Witness Name: Catherine Calderwood
Statement No.: 1
Exhibits: CC
Dated: 26 April 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF CATHERINE CALDERWOOD

In relation to the issues raised by the Rule 9 request dated 10/02/2023 in connection with Module 1, I, CATHERINE CALDERWOOD, will say as follows: -

Personal Details

1. I was Chief Medical Officer for Scotland from April 2015 until 5th April 2020. This role is the most senior medical advisor to the Scottish Government and NHS Scotland and the Responsible Officer for Scotland's 15,000 doctors. In Scotland, the Chief Medical Officer reports to the Director General for Health and Social Care in the Scottish Government. As this role also functions as the Chief Executive of NHS Scotland, the responsibilities of the Chief Medical Officer are to both the Scottish Government and NHS Scotland. As the Responsible Officer, I would also require to liaise with the General Medical Council.

2. This witness statement relates to the matters addressed by the Inquiry's module 1, which is considering pre-pandemic planning.

3. I have prepared this statement myself by reference to records and material provided to me by the Scottish Government. I have also received assistance from the Scottish Government Covid Inquiry Information Governance Division and the Medical and Dental Defence Union of Scotland (MDDUS).

Systems, processes & structures for pandemic preparedness

4. There were detailed systems, processes and structures for pandemic preparedness in Scotland in place when I became CMO. The Scottish Government was part of a UK-led pandemic flu plan called the UK Influenza Preparedness Strategy 2011, provided [CC/0001 - INQ000102974], which had been developed following the swine flu pandemic. Following an updated 2011 strategy, Health Boards in Scotland submitted updated pandemic plans to the Scottish Government in 2012/2013.

5. In 2015 Exercise Silver Swan, report provided [CC/0002 - INQ000103012] was carried out across Scotland and lessons learned were applied to a range of stakeholders across Government, health bodies, local authority and resilience partnerships. A Scottish Government Pandemic Preparedness Board was established in 2017. Further tabletop exercises were performed - Exercise Cygnus in 2016, report provided [CC/0003 - INQ000103011] was a UK Government exercise. I delegated Dr Gregor Smith then Deputy CMO, to attend.

6. A range of improvements and changes were made to local and national influenza pandemic preparedness arrangements following these exercises. However, some of these recommendations were still outstanding at the time of the Covid-19 outbreak and work on implementing these was paused due to the need for staff to move to roles in the pandemic response.

7. Exercise Iris, report provided [CC/0004 - INQ000103013] took place in 2019 to assess Scotland's response to a suspected outbreak of Middle Eastern Respiratory Syndrome (MERS-CoV). The group reported and actions were implemented through a subgroup of the Scottish Health Protection Network set up to specifically look at preparedness for managing High Consequence Infectious Diseases. A number of recommendations were completed although nine remained outstanding at the point of the Covid-19 pandemic.

8. These regular pandemic preparedness exercises are key policies in this context and formed the roadmap for dealing with a pandemic. These policies were part of a four-nation approach to the threat of a pandemic to ensure that expert knowledge and experience was shared across the four nations and that key lines of communication were opened up. It was also important to understand how individual nations would deal with a pandemic as the structures and healthcare systems are different and key personnel would have differing roles and responsibilities.

9. At the time of the outbreak of Covid-19 there were several structures in place for the delivery of Public Health in Scotland including Ministers with portfolio responsibility for aspects of Public Health and a number of health divisions in the Scottish Government with Public Health responsibilities which worked closely with the CMO Directorate.

10. Within NHS Scotland, the Directors of Public Health provided public health advice to their NHS Health Boards, and to Local Authorities and provided an independent annual report as well as managing staff and communicating with the public and contributing to emergency planning. I worked closely with the Directors of Public Health, meeting with them regularly both collectively and with individuals as the need arose.

11. Scotland also had four statutory bodies with Public Health responsibilities, prior to 1st April 2020 when Public Health Scotland came into being. Health Protection Scotland within National Services Scotland, Health Scotland, NHS Education for Scotland and Healthcare Improvement Scotland. In addition, Scotland was part of a five-nation (including Ireland) Public Health group which met regularly and fed back to the Directors of Public Health and myself at our meetings.

