and to, on that same sort of basis; is that right?
 11 **A.** On the same sort of basis, but with SCAG, when it was
 12 established, initially Roger was the -- was a member to
 13 represent our division, and then when Roger moved on,
 14 I became the member of SCAG to represent our division.
 15 So it went -- again, there was a kind of a both-way
 16 relationship with SCAG. We would present the work we
 17 had done to SCAG -- to look for commentary, critique,
 18 discussion -- or SCAG could ask us to produce the
 19 particular pieces of work, and we would go and do that.
 20 **Q.** Then updating, controlling and sharing the central
 21 assumptions and parameters that everyone should be
 22 working to; is that a sort of proced -- that's not
 23 modelling assumptions necessarily, that's much more --
 24 is that more in the sort of "these are the key
 25 performance indicator styles" approach?

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1 there was subsequent issues in terms of subgroups about
 2 children and education -- before those subgroups came
 3 about, were you asked about modelling into or providing
 4 evidence in terms of things like education closures and
 5 the like?
 6 **A.** So we were asked to look at what would be the impact,
 7 let's say, on R and then the subsequent case numbers of
 8 the closure of schools, that would be a valid
 9 modelling --
 10 **Q.** When was that sort of -- I appreciate it's not meant to
 11 be a memory --
 12 **A.** Oh, goodness. It would have been done at various points
 13 in time, because schools were opened, closed, and then
 14 partially opened, you know, so there was -- it would
 15 have taken place at different times, it would've done
 16 that kind of modelling.
 17 And that would have been based -- just to clarify,
 18 as well, the basis on which it would have been done --
 19 it would have been based on assumptions that would have
 20 come from SAGE.
 21 **Q.** I apologise, Dr MacDougall, I'm being asked if you could
 22 just try and slow your responses slightly.
 23 **A.** I apologise.
 24 **Q.** I apologise. I know it's very difficult.
 25 At the very beginning, 4 March, 10 March, 12 March,

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1 **A.** Could be modelling assumptions but, it would be just
 2 generally: here's what we're assuming about the pandemic
 3 at the moment, based on the current state of what we
 4 know in terms of the science, in terms of what SAGE is
 5 telling us, in terms of what SPI-M-O is, and ensuring
 6 that everybody across the office had that same broad
 7 understanding of what was happening.
 8 **Q.** Was the MAH asked to provide specific advice on specific
 9 policy questions from the outset or from early March, or
 10 was it more sort of general "Show us where things are
 11 going"?
 12 **A.** So it started off obviously with "Show us where things
 13 are going", but as soon as government moved to
 14 a position of wanting to introduce NPIs or wanting to,
 15 you know, make changes of any sort, then we were asked
 16 if we could model through the impact of certain of those
 17 changes that were going to be made. So that became
 18 a regular -- a regular occurrence throughout the whole
 19 of the pandemic.
 20 **Q.** From -- if I might take some sort of specific examples,
 21 were you asked, for instance, to model issues about
 22 discharge of patients into care homes and the effect of
 23 that?
 24 **A.** No, we did not model discharge into care homes.
 25 **Q.** Were you asked, in terms of care -- appreciating that

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1 when SGoRR come and ask you to have greater input?
 2 **A.** Yes.
 3 **Q.** Of course you've already given evidence that there was
 4 embedded analysis in each different department, for
 5 instance.
 6 **A.** Yes.
 7 **Q.** The -- I think it's uncontroversial that knowledge of
 8 the existence of the threat of Covid was growing.
 9 **A.** Yes.
 10 **Q.** And the early COBR meetings in which people were,
 11 you know, recognising that there was a need to ascertain
 12 whether there was sufficient resilience in the system,
 13 what's it going to look like in Scotland, have we got
 14 enough beds, have we got --
 15 **A.** Yes.
 16 **Q.** Was that sort of analysis being done within the
 17 departments before you set up MAH, or were you having to
 18 start effectively from not necessarily zero but a very
 19 basic level of blank sheets to start?
 20 **A.** So because I wasn't involved before 4 March, I can't
 21 comment on exactly what was happening, but I don't think
 22 one could say that nothing was happening.
 23 **Q.** Could effort -- could MAH have been set up earlier?
 24 **A.** It's a question that as analysts we will always say we
 25 want to be in the room from the beginning, but there's

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

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

10 Q. And what do those guidelines say, briefly?

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

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

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

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

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

4 A. That's right, yes.

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

10 A. Yes.

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

13 A. Yes.

14 Q. -- there was less information --

15 A. That's correct.

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

17 A. Yes.

18 Q. You had a weekly call.

19 A. Yes.

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

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

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

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

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

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

9 A. Yes.

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

12 A. Yes, yes.

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

16 A. Yes.

17 Q. Thank you.

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

22 A. Yes, that's correct.

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

24 A. Yes.

25 Q. So you recognised the importance of effectively not

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

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

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

22 A. Yes.

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

24 A. Yes.

25 Q. -- analysis that you were providing --

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1 A. Yes.

