

Monday, 22 January 2024

1  
2 (10.00 am)  
3 **LADY HALLETT:** Good morning.  
4 **MR DAWSON:** Good morning.  
5 **LADY HALLETT:** I'm grateful everyone's managed to get  
6 through. By the looks of our public gallery, not that  
7 many of our normal attendees are present, but I'm  
8 grateful for everybody else who has obviously made  
9 a huge effort to get through.  
10 **MR DAWSON:** There is one minor preliminary matter, my Lady,  
11 that I was just intending to deal with. This week  
12 your Ladyship will hear evidence from a number of  
13 medical and scientific witnesses. Your Ladyship will,  
14 however, not hear evidence from former Chief Medical  
15 Officer for Scotland, Dr Catherine Calderwood, who has  
16 been excused participation due to ill health.  
17 The first witness this morning is Caroline Lamb.  
18 The questioning will be done by my learned friend  
19 Ms Arlidge.  
20 **LADY HALLETT:** Thank you.  
21 **MS CAROLINE LAMB (affirmed)**  
22 **Questions from COUNSEL TO THE INQUIRY**  
23 **MS ARLIDGE:** My Lady.  
24 You are Caroline Lamb?  
25 **A.** I am.

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1 **Q.** INQ000346089 deals with care homes.  
2 **A.** Yep, correct.  
3 **Q.** And finally, INQ000372948.  
4 **A.** Yeah.  
5 **Q.** They're all familiar?  
6 **A.** They are.  
7 **Q.** They're all what you were expecting to come up on the  
8 screen?  
9 **A.** Absolutely.  
10 **Q.** Now, you gave evidence in Module 1, so --  
11 **A.** I did.  
12 **Q.** -- you'll remember we have a stenographer who is  
13 providing a live transcript and provides a transcript at  
14 the end of the day, so I'd just ask you to keep your  
15 voice up and remember that a nod doesn't reflect on the  
16 transcript so easily.  
17 You are currently Director-General Health and Social  
18 Care and the chief executive of NHS Scotland; is that  
19 right?  
20 **A.** That's correct.  
21 **Q.** And you started your role in Scottish Government as  
22 director of digital and service engagement at that  
23 directorate in December 2019?  
24 **A.** That's correct.  
25 **Q.** You then moved on to, in that role, expanded into

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1 **Q.** You've provided the Inquiry with a number of witness  
2 statements in various guises in respect of your role at  
3 the directorate of health and social care. I'm going to  
4 have to take you to them all very briefly at this moment  
5 in time.  
6 So if we first turn to your own personal statement,  
7 or your individual statement, that is INQ000315534.  
8 Hopefully that's familiar to you.  
9 **A.** It is, yes.  
10 **Q.** On page 12 is your signature and statement of truth.  
11 Are you happy that that statement remains true?  
12 **A.** Yes, happy with that.  
13 **Q.** There are also -- there's a statement INQ000215470, and  
14 this sets out details about the roles of various  
15 directorate subgroups within the directorate. Again,  
16 are you content that that remains true and honest to the  
17 best of your knowledge and belief?  
18 **A.** I am, yeah.  
19 **Q.** We then have an addendum statement dated  
20 10 November 2023, INQ000343900.  
21 **A.** Yep.  
22 **Q.** Again --  
23 **A.** Content.  
24 **Q.** And INQ000215488.  
25 **A.** Yes, correct.

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1 various things that were Covid-related specifically.  
2 We'll come to those in a moment. But in January 2021,  
3 you became Director-General and chief executive of  
4 NHS Scotland; is that right?  
5 **A.** That's correct.  
6 **Q.** So taking the first year of your role, from about --  
7 we'll be discussing various of these roles in more  
8 detail during the course of your evidence, but from  
9 about mid-March 2020 until early May 2020, were you the  
10 delivery director for intensive care capacity expansion?  
11 **A.** That's correct, yes.  
12 **Q.** Thereafter did you become involved in the contact  
13 tracing system development in Scotland?  
14 **A.** Yes, I did, I led the delivery of contact tracing.  
15 **Q.** And then after, from August 2020, you moved on to be  
16 delivery director for the vaccination programme; is that  
17 right?  
18 **A.** That's correct.  
19 **Q.** Then 2021, as we've just discovered, you became chief  
20 executive of NHS Scotland. Just for clarity's sake, is  
21 it right you're not a clinician or a doctor?  
22 **A.** That's correct.  
23 **Q.** You're a leader in bringing things together rather than  
24 providing clinical advice --  
25 **A.** Absolutely, yes.

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1 Q. -- is that fair?

2 Just in terms of the sort of provision of advice to  
3 Scottish Government and to ministers, the witness  
4 statement -- one of the corporate witness statements,  
5 INQ000215470, sets out how ministers -- how advice is  
6 provided to ministers in the following terms. It's  
7 paragraphs 39 to 40.

8 I won't take you through the whole thing, don't  
9 worry, I won't read it all out, but effectively policy  
10 papers are drawn up by -- within the directorate, passed  
11 to Chief Medical Officer, for example, their team, to  
12 look at it from clinical perspective, and bringing  
13 together no doubt a number of threads within a policy  
14 paper that is going up to ministers; is that right?

15 A. Yes, that's correct, yeah.

16 Q. In terms of the commissioning of that advice, is that  
17 something that the directorate itself says "Ministers  
18 need to know about this particular point, we're going to  
19 produce a policy paper", or is it ministers coming to  
20 the directorate and saying "We want to do this, can you  
21 give us a policy paper"?

22 A. It could be either. So it could be us, officials within  
23 the DG, putting advice up to ministers on something that  
24 they needed to be aware of. It could be ministers  
25 asking for additional advice relating to something that

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1 to provide sort of holistic and comprehensive advice to  
2 ministers. So there would be disagreements within those  
3 areas, particularly about the relative balance between  
4 responding to each one of those -- each one of those  
5 four harms. But the mechanisms for pulling together the  
6 advice were designed to try to enable us to provide the  
7 most comprehensive advice to ministers possible, and  
8 that would often include options for ministers to make  
9 decisions on.

10 Q. You've mentioned the four harms, so if we move to the  
11 four harms just briefly at this point. When you became  
12 Director-General, is it right that you at that point  
13 became a member of the four harms group, so you were  
14 attending those meetings?

15 A. That's correct, yes.

16 Q. And that group, the Inquiry's heard evidence, had been  
17 meeting since October 2020, so two or three months  
18 before you joined.

19 What sort of briefing were you given to explain what  
20 the purpose of that group was, as effectively a late  
21 joiner?

22 A. So I was already aware of the work of the four harms  
23 group because I was a member of the DG before I became  
24 Director-General. So I was aware that we would often  
25 discuss on our daily directors' calls what were the

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1 we'd already put up. Or it could be ministers asking us  
2 for advice in relation to, as you said, an intervention  
3 or a policy that they wished to pursue.

4 Q. When that policy paper is provided, it goes to Cabinet  
5 via the CMO; is that right?

6 A. So --

7 Q. In most cases?

8 A. During the Covid -- during the period of the Covid  
9 pandemic, there were many papers going to Cabinet, so it  
10 would depend on the content of that. But there would  
11 be -- the Chief Medical Officer, the CMO, certainly  
12 attended Cabinet meetings, and was there to provide  
13 advice on the papers that were going, not all of which  
14 would have been coming from the CMO, or indeed from  
15 officials within the DG Health and Social Care, they  
16 would come from across government.

17 Q. And were the policy papers on the whole or entirely  
18 consensus papers or were they range of options and  
19 balance -- and disputed ...

20 A. Again, they could be both, so you will have heard about  
21 the four harms group that was set up in order to try to  
22 look at the impact of policy interventions in the Covid  
23 pandemic from a range of different perspectives, and  
24 that group was very much set up to enable discussion  
25 amongst officials from different perspectives in order

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1 topics that were going to be discussed at the  
2 four harms, what was the evidence that we were pulling  
3 together, particularly around harms 1 and 2, which were  
4 the health-related harms that were a particular focus  
5 obviously for people in the DG Health and Social Care.  
6 So I don't think I really needed briefing about the  
7 purpose of the four harms, I was already well aware of  
8 it. And even before that four harms structure was  
9 formally established I think we were already trying to  
10 look across to other colleagues across Scottish  
11 Government in terms of recognising that, whilst  
12 obviously there was a very significant health impact of  
13 the Covid pandemic, that wasn't the only impact.

14 Q. As you just identified, harms 1 and 2 obviously of  
15 primary relevance and importance to your group, to your  
16 directorate. Professor Cairney last week gave evidence  
17 that his impression of the four harms group was it was  
18 about -- it was a statement of the problem, it wasn't  
19 a statement of the solution. So it was reminding those  
20 involved in decision-making of the balance, the  
21 trade-offs that existed, as you say, in terms of one  
22 intervention leading to harms in another area.

23 Was that something that you had a similar  
24 impression, as someone who was contributing yourself  
25 within that group?

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1 **A.** My impression was that the four harms group was bringing  
2 together not just officials and clinicians from within  
3 the DG Health and Social Care, and indeed colleagues  
4 from the wider system through the National Incident  
5 Management Team, but also colleagues with an interest in  
6 the social impacts and the economic impacts, and  
7 I suppose there was very much that recognition of trying  
8 to understand what the impact was across all those four  
9 areas.

10 I think potentially it was simpler in the --  
11 particular in the early days of the pandemic to  
12 understand the health-related harms than it was to  
13 understand the social and economic-related harms, and  
14 therefore, you know, maybe there was more of a focus on  
15 just trying to understand what those social and economic  
16 harms were.

17 But it was absolutely about trying to provide advice  
18 to ministers that set out the broad context and enabled  
19 them to make the choices with advice around what some of  
20 the other impacts would be as well as just the health  
21 impacts.

22 **Q.** And in your role, did you -- was it your role to  
23 advocate for the -- harms 1 and 2, or to take part in  
24 that balancing exercise yourself in terms of providing  
25 advice to the ministers?

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1 to actually -- for us as officials but also in  
2 presenting our advice to ministers, to be really clear  
3 about all the different aspects and all the different  
4 harms that were occurring. So I think that was really  
5 valuable. But yes, it's undoubtedly challenging,  
6 because there are judgement calls and balances to be  
7 made about -- and, as I say, I think probably  
8 particularly in the early stages the data and evidence  
9 that we had was more -- was more relevant to harms 1  
10 and 2 than it was to harms 3 and 4.

11 **Q.** And to what extent did you sort of liaise with  
12 colleagues in different departments with different harms  
13 to hand, for instance? So, for instance, harm 2, the  
14 broader health consequences.

15 **A.** Yep.

16 **Q.** You've got the direct broader health consequences of  
17 someone not being treated for cancer or the like at  
18 a particular moment in time. But that inevitably has  
19 an economic effect or a societal effect as well, doesn't  
20 it, because firstly, from an NHS Scotland point of view,  
21 those costs are being pushed down the line and it's more  
22 expensive to treat people who are sicker in the future?  
23 And those people who are sick may not be able to go to  
24 work so much, so there's an economic impact.

25 So how did you in your role and your team's role

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1 **A.** So I think my role and the role of colleagues within the  
2 DG was very much to present the evidence that we had,  
3 which changed at different stages of the pandemic, to be  
4 really clear about what was -- what -- the impact around  
5 harm 1, so, you know, be really clear about the numbers  
6 that we had in hospital and intensive care, the  
7 people -- the rate of Covid in the community, but also  
8 about the knock-on impact on harm 2.

9 Now, whilst we are, of course, extremely passionate  
10 about health and social care services and providing  
11 those services for the people of Scotland, I think our  
12 role was really to very much present that evidence and  
13 to be really clear about the impact in relation to  
14 harms 1 and 2 rather than particularly advocating for  
15 those harms as opposed to other harms that were  
16 undoubtedly occurring as well.

17 **Q.** Because some might say trying to delineate between  
18 different harms broadly is not quite as straightforward  
19 as: this number of people dying from Covid, this number  
20 of people have Covid, this number of people aren't able  
21 to access cancer treatment this week; because  
22 effectively they all link in with each other, don't  
23 they?

24 **A.** Absolutely. I think that was both one of the -- that  
25 was why the four harms was such a valuable forum to try

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1 seek to advance those sorts of interconnected elements  
2 within the four harms strategy?

3 **A.** So I think we were -- we probably started off in the  
4 early days being most concerned about harm 1 and about  
5 protecting, absolutely protecting people from Covid, and  
6 then as we sought to re-mobilise health services and to  
7 try to get back to a position where people were able to  
8 get screening appointments, for example, we were also,  
9 I think, hugely conscious of the backlogs that were  
10 building up and, as you've rightly pointed out, the fact  
11 that that ill health doesn't go away and it gets more  
12 difficult to treat.

13 And equally I think we were also conscious of the  
14 economic impact in terms of the number of people who  
15 were economically active in society, but also what that  
16 means for people as well. So we have -- I gave evidence  
17 in Module 1 about our focus on health inequalities and  
18 on the -- all the factors that contribute towards good  
19 overall health that actually have nothing to do with  
20 health and social care systems, it's all about whether  
21 people are able to get good employment, get good  
22 housing, whether they're able to live in a good  
23 environment. So I think to characterise us as being  
24 narrowly focused on harms 1 and 2 doesn't take into  
25 account the fact that we have been -- had a commitment

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1 for many years towards trying to improve health  
 2 inequalities, and critical to that is having, as I've  
 3 said, good jobs, good housing, good education. So  
 4 I think we're always mindful of those other factors as  
 5 well.

6 **Q.** Over the course of your time on the group, did you find  
 7 that there was a shift in focus, in terms of the group,  
 8 the ministers' approach to balancing the four harms?

9 **A.** I think that the shift in focus also related to the  
 10 progression of the pandemic and where the pandemic was  
 11 at any one point and, you know, again, as you'll be  
 12 aware, that went through peaks and troughs, so with --  
 13 through the first wave and then into new waves and new  
 14 variants. But I think there was absolutely  
 15 an understanding of the impact that the pandemic and the  
 16 measures that would be taken to control the pandemic  
 17 were having on other aspects of social life and economy  
 18 as well.

19 **Q.** We move on to another element of your role in the first  
 20 year of your time as a Directorate. From January 2020  
 21 to January 2021, Test & Protect steering group  
 22 membership.

23 **A.** Yep.

24 **Q.** I think you joined -- you were chairman of the Test &  
 25 Protect steering group from the outset; is that right?

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1 Chief Scientist for Health. We don't need to bring it  
 2 up on screen, but for reference and for the transcript,  
 3 that's INQ000273976.

4 Now, he was involved in something called SABoT(?),  
 5 and that was about testing strategies, making sure that  
 6 people were physically getting the testing samples and  
 7 the mechanisms as well as the operation -- so the  
 8 operationalisation of things as well as the strategy.