12. The CMO Directorate had responsibility for the Chief Scientist and the Chief Scientist's Office. The Research and Development budget for NHS Scotland was managed from this office (with a budget of £69m approximately during my time as CMO). This gave ready and rapid access to key experts, universities, and research collaborations both in Scotland and further afield. I developed a close

relationship with my Chief Scientists and with the wider research network in Scotland including very positive relationships with each of our five medical schools in Scotland and met with key senior individuals regularly. This enabled rapid advice and the mobilisation of key individuals once new scientific advisory groups were required to advise Government in Scotland in the early weeks of the pandemic. I asked the former Chief Scientist Professor Andrew Morris to set up and Chair the Scottish Covid-19 Scientific Advisory Committee which met and started work within days of being commissioned.

13. As Scotland is a small country, there were very good relationships between these various organisations and individuals with responsibility for aspects of Public Health. Whilst not a policy as such, these relationships were very valuable as the emergency unfolded. In the rapidly changing situation at the beginning of the pandemic, the clear lines of responsibility for various aspects of Public Health and open channels of communication which were formed almost immediately, allowed the response to be mobilised quickly and effectively.

14. There was specific budget within the overall healthcare budget to fund pandemic and emergency preparedness within NHS Scotland and specifically public health. However, a small proportion of the overall healthcare budget is used to fund public health. There has long been criticism from those working in public health, in prevention services and in resilience groups to name a few, towards Government and funding bodies. Their view is that public health has not received the funding required for optimal functioning and outcomes and in particular investment in the prevention of ill health as well as planning for eventualities such as a pandemic. This is not unique to Scotland.

15. Could the preparedness have been improved across the system? Of course with hindsight and detailed knowledge of the extent and behaviour of this virus there would have been different priorities in pre-pandemic preparedness. Those lessons will now be learned and applied. At the time there were key activities and outputs in relation to pandemic planning, preparedness and resilience based on past experience and drawing on expert and scientific advice given at the time. These were carried out under expert guidance and followed established

methods. The exercises led to recommendations which were acted on and operational preparedness as described. Of course, had the timing, nature and extent of this pandemic been fully understood, the full implementation of all the recommendations, and in particular those following Exercise Iris, would have been expedited but this was not the case.

16. The four-nation and Scotland specific Pandemic Preparedness Board already existed and had issued guidance and advice pre March 2020. For example, draft guidance was already being drawn up during 2019 [CC/0005 - INQ000148759] which was immediately further worked on once legislation was required early in the pandemic and this formed part of the Coronavirus Act 2020. Significant stockpiles of PPE, antiviral medication, antibiotics and influenza vaccine were held in a 'reasonable worst case scenario' planning mode.

17. However, there was no experience or prior knowledge of a virus acting as Covid-19 did in our context in the UK. We were dealing with very many 'unknowns' and very little information was available at the points when we were required to make very difficult decisions. These decisions were made using the learning from the exercises undertaken in planning for such an event and the very limited, emerging scientific evidence available at the time shared between the four nations.

18. Some issues with the tabletop exercises became apparent during the very early part of the pandemic. In particular within clinical situations both in the community in GP practices and in acute hospital settings, the volume of cases and the rapid spread meant that the systems and processes rehearsed in the tabletop exercises (for e.g. mask fitting) became overwhelmed very quickly as did the supplies of PPE stored locally.

19. An increase in workload was of course expected in a pandemic but it was not anticipated to the extent experienced. Staff illness, the impact of gaps in key services including supply services, the need to mobilise staff from other areas into the Covid-19 response and the uncertainty around correct guidance which was required to change on an almost daily basis, also required very rapid action.

It is arguable whether any tabletop exercise could ever mimic the reality of this pandemic or whether it could cover the whole of the complexity of the NHS, supply chain, logistics and wider system issues which were faced.