2 Q. -- to the hub to their respective director general
3 areas?

4 A. Indeed.

5 Q. So at that point is it fair to say that you didn't have
6 so much direct contact with the director general or the
7 directorate decision-makers in terms of sharing your
8 modelling?

9 A. So in terms of sharing modelling, at this point I was
10 engaged primarily with the senior policymakers in the
11 health DG, and was -- and I have to say occasional,
12 because I can't necessarily say I was at every
13 meeting -- but was invited to gold meetings and various
14 other meetings where ministers were present to present
15 on modelling and -- I think Mr Halliday said the same --
16 we took it in turns to present information at those
17 types of meetings.

18 Q. You say -- staying with the same paragraph of your
19 statement, you say it became a key -- the weekly Covid
20 --

21 A. Mm-hmm.

22 Q. -- became a key communication tool for disseminating the
23 modelling the evidence and the analysis. It was
24 regularly attended by over 100 people, including the
25 Chief Medical Officer, CSA, NCD and senior colleagues.

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1 A. Yes.

2 Q. -- behind modelling as it went through?

3 A. Yes.

4 Q. So how were you able to ensure that those
5 decision-makers and those senior members who were
6 attending were able to, you know, understand what is
7 modelling and the like?

8 A. I think we tried to present the information in a way
9 that was readily comprehensible, but we also -- the call
10 itself wasn't just my team presenting information, there
11 was also a period of time set aside for questions, and
12 it was made very, very clear that any question could be
13 asked, so it could be what people might think of as
14 a very basic question, that was absolutely fine, or it
15 could be a more complex question, and we had a mix of
16 both, and we used that as feedback. So if we were
17 getting feedback that seemed to indicate that people
18 didn't understand one element of our presentation, then
19 we would change that for the following week.

20 Q. I'm relieved to hear that no question is too stupid from
21 me at least.

22 Can we think about -- and appreciating you're not
23 a modeller, but you've already touched on slightly in
24 terms of how modelling, what modelling is and how it
25 works. It's a term that is used sort of

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1 To be clear, is that the "by the end of May" time,
2 or is that later on? So you say earlier in your
3 statement "By the end of May it was for all interested
4 parties", but did it continue to expand into people like
5 the CMO attending and --

6 A. Yeah, it was opened up to all interested parties, so
7 quite literally an invite was sent out to anybody in the
8 government who was working on Covid who would find it
9 useful to have a weekly update, and attendance built up
10 as more people got involved, more people got engaged,
11 and as the range of our evidence expanded as well, and
12 that naturally expanded as more evidence became
13 available and more research became available.

14 Q. So when -- again I don't need a specific date, but
15 approximately when did the CMO start attending those
16 weekly calls?

17 A. Oh, goodness. I'm not sure. I just can't hazard
18 a guess on that, honestly.

19 Q. And as they expanded and you had more people joining and
20 an open invitation, presumably the -- with other
21 analysts, they understand the principles about
22 modelling, they understand more readily how the evidence
23 is being assessed, did it -- did your calls have to
24 engage at a level of trying to explain what it all meant
25 and explain the principles --

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1 interchangeably, isn't it, to not necessarily reflect
2 those three areas that you were talking about, but if we
3 take them all in stages in slightly more detail, but
4 very slightly more detail, than you spoke to a moment
5 ago: epidemiological modelling, that was done in both
6 in-house in Scottish Government, wasn't it, and also by
7 applying -- by using other external modelling groups, so
8 SPI-M, as you've already spoken to, that fed into SAGE?

9 A. Yes.

10 Q. You were working with other universities?

11 A. Yes.

12 Q. And Scottish Government had their own --

13 A. Yes.

14 Q. -- modelling approach in which, is it right that they
15 were using the Imperial College of London's modelling?

16 A. Yes.

17 Q. Like base --

18 A. Yeah.

19 Q. -- sort of structure, as it were, and then applying
20 Scottish specific data to it?

21 A. That's correct. So from a very early stage
22 Imperial College published their modelling code and so
23 it was available to use. We obviously spoke to
24 Imperial College and we made adjustments for Scotland so
25 we could make adjustments for the age profile of the

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

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

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

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

25 You've probably heard about the consensus approach
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1 you'll project forward and you'll get an idea of what
 2 might happen, and I think some of the early
 3 Imperial College models, for example, that's what will
 4 have happened, because if no action is taken, here's
 5 what things might look like. Whereas more useful
 6 modelling is to try and say: well, okay, what if we did
 7 this type of intervention or that type of intervention,
 8 can we do some sort of scenarios or estimates as to what
 9 difference that might make?