9 Did that interact with your steering group on Test &  
 10 Protect?

11 **A.** Yeah, so the group that David Crossman chaired was  
 12 a subgroup of the Covid-19 Advisory Group, and it was  
 13 very much looking at the scientific, the technical  
 14 evidence around different sorts of testing, and then  
 15 using that to help inform our strategy around where we  
 16 would prioritise our testing capacity, and then, yes,  
 17 you know, how that would actually be delivered. And to  
 18 bear in mind that that involved not just having the  
 19 capacity in labs to actually perform the tests, but  
 20 having the capacity to take samples from people, whether  
 21 it's in the community or in hospital setting or  
 22 whatever.

23 So, yeah, there was absolutely a feed-through.  
 24 I think the way that generally happened was from the  
 25 group that Professor Crossman chaired feeding through

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1 **A.** So my recollection is that I first got involved in Test  
 2 & Protect in probably mid-March, early April -- no,  
 3 sorry, let me correct myself there.

4 I think Scotland launched the Test & Protect  
 5 strategy on 5 May, and that's the point at which I was  
 6 appointed delivery director for the contact tracing  
 7 element of Test & Protect. Prior to that, I'd been,  
 8 first of all, involved in ramping up our digital  
 9 approach, and particularly the video conferencing near  
 10 me that enabled online consultations, and then, as you  
 11 said earlier, in the work around expanding ICU. But my  
 12 engagement in Test & Protect really started formally  
 13 from, I think it was actually 5 May.

14 **Q.** So is it the case that you were involved with the Test &  
 15 Protect for the app and the contact tracing we'll come  
 16 on to in a moment, rather than the setting up of the  
 17 strategy about testing itself in the early stages of the  
 18 pandemic?

19 **A.** Yeah, that's correct. My role was very much on the  
 20 delivery side, to make sure that our strategy could be  
 21 put into practice and delivered.

22 **Q.** There were various different testing groups or  
 23 committees set up to deal with testing and strategising  
 24 about ramping up testing capacity and the like. The  
 25 Inquiry has a statement from David Crossman, who was

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1 into policy advice to ministers that became our testing  
 2 strategies which then got operationalised through the  
 3 Test & Protect strategy. Initially focused around  
 4 testing but then extending into contact tracing as we  
 5 had the capacity, the testing capacity to be able to do  
 6 that.

7 **Q.** In your roles -- I appreciate you weren't on the SABoT,  
 8 for instance, and you were in the operationalisation of  
 9 the contact tracing, but to what extent were the numbers  
 10 of tests literally available core to the strategy in  
 11 terms of contact tracing, in terms of Test & Protect  
 12 going forwards? How did that change over the course of  
 13 the first three or four months, say?

14 **A.** So that was absolutely fundamental to being -- the  
 15 number of test -- having availability of tests and  
 16 having a reduced amount of community transmission was  
 17 really important to being able to build a sustainable  
 18 contact tracing system, so -- to -- to get into contact  
 19 tracing at scale, which is what we did from the  
 20 announcement of the strategy to -- it was launched  
 21 I think about 28 May, we launched the Test & Protect, so  
 22 the "protect" bit being the contact tracing and support  
 23 to isolate element. It was important that we were  
 24 confident that we had enough testing capacity then so  
 25 that people who were able to get tested and to confirm

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1 whether they were in fact Covid-positive so that we were  
 2 then able to kick off the mechanisms to trace their  
 3 contacts and provide them with appropriate advice.  
 4 **Q.** And at the start of the pandemic, to what extent did  
 5 Scotland have its own testing capacity or was it reliant  
 6 upon external, private labs?  
 7 **A.** So to a very, very -- very small extent. Clearly at the  
 8 very start of the pandemic then, first of all,  
 9 an appropriate test had to be developed. In the early,  
 10 very early days, we were reliant on sending tests down  
 11 to, I think it's Colindale. We then took measures to  
 12 develop, I think as soon as a test was available, took  
 13 measures to develop capacity. Originally we had  
 14 capacity in Edinburgh and Glasgow. I think it was about  
 15 350 tests a day. We extended that into Dundee and then  
 16 worked really hard to build our NHS Scotland capacity  
 17 alongside also engaging with UK Government around the  
 18 set-up of the Lighthouse labs.  
 19 **Q.** Because there is effectively a need to get ahead of the  
 20 game for two reasons. Or many reasons but let's look at  
 21 two here. One, because the whole world is about to want  
 22 to get into testing, so, in terms of capacity, you have  
 23 to be ahead of the game to ensure you have enough  
 24 materials and enough capacity in that regard, don't you?  
 25 And then, secondly, in order -- you have to get ahead of

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1 exactly what the context is of that statement from  
 2 Derek, but my -- my impression could be that that might  
 3 be about the way in which Scottish Government was able  
 4 to pivot to support the huge amount -- the huge volume  
 5 of extra work that was involved within the DG Health and  
 6 Social Care to produce the advice, to produce --  
 7 you know, to support delivery organisations to get all  
 8 of this set up, but I'm --  
 9 **Q.** Because something like this requires good funding, good  
 10 focus, a concerted effort from multiple different  
 11 departments and individuals, and lots of cogs in the  
 12 wheel to get things moving at the earliest  
 13 possibility -- possible time?  
 14 **A.** Yes, it absolutely does. I think that I -- you know,  
 15 I said in my opening statement at Module 1 just how  
 16 grateful I am to everybody who worked across Health and  
 17 Social Care, in the DG, and in health boards and  
 18 social care organisations, but, you know, people really  
 19 went the extra mile to pull together -- local authority  
 20 colleagues as well -- in terms of providing -- you know,  
 21 identifying locations for testing sites, identifying  
 22 locations that would help us to get people who maybe  
 23 would find it more difficult to travel to some of the  
 24 bigger sites. It was an enormous team effort, yes.  
 25 **Q.** And in terms of your role in Test & Protect, were you

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1 the game in order to physically have the number of tests  
 2 to make sure that you're putting the swabs where you  
 3 need to put the swabs and tracing outbreaks?  
 4 **A.** Yeah.  
 5 **Q.** Do you agree with both of those?  
 6 **A.** Yeah, so I'd agree with both of those statements.  
 7 I think that having the actual technology to be able to  
 8 do the testing was important, but also then having the  
 9 facilities, the people on the ground to actually be able  
 10 to carry out the sampling, yeah, absolutely,  
 11 particularly taking swabs, yes.  
 12 **Q.** The Inquiry heard evidence last week that there was some  
 13 concerns expressed by some of your colleagues --  
 14 Derek Grieve in the public health side of things -- that  
 15 there was insufficient urgency amongst some departments  
 16 and some members of Scottish Government about ramping up  
 17 the response to the threat posed by the pandemic.  
 18 Was the limited number of tests in February/March  
 19 a result of that, in your view, or at least contributed  
 20 to by that?  
 21 **A.** So I wouldn't -- I don't think so. I think that we  
 22 were -- certainly given that our focus originally was on  
 23 NHS Scotland and working with NHS Scotland to ramp up  
 24 tests, absolutely NHS Scotland was very, very acutely  
 25 concerned to get those tests ramped up. I'm not sure

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1 involved in discussions about prioritising those limited  
 2 tests at the beginning?  
 3 **A.** I wasn't directly involved in the discussions around  
 4 prioritisation so I -- you know, I was aware of the  
 5 approach that was being taken, which was very much  
 6 around prioritising, first of all, being able to treat  
 7 people and be able to know who had Covid-19, and then  
 8 move progressively towards protecting the vulnerable,  
 9 and then out into trying to break chains of  
 10 transmission. But I wasn't directly involved at that  
 11 point in those -- in the provision of that advice or the  
 12 co-ordination of that advice.  
 13 **Q.** Was that advice that came from SABoT or your  
 14 directorate?  
 15 **A.** So it was a -- SABoT was providing advice and that  
 16 advice was then corralled through the clinicians within  
 17 particularly the Chief Medical Officer, Chief Nursing  
 18 Officer and others within the DG.  
 19 **Q.** And in terms of that corraling of that advice, who was  
 20 making the decisions or advising about who to prioritise  
 21 for testing, for instance?  
 22 **A.** So the advice around prioritisation came from  
 23 clinicians, and was also, I suppose, you know, linked  
 24 with advice from officials around how many tests we had,  
 25 how quickly we expected to be able to ramp up that

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1 testing capacity, what was the likely demand for testing  
2 in each of those groups, so -- and then -- but -- and  
3 the decisions around the apps, the prioritisation was --  
4 that advice then went to ministers and ministers made  
5 the decisions around the prioritisation.

6 **Q.** In terms of sort of sections of society who could have  
7 been prioritised, or balancing all of those things into  
8 the mix, to what extent is it effectively determined by  
9 which clinician is shouting the loudest in those  
10 circumstances rather than a broader analysis? So, for  
11 instance -- it's in the title of your directorate,  
12 you've got health and social care.

13 **A.** Yeah.

14 **Q.** So to what extent is there someone in the room  
15 advocating for social care to have greater  
16 prioritisation in testing capacity usage?

17 **A.** So my recollection of the conversations at the time  
18 around testing and then, when I was more directly  
19 involved in the delivery of the vaccination programme,  
20 around, you know, how we approached our role out of the  
21 vaccination programme, was that absolutely our Chief  
22 Nurse particularly was a huge advocate for social care  
23 and for doing as much as we could to protect vulnerable.  
24 And actually some of the early decisions that were made  
25 around the prioritisation of our testing capacity as we

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1 you've got the hospital side of things and the  
2 social care side of things. You can understand how many  
3 patients are being discharged from hospitals into care  
4 in the community, and you can work out how many patients  
5 are coming into hospital with Covid from care homes or  
6 care -- or who were receiving care in the community.  
7 And all of that would be useful information, wouldn't  
8 it, to consider the risk profiles and to look at whether  
9 that particular cohort required prioritisation of  
10 testing?

11 **A.** So what I would say to that is I don't think that we had  
12 the -- we didn't have as good data as we would have  
13 liked to have, particularly in those early days. So  
14 whilst we have good data on who's in hospital, that  
15 doesn't necessarily extend to knowing where they've come  
16 from. And we were -- we did not have great data on  
17 exactly who was in care homes.

18 **Q.** Should you have --

19 **A.** We took measures to improve that really quickly, but we  
20 had to put that in place.

21 **LADY HALLETT:** But going back to Ms Arlidge's question, you  
22 would have had the data on people going from hospital to  
23 care homes, wouldn't you?

24 **A.** We would have data on people being discharged from  
25 hospitals, but not necessarily what setting they were

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1 started to ramp it up -- but we were nowhere near the  
2 numbers of daily tests that we had later in the  
3 pandemic -- some of the early decisions were around,  
4 first of all, around testing -- testing people before  
5 they -- who were being discharged from hospitals to  
6 care homes.

7 **Q.** The Inquiry heard last week about various studies,  
8 for example, that have been gone into, the effect or  
9 otherwise of testing before release into care homes.  
10 But if we take it back a few months in the piece, say,  
11 lots of -- there were lots of deaths in care homes from  
12 the very earliest stages of the pandemic, weren't there?

13 **A.** Yes.

14 **Q.** And the majority of deaths in the first wave were in  
15 care homes; is that right?

16 **A.** Yes, I believe that's correct, yep.

17 **Q.** So in terms of -- and of course even from the very  
18 beginning everyone was conscious that some demographics  
19 were more vulnerable to either very serious consequences  
20 or death as a result of Covid infection, and age was  
21 a significant factor in that.

22 So with the social care hat of the DHSC element,  
23 some might say that department is in the best position  
24 to understand the number of patients being discharged  
25 from hospitals into care homes, for example, because

22

1 being discharged to.

2 **MS ARLIDGE:** Would that not be considered of central  
3 importance in circumstances where patients were being  
4 discharged with -- because if there's Covid in people  
5 who are sick or exposing people to people who have been  
6 in hospital with Covid, is that not a key fundamental  
7 marker to understand where there is risk at its highest?

8 **A.** So I absolutely agree that we did not have as good  
9 a quality data around the social care, the whole of the  
10 adult social care sector, at the beginning of the  
11 beginning, as we would have liked, and I think that  
12 reflects the fact that whilst Scottish Government and  
13 Scottish ministers are responsible for NHS Scotland and  
14 for healthcare in Scotland, the statutory responsibility  
15 for adult social care sits with local government and it  
16 is a much more fragmented system than the way in which  
17 we provide healthcare services.

18 We worked extremely hard to try to improve the data  
19 that we had around care homes and around adult social  
20 care more broadly. In the first instance that we did  
21 that setting up the safety huddle tool which was  
22 designed not only to give better information at both  
23 a national and a local -- by "local" in this context  
24 I mean NHS board level -- but also to gather information  
25 around things like, for example, infection prevention

24

1 and control measures, staff absences within those homes,  
 2 because there are -- I think some of the research that's  
 3 been done since the start of the pandemic would  
 4 demonstrate that there are -- there were a number of  
 5 factors that influenced the extremely tragic death rate  
 6 in care homes, and one of those was around admissions  
 7 from hospitals, but actually there was a much stronger  
 8 correlation in the Public Health Scotland report around  
 9 the size of the care home, which probably linked to the,  
 10 you know -- and links as well, sorry, to the prevalence  
 11 of Covid in the local community.

12 **Q.** What consideration, therefore, was in -- particularly in  
 13 circumstances where you didn't have the data that you  
 14 would have liked, that -- care homes are effectively  
 15 a completely different kettle of fish than discharging  
 16 into ordinary -- you know, in a normal circumstance --  
 17 because in a care home there is inevitable need for  
 18 close contact with patients, lots of care home residents  
 19 simply wouldn't be in a position to function without  
 20 that sort of care, some of the residents wouldn't be  
 21 able to understand why social distancing or PPE was  
 22 required, and all that sort of thing. So having all of  
 23 the particular features of a care home, at what point  
 24 did your directorate sort of say "Well, hang on  
 25 a minute, this is a perfect storm potentially brewing"

25

1 That was then -- I think that guidance was then  
 2 updated again at the end of March, and again later on,  
 3 probably April or May, and the Cabinet Secretary made  
 4 her announcement about testing on discharge in  
 5 mid-April.

6 So there was a huge focus around what needed to be  
 7 done to try to support care homes, to keep their  
 8 residents safe, to support them around infection  
 9 prevention and control and really good procedures around  
 10 that and other things, and you'll also be aware that the  
 11 Cabinet Secretary asked directors of public health in  
 12 NHS boards to convene multidisciplinary groups to ensure  
 13 that support was provided to care homes.

14 **Q.** But by the time this guidance starts coming in, people  
 15 are already dying at a high rate in care homes, aren't  
 16 they?

17 **A.** So the first guidance was issued on 12 March, which was,  
 18 you know, I -- it wasn't -- it wasn't that there was no  
 19 guidance there before, there was guidance there in the  
 20 National Infection Prevention Manual, which had been in  
 21 place since 2012, the health and social care pandemic  
 22 flu plan was clear about the additional risks in  
 23 care home-like environments for elderly people and the  
 24 increased infection prevention and control measures that  
 25 need to be followed. But I think that wasn't there was

27

1 and what efforts were made to do something about it?