20. The context was also very challenging. The additional measures required were being introduced into a healthcare system which was already working at or near capacity with very little 'slack' in the system. There were very small numbers of additional staff available immediately to add resource for the additional measures which were required, to try to prevent spread for example, or to cover staff shortages due to illness. Added to this was that all staff in all areas - Government, health and social care and wider public services - were all experiencing, learning and having to carry out new processes and tasks for the first time. They were all also dealing with their own families, home situations, illness and fear.

21. With the benefit of hindsight, the learning from Exercise Iris which planned for an outbreak of MERS could have been much more valuable had this been done in conjunction with timely advice from countries which had experienced the outbreaks.

22. During March 2020, I set up a meeting through a personal contact with the CMO in Singapore and our officials to discuss their response to Covid-19 to date. That meeting was extremely valuable. Due to past experience with outbreaks of SARS and MERS, a Taskforce along with various containment measures had been developed by the Singapore Government and these had been re-mobilised very early in their Covid-19 response. For myself and Scottish Government senior colleagues, this was a key learning moment and one which I would have valued several months previously. Real-time connection in a formalised manner with countries with other, different experiences and ways of working would have been a very helpful addition to our very early Covid-19 response.

23. Scottish Government and Public Health bodies now need to look carefully at the proportionality and suitability of the planning response for the future. What worked well and what was less good when faced with the reality of a rapidly

spreading unknown virus within health and social care and throughout society. I hope that this UK Inquiry will go a long way to answer these questions and inform and improve planning for the future.

24. Existing scientific committees and advisory groups should be revised and strengthened and data gathering abilities increased and prioritised and communication channels further strengthened and formalised with clear reporting lines. This should include learning from other countries worldwide where differing policies were applied during Covid-19. The context of different healthcare systems, many of which are not publicly funded, the underlying health of other nations and key demographic differences will make comparisons very challenging but opportunities for learning should not be lost. I understand that a Standing Committee on Pandemic Preparedness was established in Scotland in August 2021, and I would expect that this Committee would deliver the functions I have set out above and more.

25. The decisions being made in the early days of the Pandemic were extremely complex and difficult and we had no timescale for a return to normality from our scientific advisers. There was no 'escape route' or way out. For example, a decision was made early on to stop elective surgery and non-urgent, outpatient procedures and appointments. The short and long-term harm of stopping healthcare procedures, versus the practical issues and potential harm by continuing with staff shortages due to illness, risks of infection and people not wanting to attend appointments, was not examined nor was a plan for reinstatement able to be made. These decisions were made under an extremely short timescale therefore it was not possible to be precise as to the harm to health which would occur by stopping some aspects of healthcare for an unknown time period, nor was there any past experience to allow this to be estimated. We were balancing the need to maintain health and social care services and the reduced ability to keep all services running against the harm of increasing infection spread amongst staff and patients and subsequently to the rest of the population. These types of detailed scenarios need to be very carefully considered as part of planning for the next pandemic. Data to allow scientific analysis of the outcomes of these very complex decisions will now be available.

Audit Scotland Report

26. Finally I have been asked if I have any remarks to make on the Audit Scotland Report, *NHS in Scotland 2020* (produced February 2021) at pages 20-22 on "Pandemic Preparedness" [CC/0006 - INQ000148758].

27. Audit Scotland completes these reports regularly to hold NHS Scotland to account. By their nature, they are compiled and published some time after the events they describe and are written from reported data, documents and reports rather than real time 'on the ground' experience. This is not a criticism as this is a valid and important means of gathering and examining data and publishing audits. In my view they should be read with this context in mind.

List of Issues

28. I have considered the Module 1 List of Issues dated 6 April 2023 and shared with me on 13 April 2023. I confirm that I have included all relevant comments in relation to those issues, within the context of the questions asked of me as Chief Medical Officer from April 2015 until 5th April 2020 in the Rule 9 request issued to me on 10 February 2023.

Statement of Truth

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

Personal Data

Signed: _____

Dated: _____26 April 2023_____