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

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

25 **Q.** They're at line 21, the social interventions applied --
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1 being really important, because any one model by itself
 2 could be misleading or could be less accurate, if you
 3 like, by bringing a number of models together and
 4 creating a consensus you get a quality assurance of
 5 what's being done.

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

9 **A.** Absolutely, yes.

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

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

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

19 **A.** It's uncertain.

20 **Q.** It becomes more and more uncertain?

21 **A.** It becomes more and more uncertain, particularly it
 22 depends on what assumptions you might want to make about
 23 whether you intervene to change the existing situation.
 24 Obviously if you assume that what's happening today will
 25 continue to happen and I am making no interventions,
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1 **A.** Oh, that's right, sorry, apologies, there you are. So
 2 yeah, that's an initial attempt to --

3 **Q.** Just as a sort of worked example, as it were, am I right
 4 in reading this that the way this -- that no
 5 interventions, when we look at reasonable worst-case
 6 scenario, the -- it's anticipated that there will be
 7 a peak of infections in Scotland per week of just over
 8 1.1 million?

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

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

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

25 **A.** Yeah.
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- 1 Q. -- and then in that position the modelling was still
2 saying -- was saying effectively the same thing is going
3 to happen it's just going to be --
- 4 A. Shifted.
- 5 Q. -- 15 weeks later, 14 weeks later in the piece?
- 6 A. That's correct, because what you would do is dampen down
7 but then you would shift.
- 8 Q. You'd see the ping back or the bounce back that we hear
9 about.
- 10 A. Yes.
- 11 Q. This document was then, I think, presented effectively
12 to Scottish Government by way of a sort of slide pack,
13 I think by your colleague Mr Halliday.
- 14 A. Yes.
- 15 Q. If we can just go to that very briefly, INQ000292555.
16 I think this is an attempt to make the information
17 slightly more accessible to those who ...
- 18 (Pause)
- 19 A. Yes.
- 20 Q. So we can see at this stage, so very early on, but there
21 have been some updates from a previous -- this is
22 I think version 1.8, but it's still early doors.
- 23 A. It's very early days, yes.
- 24 Q. On page 4, we look at the key assumptions that have been
25 applied in that modelling.

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- 1 doing modelling, whereas for example number 10 there
2 would have been quite specific to us. And number 7, we
3 haven't adjusted for Scottish geography, so they would
4 have been quite specific to us.
- 5 Q. If we move to a slightly separate section of your
6 evidence, please, in terms of the route out, the route
7 map.
- 8 A. Yes.
- 9 Q. So we know that the Scottish Government published their
10 route map, their framework for decision-making, in
11 April 2020, and is it right that your team were then
12 asked to provide data and evidence in respect of the
13 issues that they were looking -- the metrics?
- 14 A. Yes.
- 15 Q. Do we see the first -- if we bring up INQ000131026, this
16 further -- you look puzzled.
- 17 A. I tell you why I look puzzled. It is true that we were
18 asked to produce information and, if you like,
19 a measurement framework in and around the four harms,
20 but it's not this document. There is another document
21 that was published around about the same time that did
22 that.
- 23 Q. Can I -- I'll take you through some of the evidence in
24 this --
- 25 A. Apologies.

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- 1 A. Yes.
- 2 Q. Who decides on how -- these assumptions and how they're
3 applied?
- 4 A. So the assumptions that we were using at that point were
5 assumptions that would have come through SPI-M or SAGE.
6 We weren't certainly creating our own assumptions.
- 7 Q. And it may be in those circumstances you can't assist
8 with this question, but it says there at the bottom:
9 "Assumes care home residents are not moved."
- 10 A. Yes. I think the position, and I'm fully appreciating
11 the issue around care home residents, I think in this
12 situation it was rather the other way round: are
13 care home residents going to be moved into hospital,
14 rather than are people being moved from hospital into
15 care homes.
- 16 Q. And then if we just turn to the next page, page 5, we
17 see the caveats that are being highlighted as not being
18 factored into things. Were these -- again, are these
19 from SPI-M-O or SPI-M, or are they ...?
- 20 A. So --
- 21 Q. Are they you and your team saying, "Well, hang on, these
22 are things that we might need to factor in"?
- 23 A. It was -- this would have been a little bit of both,
24 because some of these were things that, you know,
25 wouldn't have been factored in by any modelling group