2 **A.** Yeah. So I think first of all we absolutely recognise  
 3 that the nature of a care home, as you've described,  
 4 with people requiring, you know, very close intimate  
 5 contact from staff, the sort of quite closed nature of  
 6 the community, did present a heightened risk.

7 We -- in I think it was middle of March, so around  
 8 12 March, Health Protection Scotland issued some  
 9 guidance on infection prevention and control  
 10 specifically aimed at care homes. We already had the  
 11 National Infection Prevention and Control Manual, which  
 12 dates back to 2012, and that contained relevant --  
 13 information that's relevant to care homes, but didn't  
 14 articulate, that didn't give example -- worked examples  
 15 for care home settings.

16 So Health Protection Scotland, HPS, issued guidance  
 17 on the 12th, that was followed up on 13 March, by our  
 18 Chief Medical Officer and Chief Nursing Officer  
 19 writing -- issuing further guidance, which was to  
 20 sort of extend into the more clinical zone, so not just  
 21 about infection prevention and control, but also things  
 22 around restrictions on visiting and isolation, and  
 23 isolation for people who were admitted either with  
 24 symptoms or even were already in the care home with  
 25 symptoms, and other factors.

26

1 guidance and, you know, worked examples that were  
 2 relevant to -- more relevant to care homes. And I think  
 3 as well that -- maybe that what we hadn't fully taken  
 4 account of was the number of care homes, the range of --  
 5 whether, you know, public sector, private sector,  
 6 voluntary sector, the number of employers and,  
 7 therefore, the additional challenges of making sure that  
 8 staff are actually aware of the guidance and trained in  
 9 it.

10 **Q.** Moving on to the Test & Protect hat that you wore, as it  
 11 were.

12 **A.** Yep.

13 **Q.** 7 May 2020, the Scottish Government announced that  
 14 they've managed to get to 3,500 tests a day and they're  
 15 trying to ramp it up to 8,000 tests by mid-May. How  
 16 many tests did you need at that sort of time in order to  
 17 make Test & Protect -- we'll go on to exactly what that  
 18 means -- a functioning system?

19 **A.** I'm sorry, I can't recall the actual modelling that was  
 20 done around that. What I do recall is that during May  
 21 and as -- no doubt as a consequence of the national  
 22 lockdown, the rates of Covid reduced quite  
 23 substantially. In fact when we first launched contact  
 24 tracing for Test & Protect on 28 May, case numbers were  
 25 very low.

28

1 Q. Perhaps a simple question.  
 2 A. Yeah.  
 3 Q. The Inquiry's heard evidence that the principle is test,  
 4 trace, isolate.  
 5 A. Yeah.  
 6 Q. Sometimes it's called "test and trace". Why was it  
 7 called Test & Protect in Scotland?  
 8 A. I'm not sure I can give you a direct answer to that. It  
 9 started off -- the policy was described as "test, trace,  
 10 isolate, support", so TTIS, and maybe Test & Protect was  
 11 just thought to be a bit snappier in terms of  
 12 communicating the public the intention, because the  
 13 intention was to test people both in order to protect  
 14 them and protect the rest of society. Now, behind that,  
 15 absolutely, there were four pillars, one was testing --  
 16 testing, contract tracing, isolated -- isolating and --  
 17 and providing people with support for isolation. So in  
 18 terms of the delivery of the programme we were working  
 19 across all those -- all those aspects, but I think Test  
 20 & Protect was just designed to be a name for the  
 21 programme that the public could relate to and that they  
 22 would engage with and -- and, you know, be part of.  
 23 **LADY HALLETT:** One could ask: why is it called Test and  
 24 Trace in England?  
 25 **MS ARLIDGE:** Test & Protect is announced on 6 May 2020,  
 29

1 contact tracing in Scotland was to build on the existing  
 2 local health protection teams in our NHS boards, so we  
 3 looked to scale up those teams, but to augment that with  
 4 a national contact tracing capacity that could be used  
 5 to support local systems where they were experiencing  
 6 peaks in infection, and also that increasingly became  
 7 an approach where the local health protection teams who  
 8 had the sort of more detailed knowledge locally would  
 9 deal with the highest risk cases from the highest risk  
 10 settings, and the national team would deal with the,  
 11 you know, more straightforward risks.  
 12 So in terms of training, public health, we worked  
 13 with Public Health Scotland to develop the core scripts  
 14 for contact tracing, we worked with NHS Education for  
 15 Scotland, who are our education board, to put in place  
 16 training packages. As you say, all of that stood up --  
 17 stood up really, really quickly. So we went through  
 18 a process -- we also stood up the actual contact tracing  
 19 system itself to enable all of that to be -- to be  
 20 logged. And it was important to us to have that as  
 21 a national system so that it would be public for the  
 22 national contact tracing facility to actually step in  
 23 and support -- support board, because everybody was  
 24 working off the same -- off the same system.  
 25 So the education and training packages were put in  
 31

1 contact tracing goes live two days later.  
 2 A. Yeah.  
 3 Q. Prior to that, presumably there's quite a lot of  
 4 employing contact tracers, because at this stage, to be  
 5 clear, this is not the app that --  
 6 A. Yeah.  
 7 Q. So this is someone tests positive and someone has to  
 8 give them a ring and say "Where have you been in the  
 9 past five days?" Is that the position?  
 10 A. Yes, yeah, that's absolutely correct. Contact tracing  
 11 was based on people phoning up. So they would speak  
 12 to -- somebody tested positive, they would get a phone  
 13 call, they would be asked to talk through their  
 14 contacts. So you're right, yeah.  
 15 Q. So inherently kind of reliant on (a) the memory of the  
 16 person who has tested positive, sometimes in  
 17 circumstances where they might be quite unwell with  
 18 their Covid infection; it relies upon the honesty of  
 19 that person; and it relies upon the ability of the  
 20 contact tracer to properly take someone through their  
 21 story. Is that fair?  
 22 A. Yes, I think that's fair, yeah.  
 23 Q. So what training did contact tracers, for instance, have  
 24 to undergo and how long did that take to set up?  
 25 A. Yeah, so we started -- the way in which we approached  
 30

1 place during the course of May. The -- when contact  
 2 tracing first launched, a lot of boards had -- because  
 3 we were still -- we were -- not all NHS services were  
 4 operating, so a lot of boards re-deployed existing  
 5 members of staff into their health protection teams to  
 6 provide that additional support. It was an online,  
 7 an internet-enabled service, so it didn't mean people  
 8 had to be sitting in a call centre, they could work  
 9 remotely, which was, again, incredibly helpful in terms  
 10 of getting that set up.  
 11 Q. Going back, taking that in stages, you say that was  
 12 basically happening in May?  
 13 A. Yeah.  
 14 Q. Lockdown comes 23 March. It's known that pandemics,  
 15 whichever kind of pandemic, testing, tracing, isolating  
 16 contacts is a key part to try and get on top of the  
 17 spread of a virus. Why was contact tracing only stepped  
 18 up in May and not on the agenda getting things moving  
 19 three months earlier?  
 20 A. So it absolutely was on the agenda. So it absolutely  
 21 was on the agenda, and we were talking about it from,  
 22 I think, April, early April, possibly earlier, but my --  
 23 I'm speaking here very much from my experience, so I was  
 24 brought into the process on about 5 May. At that point,  
 25 Public Health Scotland had already been working up the,  
 32

1 you know, what were all the different workstreams that  
 2 needed -- were needed, so, you know, the thinking on  
 3 that was already well advanced. I think it was  
 4 a combination of getting to the point where we would  
 5 have the testing capacity available. And also, again,  
 6 my understanding is that contact tracing, you know, WHO  
 7 would indicate that there is a level of transmission  
 8 within the community at which contact tracing is not  
 9 really viable and not the best use of resources. So we  
 10 had to get back to having a lower level of transmission  
 11 in the community, and then be ready to launch that --  
 12 launch the process, which we were.

13 **Q.** So it goes live on 28 May. About a month later, on  
 14 21 June, I think leaflets are sent out to the public  
 15 sort of explaining what it's all intended -- sort of why  
 16 it's happening and sort of giving more detail. Was it  
 17 being found that people were simply not understanding  
 18 the principle of Test & Protect?

19 **A.** I'm sorry, but I can't recall the reason why those  
 20 leaflets were sent, what I do recall is that from the  
 21 first few weeks of operation of the Test & Protect  
 22 system, there were, as I've said before, extremely low  
 23 case numbers. And, whilst that might be a really good  
 24 way to test a brand new system, actually in terms of  
 25 that wider public knowledge of that, maybe it probably

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1 digital forms to people for them to fill in with their  
 2 contact details.

3 **Q.** And the app launches on the 10th, within 24 hours  
 4 600,000 people have downloaded it, and within a week  
 5 I think it's -- about a week, there are 100 people that  
 6 are told to self-isolate. What studies were going on to  
 7 make sure that it was actually working?

8 **A.** I'm sorry, I'm not sure I can answer that. By the time  
 9 we got to that point, I was actually working on the  
 10 vaccination programme, so my recollection -- obviously  
 11 I was aware of the app being developed and my digital  
 12 directorate would have been very involved -- would have  
 13 been very involved in that, but I'd need to refer you  
 14 elsewhere for details around --

15 **Q.** You may, therefore, not be able to help with the next  
 16 question, but I'm going to ask it anyway --

17 **A.** Okay.

18 **Q.** -- and if you can't help us, say so.

19 11 November it's been announced that there has been  
 20 a coding error in the app and so the estimation is about  
 21 half of those testing positive, their contacts aren't  
 22 being traced properly, so there's a chunk of people who  
 23 have just gone missing under the app. Do you have any  
 24 insight into that? Can you recall that?

25 **A.** I can't -- I can't specifically recall that. What --

35

1 meant that there wasn't a huge amount of activity going  
 2 on for the first couple of weeks.

3 **Q.** Fast forward a bit longer to when it moves from contact  
 4 tracers and then moves into producing an app?

5 **A.** Yeah.

6 **Q.** So 10 September, I think, is when the Protect Scotland  
 7 app goes live. It's -- again, just so we're clear, this  
 8 is sort of the "ping" --

9 **A.** Yes.

10 **Q.** -- "pingdemic" and all of the things that were in the  
 11 press at the time, designed to work on phones to  
 12 physically locate you next to someone and so trace  
 13 contacts in that --

14 **A.** Yes, that's correct, yeah.

15 **Q.** Did the human contact tracing then come to an end at  
 16 that point?

17 **A.** No, it didn't. We very much regarded the app as being  
 18 an additional tool in the tool box around contact  
 19 tracing, and it was, you know, very much there to,  
 20 you know, support people to look after themselves as  
 21 well in terms of, you know, knowing that they'd been in  
 22 contact with somebody.

23 So, no, the human contact tracing continued and we  
 24 also continued to develop our digital approaches to  
 25 contact tracing, which included being able to send

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1 I guess what I would say is that the fact that we still  
 2 had the physical contact tracing capacity in place -- so  
 3 we were -- at no point were we relying just on the app.

4 **Q.** I think the next day, so 12 November, there was  
 5 an announcement that it was felt that something like 8%  
 6 or three and a half thousand people had not been traced  
 7 by contact tracers since the beginning of July. So that  
 8 combination of the app perhaps not working so well or  
 9 something going wrong in the coding and the contact  
 10 tracers not making contact with three and a half  
 11 thousand people does suggest, doesn't it, that there  
 12 were people falling through the gaps, and that  
 13 inevitably led to infections that -- because people  
 14 weren't isolating because they didn't know they had to?

15 **A.** So I absolutely accept that, and I do recall, you know,  
 16 our concerns about the -- when the contact tracing  
 17 centres were making multiple calls to people who were  
 18 contacts but had not been able to -- had not been able  
 19 to trace them, had not been able to speak to them. So  
 20 yeah, there were issues around -- and particularly as,  
 21 you know, life got a bit more back to normal and people  
 22 had more contacts.

23 **Q.** And as life got back to normal and sort of more people  
 24 moving around as well, we hear the phrase regularly, the  
 25 virus doesn't respect borders, but it's right, isn't it,

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1 that Protect Scotland was a different app to the app  
2 that was in England, and so if people were crossing the  
3 borders or contacting people from England or vice versa  
4 that app wouldn't necessarily pick up those contacts; is  
5 that right?

6 **A.** So it was a different app, we took a different approach  
7 to information governance around the development of the  
8 app. I think we worked pretty hard with the other UK  
9 nations to try to make sure that they were compatible,  
10 but, I'm sorry, I don't know the detail of the extent to  
11 which they were compatible or not.

12 **Q.** Again, because you had moved on to different roles, it  
13 may be that you're not able to help so much in terms of  
14 the Status app, so that was the -- I appreciate you were  
15 involved in vaccines at the time, so it may be that  
16 you've got some oversight of this. But in  
17 September 2021, so some time later, there's the  
18 COVID Status app is produced or set out, and that's  
19 effectively the vaccine passport; is that right?

20 **A.** Yeah, that's what it came to be called, yeah.

21 **Q.** Colloquially called the vaccine passport. And that was  
22 released at a time when infections were getting higher  
23 and higher in Scotland, September 2021, hit by the  
24 Omicron wave.

25 Was there a risk or did it occur that the vaccine

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1 around, you know, the CMO, the CNO and then the four  
2 CMOs -- in my understanding four CMOs worked together to  
3 develop the list, the definition list of those who were  
4 felt to be most vulnerable to the virus. We worked with  
5 Public Health Scotland, with colleagues in local  
6 authorities to try to come up with as complete a list as  
7 possible, and clinicians locally had the ability to add  
8 to that list. So if they felt that -- you know, if  
9 a general practitioner felt that they had somebody who  
10 wasn't on the list but should be, then they could add  
11 those on to the list.

12 So it was -- formed part of our discussion from  
13 a pretty early stage, both in relation to identifying  
14 and categorising that shielding list, but also then what  
15 were we going to put in place to support those people.

16 **Q.** And again, sort of expanding into the social care side  
17 of the DHSC title, you've got people who are clinically  
18 extremely vulnerable as a result of their pre-existing  
19 conditions or treatment that they're undergoing, but  
20 you've also got people who are vulnerable because of  
21 health conditions that wouldn't necessarily make them  
22 more vulnerable to the virus but are unable to access  
23 society in a result of things like lockdown and the  
24 like, and perhaps feel more vulnerable, whether or not  
25 they are in the clinically extremely vulnerable list.

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1 made everyone "Oh, look, I've got a vaccine, you know,  
2 this is my passport to freedom" in circumstances where  
3 society is opening up, but infections are climbing  
4 rapidly?

5 **A.** I think you'd probably need to ask a clinician for  
6 a view on the extent to which maybe that -- or  
7 a behavioural -- I think that it was the case that  
8 I think one of the reasons, one of the -- part of the  
9 thinking behind having the vaccine Status app was to,  
10 absolutely, to encourage people to take up vaccination  
11 because that was, you know, our single route towards  
12 protecting -- protecting people better.

13 **Q.** Can we now move to a completely different area.

14 **A.** Okay.

15 **Q.** Shielding and the involvement of your department in  
16 shielding broadly, not in a clinical sense at all, but  
17 in terms of the impact of shielding on decision-making  
18 by ministers in Scotland.

19 So a shielding programme is implemented in  
20 mid-March 2020. When was shielding first on the agenda,  
21 as it were, in the department?

22 **A.** I think there were discussions from quite early on as it  
23 became clear that the threat that we were facing from  
24 the pandemic about how we could protect the most  
25 vulnerable, so ... aware of conversations particularly

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1 So practicality in sort of shielding policy and  
2 ensuring access for people, the Inquiry heard last week  
3 that effectively a two-tier approach to shielding  
4 developed almost accidentally, because highest-risk list  
5 were given access to services with a priority for online  
6 delivery slots and prescription deliveries and that  
7 sort of thing, but people who were not at the highest  
8 risk under the clinically vulnerable analysis but still  
9 vulnerable as a result of, for instance, their  
10 disability, meant that they were in a second tier, they  
11 didn't have that priority access and they didn't have  
12 the -- they were reliant still on other people to assist  
13 them and give rise to greater risk for them.

14 So was there any thought put to the fact that people  
15 might be de-prioritised under the shielding, because of  
16 the overly -- not necessarily overfocused but the focus  
17 on shielding necessarily meant that services might be  
18 being removed or made harder to access to others?

19 **A.** So I suppose to respond to that in a couple of ways.  
20 Firstly, I don't think there was any -- ever any  
21 intention or to somehow sort of ration support that was  
22 available and to focus that at the clinically vulnerable  
23 group. Our local authorities worked through their local  
24 resilience partnerships and through -- using their --  
25 I can't remember precisely what they call them, but

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1 their lists of the most vulnerable people that they  
 2 would use in relation to other, you know, civil  
 3 emergencies, et cetera. They worked, I think, really  
 4 hard, as did many voluntary organisations and others.  
 5 So I think that, you know, the shielding list was very  
 6 much about those who were clinically vulnerable, but  
 7 there were other support mechanisms that, you know --  
 8 like I say, I know -- I don't know the direct details  
 9 but I know local authority colleagues worked really hard  
 10 to put in place around people who weren't clinically  
 11 vulnerable but would be vulnerable for other reasons.

12 **Q.** To what extent did things like the data issues that  
 13 we've already covered cause problems in making sure that  
 14 those vulnerable -- not the clinically extremely  
 15 vulnerable, the vulnerable people -- didn't fall -- or  
 16 did that lead to them falling through the gaps?

17 **A.** I don't think I could answer that one, because that will  
 18 depend on how good the data was that was held at  
 19 a local, local authority level and that may well differ  
 20 from one authority to the other.

21 **Q.** You spoke earlier about the recognition of inequalities  
 22 and -- inequalities in health, inequalities in  
 23 socioeconomic status and the like.

24 In one of the corporate statements, INQ000215470,  
 25 paragraph 46, you say that the advice was based -- CMO's

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1 there are also things that are just different. So,  
 2 for example, school terms are different in Scotland than  
 3 in England. So, you know, so there were some things  
 4 around decisions around schools that just needed to be  
 5 different because we have a different system.

6 **Q.** The Inquiry has been provided with various papers in  
 7 this regard, a presentation from -- again, it doesn't  
 8 need to come up, but just for the transcript -- Scottish  
 9 Government's Communities Analysis Division, which is the  
 10 "*Impact of Covid-19 on Equality Groups: Disability  
 11 analysis*", was undertaken in October 2020, and there was  
 12 a report from the Scottish Government titled  
 13 "*Coronavirus ... impact on equality (research)*",  
 14 September 2020. So there's research being undertaken  
 15 about the unequal impact of the virus and the underlying  
 16 inequalities.

17 What concrete measures were being put in place to  
 18 combat those inequalities in the second and third waves  
 19 of the pandemic when, looking back and -- because you  
 20 see these reports, so what are those reports being  
 21 operationalised into, in order to protect those who are  
 22 more vulnerable for the various inequality reasons?

23 **A.** I would say that, look, the key aspect of that was in  
 24 relation to the vaccination programme, with vaccinations  
 25 being the thing that we could most positively do to

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1 advice was based on what was considered best for  
 2 Scotland having regard to health status of Scottish  
 3 population and its characteristics, noted that it's  
 4 an older population than the average UK -- it's  
 5 all right, you don't need to go through it line by  
 6 line -- and multimorbidities, more multimorbidities. So  
 7 greater vulnerabilities, greater risks, different  
 8 socioeconomic risks, different ethnic group risks than  
 9 in the UK as a whole.

10 You say in that statement that:  
 11 "Where there was a divergence of approach to NPIs in  
 12 Scotland compared with other UK nations, this was driven  
 13 by differences in the Scottish population and other  
 14 factors. Advice was given solely on what was genuinely  
 15 considered to be appropriate for Scotland. Where it was  
 16 possible to achieve consistency with the other UK  
 17 nations, that was desirable, but it was not always  
 18 possible."

19 Why wasn't it always possible?

20 **A.** So, I think that, for two things. One, you referred to  
 21 the different characteristics of a Scottish population,  
 22 and I think as a result of those characteristics (older  
 23 population, more multimorbidities), we were inclined  
 24 probably to be more cautious, because of the nature of  
 25 that population. I think the second area is, you know,

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1 protect everybody, and we -- the vaccination programme  
 2 had its own separate workstream around equalities, and  
 3 that was all about trying to ensure that we didn't  
 4 just -- you know, it wasn't good enough just to hit the  
 5 standard level of take-up for vaccinations, we needed to  
 6 push it as hard as possible and we needed to try to  
 7 ensure that we removed as many barriers as possible in  
 8 relation to people from different communities, whether  
 9 they be ethnic minority communities, whether they be  
 10 Gypsy and traveller communities, whether they be some of  
 11 our more socially disadvantaged communities, in ensuring  
 12 that vaccination was easily available and that people  
 13 were supported to get vaccinations.

14 The testing, our approach to testing also developed  
 15 in relation to, you know, understanding some of those  
 16 inequality impacts, again with mobile testing units with  
 17 very local testing units and again trying to ensure that  
 18 as far as possible we were reaching every corner of  
 19 Scottish society.

20 **Q.** Because some communities might be less likely to come  
 21 forward for tests and some communities might be less  
 22 willing to come forward for vaccinations?

23 **A.** Yeah. That's absolutely right.

24 **Q.** Turning then to NHS capacity in Scotland. At the start  
 25 of 2020 you were involved in ICU capacity development,

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1 but I want to look at it in two stages, very briefly:  
 2 there's the ICU -- develop ICU capacity and then there's  
 3 broader NHS capacity issues, both of which I think fall  
 4 within your pile of things that you have to get through  
 5 on a daily basis.

6 It's an often repeated comment, both in this Inquiry  
 7 and in broader circumstances, that the lockdown was to  
 8 prevent -- to stop the NHS being overwhelmed, and there  
 9 was ICU -- that relates to both ICU capacity in terms of  
 10 just simply not having enough ventilators, et cetera, if  
 11 the virus became -- if everyone needed a ventilator --

12 **A.** Yeah.

13 **Q.** -- there simply weren't enough ventilators to go around.  
 14 Equally, not everyone needed a ventilator, but needed  
 15 a bed and varying levels of clinical assistance in  
 16 hospital settings.

17 In the first three months, so when you were looking  
 18 at ICU capacity, what was being done in the non-ICU  
 19 capacity expansion plans?

20 **A.** So in terms of the non-ICU capacity, I think two things.  
 21 First of all, recognising that we had -- we have the  
 22 physical infrastructure that we have, we were concerned  
 23 obviously about the number of beds but actually probably  
 24 more concerned about the people to staff those beds as  
 25 well, particularly when, you know, healthcare workers

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1 lot easier to predict and manage than others, because,  
 2 as you say, doctors and nurses and staff get sick  
 3 themselves. So when you talk about expanding ICU  
 4 capacity and indeed just general NHS capacity, how do  
 5 you bring in extra sort of human capacity as the  
 6 pandemic progresses?

7 **A.** Yeah. Yeah, so what we did in relation to that was  
 8 we -- essentially we issued a call to people who were,  
 9 you know, recent retired, people who maybe had been  
 10 working in the healthcare professions and weren't any  
 11 longer. The regulators, the GMC, the Nursing and  
 12 Midwifery Council supported all UK governments in terms  
 13 of being able to get people back onto the register. We  
 14 had -- one of our health boards supported us to set up  
 15 a portal which enabled people to register their interest  
 16 and desire to come back and support NHS Scotland. Not  
 17 just NHS Scotland but also social care as well. And  
 18 through those portals, NHS boards were able to -- and  
 19 social care organisations would be able to identify  
 20 people who were able and willing to come back into the  
 21 system of support. So we did track new staff in the  
 22 early stages of the pandemic. We also brought students.  
 23 So final year students, medical students and nursing and  
 24 AHP students, came into the wards to work as well.

25 **Q.** So you stepped up that capacity in the early stages

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1 are not immune from becoming ill with Covid as well. So  
 2 that is why we were focused on really trying to preserve  
 3 the capacity that we had in the NHS for the people who  
 4 would be -- who would most need it. So we knew that we  
 5 needed to obviously support people with Covid but on top  
 6 of that retain the capacity to deal with emergency  
 7 unscheduled care and also to keep cancer treatments,  
 8 for example, going. So as a result of that we stood  
 9 down a lot of our elective capacity, so the -- a lot of  
 10 the planned care didn't happen during that period, in  
 11 order to protect that capacity and to enable us to --  
 12 enable the NHS boards to deploy staff who would maybe  
 13 normally be involved in elective care to be able to  
 14 staff both ICU and to provide extra capacity in  
 15 emergency and unscheduled care as well. There was also  
 16 the Louisa Jordan development as well.

17 **Q.** We'll talk about Louisa Jordan in a moment.

18 Capacity is effectively multifactorial, isn't it?

19 **A.** Yeah.

20 **Q.** It's having physical beds, it's having ventilators, it's  
 21 having the staff, sufficiently trained stuff to man the  
 22 ventilators, to treat patients. It's having enough  
 23 people to, you know, repair the ventilators and to clean  
 24 them and to do all of the backroom efforts as well.

25 But presumably some of those factors are an awful

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1 by -- and by closing down wards, as you've already said,  
 2 and closing down electives.

3 **A.** Yeah.

4 **Q.** That occurs sort of fairly early on in matters, and when  
 5 everyone is in sort of crisis mode, I suppose is the way  
 6 of putting it. But the capacity issues continue for  
 7 some time, don't they, because -- if we have up, please,  
 8 INQ000274150.

9 Which is a slide that we looked at last week with  
 10 the statisticians. So I'm not going to take you through  
 11 the statistics in that way.

12 It's page 15, please.

13 What we see here is the number of patient -- or  
 14 per capita rates of Covid-19 patients in hospital. So  
 15 we see the peaks of the early pandemic, when capacity is  
 16 being increased. We'll ignore the change in methodology  
 17 for this purpose, we don't need to get into that.

18 October 2020, there's the second wave, as it were.  
 19 And then what I want to look at is effectively the third  
 20 wave, the October 2021 peaks that we see there. Because  
 21 I'll come on in a moment to what that looked like on the  
 22 ground, but we see, don't we, that in Scotland in that  
 23 period from sort of September 2021 onwards there is  
 24 a large part of the time when there are more patients  
 25 per capita in hospital in Scotland than there are in the

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1 UK with Covid. So there is all of a sudden higher rates  
2 of Covid in hospitals in Scotland -- not all of  
3 a sudden, but for quite a sustained period, at the back  
4 end, second half or back end of 2021.

5 If we therefore can have up, please -- and before we  
6 do, I appreciate of course that this is only to deal  
7 with Covid patients. There's a whole load of other  
8 patients that require treatment at the same time for  
9 different things. So this doesn't tell us how full the  
10 hospitals are, it tells us that there are more people in  
11 hospital with Covid than elsewhere in the country.

12 So if I take you, please, to INQ000360218, it's  
13 a series of -- I'll take them very briefly, I was just  
14 going to say. We've got problems in capacity in terms  
15 of ambulances not being able to -- so ambulance service  
16 is stretched to breaking point, we see that in that  
17 article, and they have problems with not being able  
18 to -- so the ambulance service themselves are  
19 struggling, but equally one of the problems that is  
20 attributed to that is they can't offload their patients  
21 in hospital because A&E wards are -- A&E is stretched  
22 past capacity.

23 Is that fair?

24 **A.** Yes, absolutely, the system was under -- that's about  
25 the time the Omicron wave hit Scotland and you see from

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1 systems were, had been trying to get back a bit more  
2 into business as usual, so hospitals were very full,  
3 hence the difficulty with offloading ambulances, yeah.

4 **Q.** And the Royal College of Emergency Medicine I think in  
5 September said "We need more beds, we need a thousand  
6 more beds in order to try to get us over this issue".  
7 Were those beds forthcoming?

8 **A.** The approach that we've taken to increasing capacity in  
9 NHS Scotland is to focus that capacity on where people  
10 need it. So with the -- I suppose, the mantra behind  
11 that being about we only want people to be in hospital  
12 if they absolutely need to be in hospital, so we have  
13 focused a lot on what we can do to support people not to  
14 turn up to the front door in the first place, either  
15 through being triaged in 111 or the ambulance service,  
16 who do an amazing job of actually seeing and treating  
17 people rather than conveying them to hospital. We've  
18 also worked on Hospital at Home, so in response to your  
19 question, Hospital at Home provides that level of  
20 service to people in their own homes rather than in  
21 hospital. And I can't recall exactly what capacity  
22 we're at on there, but it's something like the  
23 equivalent of three district general hospitals. So we  
24 have increased capacity, but we've not always done it in  
25 the acute hospital --

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1 the earlier graph that Scotland had a much more severe  
2 increase in that period than England. I think England  
3 then sort of caught up with us around Christmas time,  
4 but essentially we went into winter earlier than we have  
5 gone into winter previously, in terms of pressures.

6 **Q.** It meant various very drastic steps had to be taken in  
7 hospitals, so non-urgent operations were cancelled,  
8 I think, in a number of trusts, the public was asked  
9 only to ring 999 in circumstances of immediate  
10 life-threatening emergency, and subsequently the  
11 military were drafted in to assist with things like  
12 ambulance driving; is that right?

13 **A.** So if I just say, we had already -- through Covid, we  
14 had introduced a reform of urgent and unscheduled care,  
15 so we were already trying to ensure that people who  
16 maybe didn't need urgent care were effectively triaged  
17 through our NHS 24, our 111 service, and therefore kept  
18 away from the front door of our hospitals. We also had  
19 a significant extra investment going into the Scottish  
20 Ambulance Service, which -- as I say, unfortunately  
21 Omicron hit us a bit before we would normally expect to  
22 get into winter pressures. But yes, it was an extremely  
23 difficult period. It wasn't -- it wasn't consistent  
24 across the whole of Scotland, so I think Omicron tended  
25 to focus across the central belt of Scotland. But our

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1 **Q.** And the acute hospital settings were being overwhelmed  
2 for -- not blanket across Scotland --

3 **A.** That's correct.