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- 1 Q. It deals with metric, I apologise if that's not the
2 direct document, but I think it deals with metrics that
3 we can look at.
- 4 A. Certainly.
- 5 Q. So if we look at page 9 of this document, we see -- so
6 this is evidence that is being provided in terms of
7 health impacts and --
- 8 A. That's correct, yes.
- 9 Q. So spread of the virus, our lockdown rules are working,
10 we get various statistics and then if we look at just at
11 the bottom of that page, if we scroll down, the charts
12 show a range of key measures in the pandemic in
13 Scotland, new cases, hospitalisations, numbers. Are
14 those the sorts of data that you were providing from the
15 MAH, even though it might be in a different document and
16 a different approach?
- 17 A. So key measures of the pandemic came from different
18 places. I think you've already heard from Mr Heald from
19 PHS, who were actually responsible for a lot of the
20 daily data in terms of cases and hospitalisations, ICU
21 and so on. So actual data was being fed through PHS to
22 ourselves.
- 23 Q. And then in an analysis of, in support of or in
24 measuring --
- 25 A. Yes.

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

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

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1 Q. -- applications.
 2 It says, the second half of that:
 3 "This is an average for all of Scotland. The
 4 R number for community transmission in Scotland is
 5 estimated to be below R number in care homes and
 6 hospitals. This is a matter of critical concern."
 7 A. Yes.
 8 Q. So in other words, general community perhaps closer to
 9 0.7, for example, but because it's an average --
 10 A. Yes.
 11 Q. -- knowing that there were higher -- there was higher
 12 R number --
 13 A. Yes.
 14 Q. -- in care and hospital settings was dragging the
 15 R number up in the average R number up --
 16 A. Yes.
 17 Q. -- is that right?
 18 A. I'd have to think about the actual proportions to say
 19 what exact difference it might make. But, I mean,
 20 obviously what you're seeing here is you've got
 21 an R number but then you're seeing actual data in terms
 22 of what's happening in hospitals and happening in
 23 care homes, that's not aligning with the community
 24 R number, so you can see that the R number may be
 25 higher.

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

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

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

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

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

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1 and perspectives.

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

4 **A.** Yes.

5 **Q.** -- studies in terms of --

6 **A.** Yes.

7 **Q.** -- contacting people?

8 **A.** Yes.

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

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

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

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

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

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

14 **A.** Yes.

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

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

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

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

5 **A.** Indeed.

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

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

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

18 **A.** Yes.