4 **Q.** -- but there were a number of trusts who were on  
5 critical footings in October 2021 --

6 **A.** Yes, there were periods --

7 **Q.** -- and were not able to provide the service as a result  
8 of multifactorial issues, but Covid being part of that  
9 18 months into pandemic; that's right, isn't it?

10 **A.** So, absolutely, Covid is part of that. There is a new  
11 infectious pathogen in our system that we didn't have  
12 before. We were also coping with the impact of the  
13 first waves of Covid, and particularly seeing that  
14 people who were presenting particularly at A&E were  
15 sicker than they had been previously. So what impacts  
16 on hospital occupancy is also the length of time that  
17 people spend in hospital, and we have seen that  
18 occupancy rise, so people spending slightly longer in  
19 hospital. Which is partly a factor of that demographic  
20 of people being older, frailer, more multimorbidity, but  
21 no doubt Covid's had an impact as well.

22 **Q.** Were lessons simply not learned in the first two waves  
23 such that by the third wave, when you had those  
24 warnings, the capacity simply hadn't been increased  
25 sufficiently?

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1 A. So I think lessons were absolutely, absolutely were  
2 learned. Omicron I think did -- the severity of the  
3 Omicron wave and -- and the time it took, which -- it  
4 hit earlier than we were expecting it.

5 MS ARLIDGE: My Lady, is that a convenient moment?

6 LADY HALLETT: Yes, of course. 11.35, please.

7 MS ARLIDGE: Thank you very much, my Lady.

8 (11.21 am)

9 (A short break)

10 (11.35 am)

11 LADY HALLETT: Ms Arlidge.

12 MS ARLIDGE: Thank you, my Lady.

13 Just before the break we were talking about  
14 capacity. I just want to touch very briefly on the  
15 Louisa Jordan, if I may. 20 April 2020, Louisa Jordan  
16 was opened in Glasgow SEC. This was -- I think, had  
17 300 beds as an initial capacity, with the option of  
18 scaling it up.

19 In terms of the -- I appreciate you weren't in that  
20 particular post at the time -- but in terms of actual  
21 use of Louisa Jordan, what was it -- what was the  
22 hospital in fact used for?

23 A. So fortunately we never had to use it in relation to  
24 sort of, you know, overflow because other facilities  
25 were unable to cope. What we did use it for, NHS

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1 used as a vaccination centre but it was part of  
2 releasing the SEC to get back to business as usual,  
3 particularly in advance of hosting COP26.

4 Q. The issues of capacity we were talking about just before  
5 the break, was ever thought given to recommissioning it  
6 or doing something similar in order to assist with the  
7 overwhelming of the NHS in the later half of 2021?

8 A. I think -- just relate to my earlier question, I think  
9 in terms of the issues that we have around managing  
10 hospital capacity, the focus there needs to be on making  
11 sure that we've only got the people in hospital who need  
12 to be in hospital so ensuring that once people are ready  
13 to be discharged they are discharged, so we do still  
14 have challenges around delayed discharges. And building  
15 more out of hospital capacity as well, particularly  
16 through Hospital at Home.

17 Q. Another topic very, very briefly. Nosocomial  
18 infections.

19 A. Yeah.

20 Q. The Inquiry of course is, will be looking at healthcare  
21 in more detail in future modules, so this is very much  
22 a sort of narrow issue in terms of Scottish Government  
23 decision-making in this regard.

24 There was a review group established in May 2020,  
25 wasn't there, to look into nosocomial infections? Why

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1 Greater Glasgow and Clyde used it for outpatient clinics  
2 once we started to get back a bit more to business as  
3 usual, and then it was used intensively as a vaccination  
4 centre as well.

5 Q. How was it staffed, in light of what you said earlier  
6 about the ability to bring in staff and --

7 A. So when NHS Greater Glasgow and Clyde were using it for  
8 outpatients, that was NHS Greater Glasgow and Clyde  
9 staff who were deployed, and obviously it was a site  
10 that was away from areas where people with Covid were  
11 being treated.

12 Q. When it was being set up, how was it intended that --

13 A. Oh, how was it intended? My apologies --

14 Q. No, no, I was going to come --

15 A. Yeah, my apologies.

16 It was intended that we would use the -- use some of  
17 the staff that we were getting through the -- through  
18 the portal but that -- also that we would use staff from  
19 within our other boards, and again that might have been  
20 redeploying them away from what might have been their  
21 original duties, given that we weren't undertaking  
22 planned care at that point.

23 Q. Why was the decision taken to decommission Louisa Jordan  
24 in April 2021?

25 A. I think the main reason -- so at that point it was being

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1 was it formed then?

2 A. I think it was formed then -- so we already have in  
3 place processes, advisory groups around nosocomial  
4 infection. I think that particular group was put in  
5 place to bring some additional capacity into that, into  
6 that work.

7 Q. Because in, as the pandemic progressed, people were  
8 still getting Covid in hospital settings, despite the  
9 fact that infection control and the like were -- would  
10 be better there than anywhere else, or should be better  
11 there than anywhere else in the community; that's right,  
12 isn't it?

13 A. Yes, that's correct, and I think there's a role for  
14 everybody working in health and social care to stay  
15 vigilant around infection prevention and control. We  
16 launched a campaign around -- I think it's called "It's  
17 kind to remind", which was about just remembering that  
18 infection prevention and control is just as important in  
19 the non-patient-facing areas in hospitals as the  
20 patient-facing areas.

21 So, you know, we spent a lot of time trying to  
22 ensure that people understand and are able to comply  
23 with infection prevention and control. But it is  
24 something that, not just Covid but for other infections  
25 people absolutely need to stay alert to.

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1 **Q.** The Inquiry has evidence, and there has been evidence  
2 heard elsewhere about, and again this is something that  
3 will obviously be covered in more detail in future  
4 modules, it arises in this regard out of evidence given  
5 last week by Dr Jim Elder-Woodward and the concerns in  
6 the disabled community, DPOs in particular, in relation  
7 to access to treatment and DNACPR, so do not attempt  
8 cardiopulmonary resuscitation.

9 The Inquiry has heard evidence and seen evidence  
10 that one of the health boards in Scotland published  
11 a Covid triage document online for a period which set  
12 out sort of how patients would be triaged in terms of  
13 accessing healthcare. Can you comment on that?

14 **A.** I'm sorry, I can't, I haven't seen that document.

15 **Q.** Okay.

16 I want to take you back -- not back, but ... you say  
17 in your statement, paragraph -- or page 11,  
18 INQ000315534, page 11, paragraph 35, you're talking  
19 about ramping up infrastructure and ensuring that there  
20 is infrastructure in place in the course of a future  
21 pandemic or in terms of testing, vaccine -- necessary  
22 infrastructure at the time had to be largely built from  
23 scratch, and I think what you're saying here is: make  
24 sure it doesn't have to be built from scratch again,  
25 keep the structures in place, to some extent?

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1 allocate it to. So whilst you say that this has been  
2 stood down as a result of UK funding withdrawal, some of  
3 this infrastructure, what steps have been taken within  
4 your directorate and more broadly to maintain the level  
5 of capacity that you think is appropriate?

6 **A.** So I'm sure you will have seen evidence that Scotland's  
7 established a Standing Committee on Pandemic  
8 Preparedness, and that has issued its draft report.  
9 It's due to issue its final report this year. That is  
10 looking at the establishment of a Scottish centre for  
11 pandemic preparedness or planning, I can't remember  
12 exactly what it's due to be called.

13 I think in terms of what we have done so far is we  
14 have tried to, as economically as possible, maintain the  
15 sort of core capacity to be able to ramp up, but a lot  
16 of that is around some of our digital capacity, some of  
17 our data flows.

18 But the fact remains that were we to need to go back  
19 to sort of mass population level testing again, then  
20 that is something that would need to be funded on  
21 a four nations basis.

22 **Q.** But it doesn't preclude the infrastructure remaining in  
23 place --

24 **A.** It --

25 **Q.** -- so it is not a question of going back to zero?

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1 **A.** Yeah. Absolutely.

2 **Q.** You then say at paragraph 37 of your statement that:  
3 "Better management of any future pandemic,  
4 regardless of the particular characteristics of that  
5 pandemic, will rely on the ability to ramp up key public  
6 health infrastructure."

7 You then say:

8 "Much of this has already been stood down as  
9 a result of the withdrawal of UK Government funding."

10 But it's right, isn't it, that the way funding  
11 works, Scotland gets a block grant for health, and  
12 Scottish ministers determine, decide as part of their  
13 role how that funding is allocated, don't they?

14 **A.** That's correct. I think my -- but I think we also have  
15 to pay attention to the fact that during the Covid  
16 pandemic there was additional funding made available  
17 specifically for areas such as testing and the  
18 Lighthouse labs, et cetera.

19 **LADY HALLETT:** Sorry to interrupt. I thought the block  
20 grant was block grant generally and then the Scottish  
21 Government decided. I think your question said a block  
22 grant for health.

23 **MS ARLIDGE:** Sorry.

24 Funding is allocated in a block, and it is allocated  
25 by Scottish Government to whatever areas they choose to

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1 **A.** I think you can keep some of the infrastructure in place  
2 but it would still require significant additional  
3 investment to ramp that up and get it going.

4 **Q.** A ramping up phase.

5 **MS ARLIDGE:** My Lady, have you got any questions?

6 **LADY HALLETT:** No, I have no questions, thank you very much.  
7 Forgive me. **(Pause)**.

8 Thank you very much indeed, Ms Lamb, for all your  
9 help for the second time. I'll try not to call on you  
10 too often but I can't guarantee there won't be  
11 another --

12 **THE WITNESS:** Yes, I expect we'll be meeting again.

13 **LADY HALLETT:** Thank you very much indeed.

14 **(The witness withdrew)**

15 **MS ARLIDGE:** I'm grateful, my Lady. We now play a bit of  
16 musical chairs in the bench.

17 **(Pause)**

18 **MR DAWSON:** My Lady, the next witness is Professor Sir  
19 Gregor Smith.

20 **PROFESSOR SIR GREGOR SMITH (affirmed)**

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

22 **MR DAWSON:** You are Professor Sir Gregor Smith?

23 **A.** I am.

24 **Q.** I was planning on addressing you as Professor Smith,  
25 would that be appropriate?

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1 **A.** Absolutely fine, thank you.

2 **Q.** You have helpfully provided a statement to the Inquiry,  
3 Professor Smith, which is under reference INQ000273978.  
4 Is that your statement there?

5 **A.** It is.

6 **Q.** You're familiar with the statement, and have had the  
7 opportunity to go through it in advance of giving  
8 evidence?

9 **A.** I have, yes.

10 **Q.** Has the content of this statement remained true and  
11 accurate as far as you're concerned?

12 **A.** As far as I'm aware, yes.

13 **Q.** Thank you.  
14 You are currently the Chief Medical Officer for  
15 Scotland; is that correct?

16 **A.** That's correct.

17 **Q.** And you originally trained as a general practitioner?

18 **A.** I did, yes.

19 **Q.** You were formerly a medical director for primary care,  
20 I believe, in NHS Lanarkshire?

21 **A.** That's correct.

22 **Q.** And you began working for Scottish Government as  
23 a medical adviser in primary care in 2012?

24 **A.** That would be correct, yes.

25 **Q.** I think there was an element of your work at that time

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1 clinical adviser to Scottish ministers and to officials.  
2 The role of the Chief Medical Officer in relation to the  
3 pandemic was to try to collate as much evidence as was  
4 possible about that emerging threat which had been  
5 identified relating to a novel coronavirus disease  
6 emerging in China at that point in time.  
7 And the DCMO, the Deputy Chief Medical Officer's  
8 role was to support the Chief Medical Officer in doing  
9 that, but also at that time a large part of my role was  
10 to take care of a lot of the other business that related  
11 to the office and to try to keep that business as usual,  
12 properly going(?).

13 **Q.** Thank you.  
14 There is another prominent role within the advisory  
15 structure of the Scottish Government called the National  
16 Clinical Director; is that correct?

17 **A.** That's correct.

18 **Q.** That post was held during the course of the pandemic by  
19 Professor Jason Leitch?

20 **A.** That's correct.

21 **Q.** I believe that role to be a unique role when comparing  
22 the advisory structures in the United Kingdom. Could  
23 you please explain broadly how it is that the duties of  
24 the holder of that role fit in with the duties you've  
25 just explained, in particular focusing on the beginning

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1 that was the particular focus of your initial engagement  
2 relating to the Scottish GP contract; is that correct?

3 **A.** So during that initial period within Scottish Government  
4 up to 2015, I was a senior medical adviser in primary  
5 care, and part of the remit there was involved in the  
6 development of a new GP contract in Scotland.

7 **Q.** Thank you. You were appointed Deputy Chief Medical  
8 Officer of Scotland in 2015.

9 **A.** That's correct.

10 **Q.** You were appointed interim Chief Medical Officer on  
11 5 April 2020?

12 **A.** That's correct.

13 **Q.** You were appointed to that role at the point when the  
14 previous Chief Medical Officer, Dr Catherine Calderwood,  
15 resigned?

16 **A.** Yes.

17 **Q.** And you subsequently became the Chief Medical Officer  
18 for Scotland on 23 December 2020?

19 **A.** That's correct.

20 **Q.** Could you please give us a broad outline of the roles of  
21 both the Chief Medical Officer and the Deputy Chief  
22 Medical Officer, the latter being the role that you held  
23 at the beginning of the pandemic?

24 **A.** So in relation to specifically to the pandemic, the  
25 Chief Medical Officer was the principal independent

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1 of the pandemic.

2 **A.** Professor Leitch will be able to give you a much broader  
3 assessment of how his role worked at that point in time.  
4 From my perspective, the National Clinical Director's  
5 role has always been complementary to that of the Chief  
6 Medical Officer, but focused on a slightly different  
7 remit.  
8 The National Clinical Director's remit has been  
9 broadly facing the NHS within Scotland rather than  
10 public health, up until that point, and at that early  
11 part of the pandemic response I am unaware as to the  
12 full extent of the National Clinical Director's  
13 involvement in discussions with the CMO at that point in  
14 time.

15 **Q.** Right, I understand.

16 **A.** My understanding is that the National Clinical Director  
17 was very focused on preparation of the NHS.

18 **Q.** Right.  
19 Given that you subsequently became the interim Chief  
20 Medical Officer, and then Chief Medical Officer towards  
21 the end of 2020, can you broadly explain for  
22 her Ladyship how it was that those roles developed as  
23 the pandemic went on and the requirements from medical  
24 advisers perhaps changed?

25 **A.** It was very clear to me that the scale of the threat and

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1 the response that was required to that threat required  
 2 much more capacity clinically within Scottish Government  
 3 advisory circles that we had at that point in time, so  
 4 I recruited additional staff when I took over in  
 5 April 2020, but I also sought to involve the skills that  
 6 the National Clinical Director and, indeed, the Chief  
 7 Nursing Officer, the third part of the senior clinician  
 8 triumvirate which existed within those advisory  
 9 structures, to try to make sure that they were very much  
 10 more involved than perhaps they previously had been in  
 11 sharing the advisory duties. That involved not only  
 12 linking back to how we became involved with ministers in  
 13 providing that advice, but also how we engaged with the  
 14 public as well in relation to that advice.

15 **Q.** Thank you.

16 Would it be correct to say that the ultimate role of  
 17 the Chief Medical Officer is to provide medical advice  
 18 to the Scottish ministers to help them inform their  
 19 decisions?

20 **A.** Ultimately I think that's correct, yes.

21 **Q.** Although, as you've already helpfully explained, the  
 22 Chief Medical Officer will draw on a lot of advisory  
 23 systems and no doubt also on the Deputy Chief Medical  
 24 Officer and National Clinical Director and others, the  
 25 ultimate responsibility for that provision of medical

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1 availability of testing, the efficacy and availability  
 2 of PPE and the like?

3 **A.** Yes, the Chief Medical Officer helps to co-ordinate that  
 4 advice from a variety of specialist advisers; you've  
 5 mentioned some of them there, the Chief Scientific  
 6 Adviser for Government is one. An important one --  
 7 which again, going back to an earlier point that you  
 8 made in terms of how we utilise all the assets within  
 9 the team that we have, was the chief scientific officer  
 10 for health.

11 Professor Crossman was a very able individual, who  
 12 I thought was -- could contribute much more than he had  
 13 been able to contribute up until that point. And we  
 14 used them specifically in relation to some of those  
 15 questions that you've posed there in terms of the  
 16 research and scientific basis for particular approaches  
 17 such as testing.

18 **Q.** So just to try to make sure we have the structures  
 19 correctly, the CMO works within the CMO department or  
 20 directorate; is that correct?

21 **A.** So the way that this works is the CMO Directorate is  
 22 a unique directorate within Scottish Government. It's  
 23 unique in some ways because it sits slightly to the side  
 24 of other directors. What I mean by that is it has  
 25 an independence which perhaps other parts of government

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1 advice to ministers sits with the CMO?

2 **A.** Ultimately the CMO's responsibility is to offer that  
 3 advice to ministers, from which they can then base  
 4 decisions.

5 **Q.** Thank you.

6 We'll hear some evidence later today from  
 7 Professor Sheila Rowan, who is, as I understand it,  
 8 a professor of physics and astronomy at University of  
 9 Glasgow. She performed the role of Chief Scientific  
 10 Adviser to the Scottish Government, at least for the  
 11 early part of the pandemic before another person took  
 12 that role over. We also know that there's another post  
 13 called Chief Scientist (Health), and I understand that  
 14 that role was held predominantly during the pandemic by  
 15 Professor David Crossman. Have I got at least all the  
 16 personalities correct in the --

17 **A.** The personalities you've described there are absolutely  
 18 correct.

19 **Q.** Thank you.

20 As far as scientific advice is concerned, is it  
 21 correct to say that the Chief Medical Officer ultimately  
 22 also provides advice to the Scottish Government on  
 23 scientific matters, in particular insofar as they  
 24 related to the pandemic, including in relation to the  
 25 role of the things like vaccine, the efficacy and

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1 don't quite have. I think a really important aspect of  
 2 the role is that independent clinical and scientific  
 3 advice that comes through the office. But within that  
 4 directorate, there are a number of clinical advisers  
 5 that I am the line manager to and responsible for, one  
 6 of whom is the chief scientific officer for health, we  
 7 have already mentioned, another of whom, another really  
 8 important figure in all of this, the Chief  
 9 Pharmaceutical Officer as well, who is able to provide  
 10 additional information and advice in relation to  
 11 therapeutics.

12 **Q.** The Chief Scientist, as I understand it, effectively  
 13 sits structurally in a different part of the Scottish  
 14 Government, not under the ambit of the directorate of  
 15 health and social care but of another directorate,  
 16 I think it's the economy directorate; is that correct?

17 **A.** I think that is correct, yes, economy.

18 **Q.** For present purposes it's in a different part of the  
 19 Scottish Government.

20 And is it correct to say that the post that  
 21 Professor Crossman held was, to a degree, a bridge  
 22 between the scientific side and the health side, in that  
 23 he was Chief Scientist (Health) and therefore would have  
 24 informed advice from both the Chief Scientific Officer  
 25 and the Chief Medical Officer?

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1 **A.** I would say that's a very good way of describing the  
 2 role of the Chief Scientific Officer in health, a bridge  
 3 between many different parts of government, particularly  
 4 in that research field. And an important aspect of  
 5 research, of course, is to link back to other aspects of  
 6 government such as economy and learning as well and to  
 7 be able to bridge some of the kind of joint ambitions  
 8 that the government would have in those areas.

9 **Q.** You've described the importance of the independence of  
 10 the Chief Medical Officer's department, but from  
 11 an administrative perspective it struck us that these  
 12 arrangements are perhaps slightly complex. Was it, to  
 13 any extent, a matter which caused difficulty in  
 14 accessing the right people, making the most and best  
 15 informed decisions, that these structures existed  
 16 somewhat in different parts of the Scottish Government,  
 17 or did you not find that in your role?

18 **A.** I can very honestly say to you that I did not find that  
 19 in my role, and that actually access to other parts of  
 20 government, access to getting the right staff was never  
 21 an issue.

22 **Q.** Thank you.

23 You sat on a number of advisory groups and attended  
 24 a large number of meetings during the course of the  
 25 pandemic in your three roles, including SAGE, the

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1 SAGE is a good example. In the early part of the  
 2 pandemic, as the Scottish Government began to receive  
 3 invites to attend SAGE meetings, I attended SAGE as  
 4 an observer to proceedings. My role there was to take  
 5 account of the information and discussion that was being  
 6 relayed over the course of those meetings and, where it  
 7 was necessary to try to kind of ask questions on behalf  
 8 of the Scottish Government, to signal those. You --  
 9 generally they had to be signalled in advance of the  
 10 meeting. Latterly, whilst DCMO, there were other  
 11 mechanisms put in place to try to signal questions to  
 12 the committee during its operation.

13 But that observer status during that period was  
 14 essentially as an information gathering mission.

15 **Q.** To stay on the UK level, what about NERVTAG?

16 **A.** Yeah, I didn't sit on NERVTAG at all. NERVTAG is a very  
 17 technical committee, it's generally staffed by people  
 18 with expertise, deep expertise in infectious diseases  
 19 and epidemiology. We had a representative on NERVTAG  
 20 from other sources within Scotland who were able to feed  
 21 back when it was relevant and appropriate for them to do  
 22 so.

23 **Q.** Indeed, we heard from Dr Jim McMenamin on Friday,  
 24 for example, who sat on that.

25 **A.** And Dr McMenamin is one of the unsung heroes in terms of

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1 four nations chief medical and scientific officers  
 2 group -- could you just say "yes" if that's correct,  
 3 rather than --

4 **A.** Yes.

5 **Q.** Thank you.

6 The scientific influenza group on modelling, SPI-M?

7 **A.** Yes -- no.

8 **Q.** No. The Scientific Pandemic Insights Group on  
 9 Behaviours, SPI-B?

10 **A.** No.

11 **Q.** The Joint Committee on Vaccination and Immunisation,  
 12 JCVI?

13 **A.** No.

14 **Q.** The Joint t Biosecurity Centre, JBC?

15 **A.** The JBC technical board.

16 **Q.** The group that we've heard of before under the acronym  
 17 NERVTAG?

18 **A.** No.

19 **Q.** The UK Health Security Agency?

20 **A.** The UK Health Security Agency board.

21 **Q.** And you did sit on the Scottish Covid Advisory Group  
 22 when it was formed?

23 **A.** Yes.

24 **Q.** What was your role when attending these groups?

25 **A.** So particularly in -- if we start off with SAGE, I think

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1 the approach that was taken in Scotland, a man who  
 2 I have enormous respect for.

3 **Q.** Thank you.

4 You also sat on the four nations chief medical and  
 5 scientific officers group. Could you explain your role  
 6 in that group?

7 **A.** The chief medical officers group -- so I -- I suspect  
 8 that the group that you're alluding to is the  
 9 JBC technical board, which was staffed full of CMOs and  
 10 the chief scientific officers, and this was a board  
 11 which was examining some of the technical parameters  
 12 under which JBC would develop data or information for  
 13 use. A good example of that might be the data that was  
 14 developed and the approach that was taken in terms of  
 15 assessing risk of other countries as -- of other  
 16 countries at the borders with the UK and people  
 17 returning or travelling to those countries. So we gave  
 18 advice on some of the parameters which data would be  
 19 useful technically to assess that.

20 **Q.** Thank you.

21 We'll hear more, I think, later in the week, about  
 22 the precise circumstances in which the Scottish Covid  
 23 Advisory Group came together from other witnesses. But  
 24 as far as your role on that group was concerned, what  
 25 was your role? In particular, was this a group that

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1 reported effectively or offered its advice ultimately to  
 2 Scottish ministers through you?  
 3 **A.** The group operated in a way whereby advice that came  
 4 from that group was provided to me and to the Scottish  
 5 ministers, and it was set up to -- and it was set up in  
 6 a way to try to allow a greater interrogation of the  
 7 data and the evidence that they were considering. So  
 8 whilst I was a member of the group, its extreme  
 9 usefulness was -- was an ability to be able to actually  
 10 get into discussion with members of the group in a deep  
 11 way at times. Sometimes that would be through the  
 12 chair, sometimes that would be by attending the meetings  
 13 himself and being able to kind of, in a two-way  
 14 mechanism, being able to both relay information that  
 15 I was party to but also hear the discussion and  
 16 interrogate the discussion which was going on within  
 17 that group as well.  
 18 The advice that advisory group was able to provide  
 19 to us was incredibly useful. Much of it was based on  
 20 the same evidence which was being considered in other  
 21 places, but the ability to be able to kind of have that  
 22 discussion in -- first-hand with those people was  
 23 incredibly valuable.

24 **Q.** Thank you.

25 **LADY HALLETT:** Professor, if you could slow down a bit,

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1 pandemic response; is that correct?  
 2 **A.** Yes.  
 3 **Q.** In Scotland, the three main individuals whom we've  
 4 looked at who provided medical advice to the government  
 5 came from different medical backgrounds; is that  
 6 correct?  
 7 **A.** Yes, we all came from different specialities.  
 8 **Q.** You've already helpfully told us that you came from  
 9 a general practice background and worked through various  
 10 government jobs. Dr Calderwood, I think, came from  
 11 an obstetrics and gynaecology background; is that  
 12 correct?  
 13 **A.** That's correct.  
 14 **Q.** And Professor Jason Leitch was originally trained in  
 15 dentistry --  
 16 **A.** That's correct.  
 17 **Q.** -- before taking qualifications in public health at  
 18 various university institutions after that?  
 19 **A.** That's correct, as far as I know.  
 20 **Q.** Would it be fair to say that, given the particular  
 21 requirements and difficulties faced in the pandemic  
 22 itself, that the background and experience which you and  
 23 your two colleagues were able to bring to bear to  
 24 providing scientific advice meant that you required more  
 25 perhaps than the UK Government advisers to translate the

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1 I'm afraid you're falling into the same trap the rest of  
 2 us fall into.

3 **MR DAWSON:** Professor, there is a stenographer, obviously,  
 4 who is attempting to keep up with your very useful  
 5 evidence, so if we could just try to take it as slowly  
 6 as we possibly can. I'm often admonished for the same  
 7 thing, I have to say.

8 You have given some helpful evidence about the  
 9 structures through which medical advice was able to be  
 10 provided to the Scottish Government during the course of  
 11 the pandemic and more generally. The Inquiry has  
 12 already heard evidence about the structures which  
 13 existed at UK Government level, and the key individuals  
 14 involved, not least Professor Whitty, and  
 15 Sir Patrick Vallance. These were individuals who, we've  
 16 heard evidence, came from, in Professor Whitty's case,  
 17 a public health background; is that correct?

18 **A.** I think Professor Whitty's background is both in public  
 19 health and infectious diseases.

20 **Q.** Indeed. And I think the Inquiry has also heard evidence  
 21 in the previous module that Sir Patrick Vallance came  
 22 from -- he's a -- as I understand it, a clinical  
 23 pharmacologist who had experience of working within an  
 24 industry relating to development of pharmaceuticals and  
 25 the like. Also an element that was very relevant to the

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1 advice of others more expert than you in the matter?  
 2 **A.** I don't think that's correct, no. I had been working in  
 3 population health and public health since probably 2006,  
 4 in various leadership roles, between managed clinical  
 5 networks to medical director roles, to subsequently  
 6 ten years of experience within Scottish Government  
 7 working at population health level as well. So I don't  
 8 think it's correct to say that.

9 But what I will say is that the information and the  
 10 knowledge which was used over the course of that  
 11 response necessarily came from a wide group of very  
 12 specialist people, both within the health protection  
 13 community and the infectious disease community, and  
 14 their input was incredibly valuable.

15 **Q.** But ultimately, as you have I think accepted and  
 16 explained, the ultimate role as far as providing advice  
 17 to the Scottish ministers are concerned falls to the  
 18 Chief Medical Officer, and neither you nor Dr Calderwood  
 19 were, like Professor Whitty, experts in public health  
 20 and infectious diseases in that way?

21 **A.** My core speciality wasn't public health but I would  
 22 still regard myself as having expertise in population  
 23 health and public health.

24 **Q.** I should say, Professor, I mean no disrespect at all in  
 25 that regard, but the reason I ask the question is

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1 because during the course of the pandemic it was often  
2 part of commentary of people who were wondering whether  
3 they had to continue to adhere to restrictions that the  
4 medical advisers who would appear perhaps didn't have  
5 the same level of expertise as the UK Government medical  
6 advisers. Was consideration given in the public  
7 communications strategy at least to the need to try to  
8 win the confidence of the public in order to try to  
9 maintain compliance and these particular comments,  
10 rather than criticisms, that were sometimes made?

11 **A.** So those comments that you have singled out there,  
12 I don't particularly recognise as being something which  
13 was an issue which was raised at all. What was  
14 important was that credible and authentic clinical  
15 leaders were able to discuss with the public the  
16 requirement to undertake the very significant ask that  
17 we made of them, and to try to explain in very simple  
18 terms as to why that was the case.

19 I think it's something that we did in Scotland very  
20 well. Certainly judging by the feedback that we had  
21 through some of the polling. Public confidence in that  
22 messaging was very, very high, and we saw really quite  
23 significant compliance from the public in relation to  
24 taking, as I say, those just quite incredible steps that  
25 we asked of them, to try and keep people safe. So

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1 virus were made within Scottish Government?  
2 **A.** I'm not quite sure where that phrase originated from,  
3 but it's one that certainly became quite commonly used  
4 over the course of the pandemic response, certainly in  
5 the media.