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

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

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1 projects or reports, but certainly wouldn't have been
 2 available or updated on anything like a weekly basis.
 3 **Q.** In terms of the polling and the studies that were being
 4 undertaken, are you aware of to what extent were
 5 Scottish specific polls and studies carried out in
 6 respect of minority groups, in respect of the particular
 7 effect that -- for instance, that we've heard about this
 8 morning -- NPIs having on ability of people in the
 9 disabled communities to access care or food or ...?
 10 **A.** So, I mean, through our own polling we could only split
 11 down so far in terms of different groups within the
 12 population because the poll simply wasn't large enough
 13 to get every group that one would -- underrepresented
 14 group that one would like, which was why then in --
 15 individual research projects were launched which
 16 involved focus groups, interviews, different types of
 17 interactions with people from different groupings, and
 18 that would have included ethnic minority groups.
 19 We also drew on the work of representative bodies
 20 themselves, so where representative bodies themselves
 21 had undertaken their own research and, you know, polling
 22 or surveying or whatever, we always invited them to,
 23 you know, share that with us and that became part of our
 24 evidence base.
 25 **Q.** Very, very briefly, a whistle stop tour of the four
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1 you simply being required to provide evidence in each,
 2 under each heading of each harm, as it were?
 3 **A.** So, I'll try and explain my role here. My division were
 4 obviously responsible for a lot of the information that
 5 fed harm 1 through our modelling work and through our
 6 scientific review work that we undertook, and we
 7 provided a lot of input into that, along with our
 8 scientific and clinical and medical colleagues. That
 9 was harm 1.
 10 Harm 2, the main work was undertaken by my
 11 colleagues in health analysis, they undertook that work.
 12 Harm 3 was myself, our Chief Social Policy Adviser,
 13 who was ultimately responsible, and our colleagues in
 14 areas such as justice, education and so on. Including
 15 some of our own work, though, because you'll notice
 16 topics here like loneliness, anxiety, trust in
 17 government, social capital. These were all subject
 18 to -- these were all part of our polling and our own
 19 research, so that was a mixture. As you can imagine,
 20 because harm 3 was that very broad, so it took a lot of
 21 inputs.
 22 Then harm 4, which was the economic analysis, was
 23 carried out by my economics colleagues and led by our
 24 Chief Economic Adviser.
 25 **Q.** In terms of your role in MAH, you weren't being asked --
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1 harms strategy --
 2 **A.** Okay.
 3 **Q.** -- which I'm going to apologise in advance for.
 4 INQ000131028.
 5 **A.** Ah, yes.
 6 **Q.** This is hopefully more familiar in terms of that's what
 7 you were expecting to be drawn up. This is the 11th --
 8 it's dated 11 December, I think, setting out the detail
 9 of the four harms.
 10 I appreciate lots of evidence will be heard about
 11 the four harms and the way it was put, how it was dealt
 12 with across government, but just very briefly in terms
 13 of your role --
 14 **A.** Yes.
 15 **Q.** -- you -- is it true that -- is it true to say that
 16 your -- the harm that you probably had in your
 17 researcher -- wearing your researcher hat, that was
 18 harm 3 in particular, as we've just said?
 19 **A.** Yes.
 20 **Q.** If we just look at page 22 of this document, that sets
 21 out sort of broad analysis, broad description of those
 22 harms.
 23 **A.** Yes.
 24 **Q.** Wearing your respective hats, to what extent were you
 25 involved in trying to balance different harms, or were
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1 or were you -- to try and undertake that balancing
 2 between the various harms as opposed to "Please provide
 3 the evidence of harm 3, harm 4"?
 4 **A.** Well, not as an individual but I was a -- one of the
 5 core attendees at the four harms meeting. So that
 6 extent, you know, I would have a perspective and I would
 7 give my views. But I was also responsible on a regular
 8 basis, if you like, for co-ordinating and bringing
 9 together all the material that was produced on all the
 10 harms and writing it up in a way that was then presented
 11 to ministers.
 12 **Q.** So providing advice in respect of that balancing
 13 exercise and --
 14 **A.** Yes.
 15 **Q.** -- where there were more red lines, as we were looking
 16 at earlier?
 17 **A.** One of many colleagues who were involved. This was
 18 a very collaborative effort.
 19 **MS ARLIDGE:** My Lady, may I just bend down to check?
 20 (Pause)
 21 I have nothing further for you. Was there anything
 22 you would like to add, Dr MacDougall?
 23 **THE WITNESS:** I -- two things I just want to say, really.
 24 First of all, I really do want to get across the
 25 idea, if we can, that this was an incredibly
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1 collaborative effort, and although by the very nature of
 2 the Inquiry you're interviewing lots of other
 3 individuals, all our activity was terribly
 4 collaborative. So you obviously just get partial views
 5 from everybody you speak to.
 6 But the other thing that I would like to do is to
 7 pay tribute to the analytical staff within the
 8 government who were responsible for the production of
 9 some really sophisticated and new and, you know, really
 10 high quality analysis and the amount of work and effort
 11 and the hours that people put in was phenomenal. So
 12 I would really like to pay tribute to my colleagues.
 13 **MS ARLIDGE:** My Lady, do you have any questions?
 14 **LADY HALLETT:** No, I have no questions, thank you very much.
 15 Thank you very much for your help, Dr MacDougall.
 16 **THE WITNESS:** Thank you.
 17 **LADY HALLETT:** Very helpful.
 18 **(The witness withdrew)**
 19 **LADY HALLETT:** Right, 10 o'clock?
 20 **MS ARLIDGE:** My Lady, just before you rise --
 21 **LADY HALLETT:** Oh, yes, you wanted to ask about publication.
 22 **MS ARLIDGE:** -- I'm going to need to ask about some -- make
 23 an application for publication in terms of all of the
 24 witnesses' statements that have been heard.
 25 **LADY HALLETT:** Certainly, all the documents that you wish to
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1 have published from today shall be published.
 2 **MS ARLIDGE:** I'm very grateful. Thank you very much,
 3 my Lady.
 4 **LADY HALLETT:** Thank you. 10 o'clock tomorrow, please.
 5 **MS ARLIDGE:** Thank you.
 6 **(4.30 pm)**
 7 **(The hearing adjourned until 10 am**
 8 **on Thursday, 18 January 2024)**
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