6 What I observed was a thirst for information and  
7 knowledge from those who were making decisions and they  
8 looked to science to try to provide that information and  
9 knowledge, so that they could try to make sense of the  
10 decisions that they were being asked to take. And what  
11 I found was a very receptive group of decision-makers  
12 who understood the limitations of some of the evidence  
13 and the science that was being presented to them, but  
14 also made great efforts to try to actually get under the  
15 bonnet and understand the science itself so that they  
16 weren't wholly reliant on just people explaining it to  
17 them.

18 **Q.** What was it that gave you the impression that  
19 decision-makers ultimately understood the science  
20 itself?

21 **A.** The questions they asked me.

22 **Q.** Could you give some examples, perhaps, of the broad  
23 questions --

24 **A.** So the questions which began to be asked in relation to  
25 aspects of the response, whether that be modelling,

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1 I don't accept that the background speciality that  
2 I have as a GP had any influence on that whatsoever at  
3 all.

4 **Q.** Thank you. You've referred to some polling as regards  
5 the communications strategy about which the Inquiry has  
6 already heard some evidence. Professor Paul Cairney,  
7 professor of political science, looked at this issue in  
8 an expert capacity and suggested to the Inquiry last  
9 week during his evidence that it was important to  
10 maintain a distinction between when people indicate  
11 a satisfaction with the way in which information is  
12 being presented as opposed to the possibility that may  
13 not necessarily indicate an understanding and hence  
14 compliance with it. Is that a distinction that you  
15 recognise?

16 **A.** I would be really interested in reading more about what  
17 he says there, and I think that we observed both a high  
18 degree of compliance and satisfaction with what was  
19 asked of the public.

20 **Q.** Thank you.

21 The phrase "following the science" is one which one  
22 hears often in connection with the pandemic and was used  
23 by a number of politicians to describe their response.  
24 Do you think that this is an accurate description of how  
25 policy decisions and ultimately strategy in fighting the

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1 whether that be transmission dynamics, whether that be  
2 even rudimentary epidemiology such as understanding of  
3 the R rate, over the course of that, even the early part  
4 of the response, the questions that came from those  
5 decision-makers began to become very insightful into not  
6 just information that was given to them but for the  
7 logical next steps that flowed from that as well.

8 **Q.** Thank you.

9 Given the complexity of the information, some of  
10 which we've seen presented in documents such as,  
11 for example, the SGoRR sitreps with which you'll be  
12 familiar, do you think that there were stages of the  
13 pandemic in which politicians did follow the science in  
14 Scotland --

15 **A.** Yes.

16 **Q.** We'll get on to the precision in a moment, I just want  
17 to finish the question. Were there times where you felt  
18 that they did follow the science and can you specify for  
19 us what time periods you think that might apply to?

20 **A.** One of the things which was very evident over the course  
21 of the discussion with senior officials and with  
22 ministers was an appreciation of what science could  
23 offer in terms of informing how to respond to the threat  
24 of the coronavirus. Some of that was about  
25 understanding the epidemiology and how it was likely to

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1 transmit through populations, and therefore shaped the  
2 type of response that was going to be required to reduce  
3 transmission. Some of that was about the clinical  
4 response that was going to be needed in order to treat  
5 people who had become infected with coronavirus.

6 There was a process by which we used that science  
7 and started to begin to integrate other fields of  
8 science into what, strictly speaking, would be health  
9 and public health research, and begin to integrate  
10 research from other areas such as behavioural science,  
11 how people might respond to a particular ask, how people  
12 might be feeling in terms of the degree of threat that  
13 they were facing. And the four harms process which  
14 subsequently became part of the way that we handled the  
15 pandemic in Scotland tried to take evidence from  
16 government advisers across four different aspects of  
17 harms that we'd identified and -- and use science and  
18 research from those areas, evidence from those areas, to  
19 try to integrate a response that was balanced in terms  
20 of its approach and recognised the various harms that  
21 both the coronavirus itself would cause to the  
22 population but also the potential for the response to  
23 cause as well.

24 **Q.** Thank you.

25 You said, I think, that certain scientific

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1 earlier stages of the type of advice which was coming  
2 from groups such as SPI-B, which had been set up as part  
3 of the SAGE infrastructure to look specifically at the  
4 behavioural response.

5 **Q.** Would it be fair to say that the logic of the position  
6 in introducing behavioural science around about the time  
7 of the formation of the Scottish Covid-19 Advisory Group  
8 was that it was important that there was a local  
9 consideration of the way in which Scottish people would  
10 react to restrictions which had not previously featured  
11 in the analysis?

12 **A.** I think that that was a helpful part of their  
13 involvement. I think that there was also insights which  
14 were developed from other places as well, and my  
15 observation would be that many of the political  
16 decision-makers who were present at that time were very  
17 good, in fact some were exceptional, at judging both the  
18 mood and response of the population.

19 **Q.** How did they go about doing that? Was it the polling  
20 that you've referred to, or something else?

21 **A.** I think some of the information came from polling, some  
22 of the information came from their own personal insights  
23 and discussions with both constituents and the many  
24 groups which they were in contact with.

25 **Q.** Was it ever part of -- or if it was, when was it part of

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1 disciplines were introduced into the analysis as time  
2 went on.

3 **A.** Yeah.

4 **Q.** You referred in particular to behavioural science. When  
5 was it that these -- was it at the advent of the  
6 four harms strategy that these different scientific  
7 disciplines were brought to bear?

8 **A.** I would -- I would recall it as far back as the  
9 March 2020 that some of these responses were beginning  
10 to be -- become much more clearly integrated into the  
11 response. Understanding particularly in terms of the  
12 degree of the ask of the population how they might  
13 respond to that. And even at the very early stages of  
14 forming the C-19 Advisory Group, we made sure that we  
15 had representation from behavioural scientists on that  
16 group, which was further strengthened later on in 2020,  
17 I think.

18 **Q.** Does it mean that decisions before around the formation  
19 of the Covid-19 Advisory Group were not informed by this  
20 wide range of scientific disciplines?

21 **A.** I think that at the earlier stages of the response there  
22 was less emphasis given on the behavioural aspects of  
23 the response than perhaps there were by the time that we  
24 had reached some of the major decisions in March 2020.  
25 However, there was perhaps a greater reliance in those

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1 the Scottish Government's approach to the fight against  
2 the virus that no death from coronavirus was acceptable?

3 **A.** It's not particularly a phrase that I recognise.

4 Certainly from a clinical perspective there was a deep  
5 realisation that tragic though it is, and it was  
6 an absolutely tragedy for some families, that it was  
7 almost inevitable, given the scale of the threat which  
8 was faced by a novel virus in a population that had no  
9 immunity to it, it was likely that there were going to  
10 be deaths. And what we sought to try to do was to try  
11 to limit the harm as far as we possibly could, to limit  
12 not only deaths as far as we could but also the other  
13 harms which arose as a consequence of illness from  
14 Covid-19 as well. We shouldn't forget that Covid-19's  
15 a disease which not only causes the risk of death, but  
16 also has long-term effects for many, many people as  
17 well.

18 **Q.** Indeed.

19 So to put my question in the context of the  
20 four harms strategy, which you've helpfully referred to,  
21 was it -- and again if it was, when was it -- part of  
22 the Scottish Government's strategy to prioritise harm 1,  
23 which was, we recall from previous evidence,  
24 Covid-related harm, as opposed to the other harms?

25 **A.** As far back as I can remember it was the priority to try

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1 to reduce the direct harms which were being caused by  
 2 Covid, that had been identified as certainly the most  
 3 significant and pressing urgent threat to the nation,  
 4 and there was a recognition that actually, left  
 5 unchecked, the harms that the virus could cause would be  
 6 far greater in the scale than the harms which would  
 7 arise from some of the other four harms which have been  
 8 identified. And by prioritising the direct harms, by  
 9 reducing the displacement effect on the health services,  
 10 and by trying to control and indeed suppress the growth  
 11 of the virus, then that would actually allow the best  
 12 chance to be able to reduce the harms in the other three  
 13 areas as well.

14 **Q.** Thank you.

15 Was it the case -- we know that the four harms group  
 16 eventually formed in October 2020, though the four harms  
 17 strategy, the framework had been laid out in April, over  
 18 that period before October, was it the case that the  
 19 priority remained harm 1 over the other harms?

20 **A.** During that period that you're describing there from --  
 21 probably from April through to October, it certainly  
 22 appeared to be the case that harm 1 and harm 2 were  
 23 given a significant degree of priority during that  
 24 period. It was recognised that in the initial response  
 25 there was a great deal of displacement in terms of other

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1 **Q.** Those being harms related to health, broadly speaking?

2 **A.** Yes.

3 **Q.** You mentioned there the integration. To what extent  
 4 were you afforded the opportunity to discuss and compare  
 5 and contrast and integrate your views on harms 1 and 2  
 6 with the other advisers you've described as being more  
 7 responsible for harms 3 and 4?

8 **A.** So very early on in the pandemic response, myself and  
 9 the Chief Scientific Adviser had discussion about what  
 10 we recognised was perhaps a benefit, in forming a whole  
 11 new group for the chief advisers from different parts of  
 12 government. Prior to the pandemic response, certainly  
 13 didn't seem that these chief advisers met on any kind of  
 14 regular basis. But I saw and I think the Chief  
 15 Scientific Adviser very clearly saw benefit as well in  
 16 trying to bring people together in a forum that allowed  
 17 us to consider a variety of types of evidence to look to  
 18 see the broader impacts on society. That was a good  
 19 forum for being able to discuss some of these impacts  
 20 and really to gain a better and broader understanding of  
 21 the impacts that we were beginning to see across  
 22 different aspects of society.

23 It had always been recognised right from the  
 24 beginning of the SAGE discussions that any response to  
 25 try to control this pandemic was likely to have broader

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1 health need within the population, and during that  
 2 period we started to try to recover aspects of the NHS  
 3 at the same time to be able to try to address some of  
 4 that unmet need that there was in the population as  
 5 well. But it certainly was my view that during that  
 6 period those two harms were given priority over the  
 7 other two areas, though it has to be said that some of  
 8 the responses during that time were still tempered by  
 9 the recognition of potential harms in those other areas  
 10 as well.

11 **Q.** And given the priority which you say was given to  
 12 harms 1 and 2 over that period, when you were providing  
 13 medical advice -- if one might describe that as the  
 14 policy of the government at that stage -- did you tailor  
 15 your advice to that policy?

16 **A.** The advice that I gave at that time was advice that was  
 17 designed to reduce the harms in harm 1 and harm 2 as  
 18 much as possible. It was for other advisers to give  
 19 advice in relation to harms 3 and 4. It was the  
 20 integration of the advice from a range of advisers which  
 21 then allowed the policy to be developed and for  
 22 decisions to be made by ministers.

23 But my priority, and I saw very clearly my priority  
 24 was to give advice solely on the benefit to reducing  
 25 harm 1 and harm 2.

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1 harms than simply the direct harms that we saw from the  
 2 virus itself. So recognising then and understanding  
 3 what those type of harms were likely to be and then  
 4 trying to risk manage those, to mitigate and reduce the  
 5 level of harm which we were seeing in those other areas,  
 6 was an important part of that response.

7 And we should remember that ultimately any harm  
 8 which befalls as a consequence of either social or  
 9 economic detriment to the population also has  
 10 a detrimental public health effect as well. If not in  
 11 the short term, then it can perhaps be felt in the  
 12 medium to longer term. So there was a benefit to being  
 13 able to try to reduce those harms as much as possible,  
 14 mitigate impacts, on a public health basis as well.

15 **Q.** So that was the theory; is that right?

16 **A.** That's the theory.

17 **Q.** The Inquiry's heard a considerable body of evidence,  
 18 which might be summarised in an expression used by  
 19 someone who appeared in the opening video that we  
 20 played. He said that when Scotland tried to emerge from  
 21 the pandemic, emerge from the lockdown in the period,  
 22 I think, that we were talking about, he said "Nobody  
 23 took a look around to work out whom we had left behind".  
 24 The way one might interpret that is that there continued  
 25 to be a significant focus on harm 1 for too lengthy

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1 a period, and that the other harms, the harms caused by  
2 the countermeasures, broadly speaking, were not given  
3 sufficient attention over that period.

4 Would that be a criticism which you would recognise  
5 as regards the practical impact rather than just as  
6 regards the theory?

7 **A.** It is -- it is a criticism, it is a story that I've  
8 heard from accounts of beforehand. Being part of those  
9 discussions when the variety of harms that we were  
10 seeing across the country were being considered, the way  
11 that that advice was then taken by decision-makers  
12 I think reflected where their perception of the greatest  
13 risk to the country existed. And ultimately any  
14 prioritisation of any harm over another probably  
15 reflected the risk thresholds of those decision-makers.

16 **Q.** The four harms group did not meet till October 2020; is  
17 that correct?

18 **A.** It did not meet on a formal basis in that time, but  
19 there were many discussions before that.

20 **Q.** By October 2020 Scotland had started to become  
21 overwhelmed by harm 1 again, hadn't it?

22 **A.** What we saw in, starting generally from the early autumn  
23 period, was first of all significant outbreaks and  
24 clusters developing across the country. Largely  
25 inevitable as we still had a largely immune -- sorry,

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1 harm 1, the virus having returned, did this mean -- was  
2 this the reason why people, like the gentleman said,  
3 were left behind and the other harms were not properly  
4 integrated into the response?

5 **A.** What I saw in that period that you're describing between  
6 April and October was regular discussion in relation to  
7 the four harms and how they were integrated together.  
8 So the fact that a committee did not meet during that  
9 time shouldn't -- it shouldn't be understood that  
10 there wasn't a great deal of discussion about how you  
11 balance those harms in that --

12 **Q.** A great deal of discussion perhaps, Professor, but  
13 perhaps little effect?

14 **A.** I would think that you would probably observe that from  
15 the submissions which were made to kind of Cabinet, for  
16 instance, during that period that there was  
17 consideration of those four harms in that period as  
18 well.

19 **Q.** Could I turn to another subject, please. What was your  
20 understanding of your responsibilities with regard to  
21 the use of informal communications in the three posts  
22 that you held during the course of the pandemic as  
23 an employee, as I understand it, of the Scottish  
24 Government?

25 **A.** So informal communications, as I've outlined in my

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1 a largely naive population in terms of immunity. And we  
2 saw more and more clusters developing over that early  
3 autumn period so that by the time we got to that kind of  
4 late autumn, early winter period, cases were certainly  
5 significant again, and there was a significant concern  
6 from a health protection perspective that if that  
7 wasn't -- that wasn't controlled, if that wasn't  
8 reduced, and if we didn't manage to achieve lower case  
9 numbers and control over the prevailing R number in  
10 Scotland, and then entering that winter period, it was  
11 only likely to increase.

12 **Q.** We saw in some statistical evidence that the cases in  
13 Scotland started to rise significantly, I think from  
14 around August?

15 **A.** Yeah.

16 **Q.** And I think there is subsequent evidence from scientific  
17 study that suggests that that was in large part  
18 connected to people bringing the virus back from being  
19 away in continental Europe, in particular Spain?

20 **A.** I agree.

21 **Q.** Yes. What I'm suggesting to you, as regards the  
22 strategy, is that although the theory had been laid out  
23 in the framework in April, the fact that a committee had  
24 not met till October, a time at which Scotland had  
25 started, by circumstance, to become overwhelmed again by

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1 statement, have been used, when in a wave, largely  
2 for -- to raise situational awareness, to kind of direct  
3 people towards particular pieces of information, to  
4 convey information about particular meetings which were  
5 taking place, which were used to try to arrange, in some  
6 cases, discussions or agreement around about particular  
7 situations.

8 The -- you will see from some of the groups which  
9 have been submitted and that I was a part of, I have  
10 described that whilst these meetings are -- that way of  
11 communication was useful for that purpose, that any  
12 information which was particularly pertinent or any  
13 decisions should be captured and put into email form.

14 **Q.** I think it's correct to say that evidence has been given  
15 during the previous week that it's not just a question  
16 of decisions being captured in that way, I think in  
17 order to put them on what's called the corporate record,  
18 but that discussions engaged -- in which individuals  
19 engaged in the pandemic response also required to be  
20 recorded that way. Is that not correct?

21 **A.** Pertinent information, yes. And I think you'll see from  
22 one of the conversations within -- and the advice I give  
23 to participants in one of the charts, that that's how it  
24 should be captured.

25 **Q.** Could we look at INQ000334433, please.

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1 This comes from a WhatsApp group chat, I understand,  
2 called "CMO weekly call", and I'm particularly  
3 interested in going to this particular passage, which is  
4 from July of 2021. This is a conversation between  
5 yourself and Graham Ellis, in which he comments:

6 "Hope this isn't FOI able?"

7 You say to him:

8 "Delete at the end of every day...."

9 And he laughs and puts his thumb up at that.

10 Was it your practice to delete messages at the end  
11 of every day?

12 **A.** Scottish Government advice in relation to this was not  
13 to retain information for longer than it was necessary,  
14 was to make sure that any information which was  
15 pertinent, as I say, any information, particularly  
16 discussions, which ended up in a decision was captured  
17 in -- within the corporate systems. So my practice was  
18 to make sure that any information which was important in  
19 that way was then captured in email form on the system,  
20 was formally recorded so that it was an auditable trail.  
21 And I think you will see evidence of my approach to this  
22 within the conversations and within other conversations,  
23 that I exhort other members of those conversations to do  
24 the same. And -- but my practice was, when information  
25 was -- had been no longer useful, it shouldn't be

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1 **A.** The most important information which was -- was about  
2 definitive information, which may include a decision.  
3 So once perhaps a consensus has been achieved, what that  
4 consensus was.

5 **Q.** I took from what you were saying a moment ago that there  
6 was a -- someone had informed you that there was a need  
7 or impetus towards not retaining too much information,  
8 and that that was an important part of your thinking in  
9 this regard. And of course organisations like the  
10 Scottish Government can't keep every piece of paper and  
11 every document or every WhatsApp message. Where did the  
12 impression of that being the impetus which should be  
13 an important part of decision-making in this regard come  
14 from?

15 **A.** So there was advice given to Scottish Government  
16 employees which specifically dealt with informal  
17 messaging and the need to delete on a regular basis any  
18 information which was not relevant.

19 **Q.** Can you remember in particular which advice? Because  
20 there were a number that you were relying upon.

21 **A.** I think this was advice which was -- the one I recall  
22 was perhaps on the Saltire website which had been given  
23 out towards --

24 **Q.** There was one which was issued on the Saltire website in  
25 April 2020. Was that perhaps --

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1 retained.

2 **Q.** My question was whether you deleted your messages at the  
3 end of every day?

4 **A.** If not at the end of every day then certainly on  
5 a frequent basis, I deleted information which was no  
6 longer needed to be kept.

7 **Q.** But your position is that, as far as you're concerned,  
8 you would have, before doing so, on a daily basis  
9 extracted pertinent information from the exchanges, sent  
10 them on to the corporate record by email, and that those  
11 emails would then have recorded the information that was  
12 within the message before you deleted it?

13 **A.** So any important decisions that were taken wouldn't be  
14 a verbatim account of a conversation but it would be the  
15 essence of any decision or any approach which should be  
16 taken on any information that had been given.

17 Generally what I found was that the information  
18 systems like this were used to convey information about  
19 exchanges which were either already beginning on emails  
20 or information which was being passed on through emails.  
21 Documents were being passed on in that way.

22 **Q.** You referred again in your answer there to decisions, so  
23 does pertinent information, as far as you're concerned,  
24 mean information which demonstrates that a decision has  
25 been taken?

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1 **A.** It would be towards the beginning --

2 **Q.** Yes, we looked at that with Ms Fraser on Friday, but  
3 that would be the one that would have --

4 **A.** That would be one, but there was also advice which was  
5 given and reminders which were given in discussions with  
6 the then Director-General, who again reminded us that  
7 official business shouldn't be done within these mediums  
8 and that there should be regular deletion, partly for  
9 security purposes, from that medium as well, and that it  
10 shouldn't be seen as a secure medium.

11 **Q.** At that time, just to be clear for the personalities  
12 again, the Director-General was Mr Wright?

13 **A.** It wasn't at that stage. I don't recall that  
14 instruction coming from Mr Wright. I might be mistaken,  
15 but I think it came from Ms Grahame(?).

16 **Q.** Thank you.

17 Could I move on to a separate area, please.  
18 Obviously as I've said at the beginning of today, the  
19 Inquiry will not be hearing from your predecessor in the  
20 post as Chief Medical Officer.

21 We are, of course, very interested in exploring  
22 matters pertaining to the early period of the pandemic  
23 at which time, as you've helpfully explained, you were  
24 Deputy Chief Medical Officer.

25 My understanding from your statement and from

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1 notebooks which you've helpfully provided is that you  
2 attended certain meetings at around that time, although,  
3 as you have set out, you also had considerable  
4 responsibilities for parts of the NHS that were not  
5 directly related to Covid at that time.

6 So would it be fair to say that there is a certain  
7 degree of limitation on what you can do to help us with  
8 the events of the period up till you becoming interim --  
9 Chief Medical Officer, but that of course, as you have  
10 done in your statement, you will help us as best you  
11 possibly can with your recollections of events?  
12 **A.** I think that's fair to say. I think that during that  
13 period I did have involvement and I participated in many  
14 meetings, even during that period, including incident  
15 management teams, including many of the SAGE meetings.  
16 I had quite a degree of involvement over that period.  
17 Where I had less involvement and where I may be able to  
18 help you less is in the direct discussions and the way  
19 that advice was conveyed to decision-makers.  
20 **Q.** I think you say in your statement that Dr Calderwood  
21 undertook the majority of engagement with Scottish  
22 ministers and senior officials around that period. Did  
23 you have conversations with Dr Calderwood, as her  
24 deputy, about the emerging information, the strategy and  
25 ultimately what advice she would be providing to

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1 that point.  
2 **Q.** Well, that was precisely the issue I wanted to hone in  
3 on, was the frustration. You mentioned, I think,  
4 earlier that when attending SAGE, representatives or  
5 officials like yourselves and others who would be there  
6 had an opportunity to ask questions but they had to be  
7 submitted in advance, was that something --  
8 **A.** That's correct.  
9 **Q.** How long did that carry on for, that practice?  
10 **A.** That practice probably carried on through the February  
11 and March period that I was involved there, but I think  
12 from that point onwards, probably late March, it became  
13 a much more integrated approach and it became much  
14 more -- much easier to be able to actually get involved  
15 in discussion and ask questions within the body of the  
16 meeting.  
17 There was one occasion in particular where -- most  
18 of the SAGE meetings were attended remotely, and at that  
19 time this was before really we had any of the platforms  
20 which enabled video meetings, it was mostly done using  
21 kind of dialled in telephones. The ability to be able  
22 to communicate in that environment was, I think,  
23 difficult, and on one occasion at least I remember  
24 travelling to London specifically to attend a meeting in  
25 person just so that I could try to glean more

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1 ministers?

2 **A.** We spoke on a regular basis in relation to the emerging  
3 advice, and we didn't speak just as much in terms of how  
4 she would relay that advice, of what advice was provided  
5 to ministers. There were a couple of occasions where  
6 I was able to kind of have direct discussion with  
7 ministers myself during that period, but that was  
8 probably by March that I would be involved in that way.  
9 **Q.** Would it be -- we obviously, as I say, have had some  
10 access to some of your diary entries, including  
11 references to some of the SAGE meetings you attended.  
12 Would it be correct to characterise them, as you said  
13 earlier, as you being there very much in an observer  
14 role -- it looks very much like you're trying to extract  
15 as much information as you possibly can, your notes are  
16 quite full -- and then perhaps take it back to feed into  
17 the decision-making system in Scotland; would that be  
18 a correct characterisation?  
19 **A.** I think that's a very correct characterisation. My role  
20 was as an observer at SAGE, was to try to glean as much  
21 information as possible. Perhaps there was a slight  
22 element of frustration that I couldn't participate in  
23 any deeper sense and perhaps at that stage we were still  
24 to see the full usefulness of SAGE in terms of being  
25 able to actually become involved in the discussion at

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1 information but also have discussion with people who  
2 were there --  
3 **Q.** Just to be clear, the remoteness element you were  
4 talking about there, did that relate to the period  
5 before things got better towards the end of March, or  
6 was that the period after?  
7 **A.** That would probably be -- so the remote -- the  
8 remoteness element would be during the initial stages of  
9 SAGE, particularly February and early March.  
10 **Q.** But as far as the input or the output, if you like,  
11 from -- for Scotland generally at that stage, you  
12 mentioned feeling a degree of frustration at your  
13 inability to explore things. Could you expand a little  
14 further? What were the effects of your inability to  
15 engage in the way that you would have wanted?  
16 **A.** So, the impact of that inability to be able to explore  
17 during the course of the meeting meant that you then had  
18 to -- rather than be able to deal with a particular line  
19 of inquiry or interest at the time you had to chase down  
20 someone afterwards to try to find out more information.  
21 It expanded on the amount of work which was necessary to  
22 try to get a sense of an answer to your question.  
23 And ...  
24 **Q.** What were the sorts of Scottish-specific, I assume,  
25 issues that you were wishing to raise, and you were

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1 having this difficulty in doing so, around that time?  
 2 **A.** So they were many and varied. And I wouldn't  
 3 characterise them as being particularly  
 4 Scottish-specific, I think that these were just general  
 5 epidemiology questions which you wanted to ask or  
 6 particular clarifications about what data or modelling  
 7 was suggesting, and these were -- these were not issues  
 8 which were, as I say, generally specific to a kind of  
 9 Scottish situation, these were about the wider virus  
 10 itself.

11 **Q.** Thank you very much.

12 **LADY HALLETT:** Were there any other people from Scotland on  
 13 SAGE at the time you were on it?

14 **A.** Yes, there was representation there. Again,  
 15 Jim McMenemy was one of the --

16 **LADY HALLETT:** I was going to say I thought there were  
 17 others.

18 **A.** Yeah, and we used to compare notes afterwards, after  
 19 a meeting, just to make sure that our understanding was  
 20 broadly similar in terms of the approach. But, as  
 21 I say, having the observer status at that point in time  
 22 did feed a little bit of frustration.

23 That was corrected, though, and I should emphasise  
 24 that that was corrected.

25 **MR DAWSON:** Yes, it was corrected, I think you say, towards  
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1 discuss this further with Professor Woolhouse and though  
 2 I do not know the content of those discussions, I recall  
 3 her taking these assessments, alongside information she  
 4 was receiving from elsewhere, with a particularly  
 5 significant gravity."

6 If I could just take you to an email chain and see  
 7 if this is the chain, it's INQ000352450. If we go to  
 8 page 7 of this document, please, this is a series of  
 9 emails all in a chain -- sorry, page 6. Yes. We could  
 10 just go to the page before that to see the top of the  
 11 email.

12 So this is the first email in the chain, the  
 13 earliest chronologically. If we go slightly above that,  
 14 yes, we see this is an email from Mark Woolhouse --  
 15 sorry, a bit further down, please, to the email below  
 16 that. Yes. The one dated 21 January. No, further  
 17 towards the end.

18 **(Pause)**

19 So you can -- this is an email -- I'm looking at the  
 20 email from Mark Woolhouse. You can see there there's  
 21 one -- from the top part of the screen -- dated  
 22 21 January from Professor Woolhouse to your predecessor.  
 23 Although that's the CMO address, that was to  
 24 Dr Calderwood, I think.

25 Is this an email do you think you would have seen or  
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1 the end of March. Thank you.

2 If that's an appropriate moment, my Lady?

3 **LADY HALLETT:** Certainly.

4 **MR DAWSON:** Thank you.

5 **LADY HALLETT:** I shall return at 1.45.

6 **(12.45 pm)**

7 **(The short adjournment)**

8 **(1.45 pm)**

9 **LADY HALLETT:** Mr Dawson.

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

11 Professor Smith, before the break we were discussing  
 12 some of the information that was available in the early  
 13 part of the pandemic about the emerging threat, and I'd  
 14 like to stay in that area, if that's possible.

15 Could we have a look, please, at INQ000273978. I'm  
 16 looking at paragraph 241.

17 And you were asked some questions about some early  
 18 email exchanges between Professor Mark Woolhouse, who is  
 19 an epidemiologist at Edinburgh University, who was in  
 20 contact in January, and from then on with your  
 21 predecessor, Dr Calderwood, and you say there that:

22 "I was aware that Professor Mark Woolhouse had  
 23 contacted the CMO (Dr Calderwood) and had seen a content  
 24 of an email which provided his view of a potential  
 25 scenario. I was also aware that the CMO arranged to  
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1 would have known about from discussions? This is the  
 2 first in the chain which starts to intimate some of the  
 3 concerns that Professor Woolhouse had at that time.

4 **A.** So I certainly recognise the tone of the email, even  
 5 from the read-through that I --

6 **Q.** This wasn't to you, so I just want to be clear that it  
 7 may be possible that the details are -- you're not  
 8 entirely au fait with.

9 **A.** I know from this communication and from other  
 10 communications from Professor Woolhouse around about  
 11 that time that he did have significant concerns in  
 12 relation to the potential threat that this virus could  
 13 cause, even at that time, and the degree of uncertainty  
 14 that still existed around about the potential that it  
 15 did have.

16 **Q.** Yes. Just to be clear, he's a witness who has appeared  
 17 on a number of occasions in the Inquiry already,  
 18 Professor Woolhouse is a consultant epidemiologist based  
 19 in the Usher Institute at Edinburgh University?

20 **A.** That's right, yes.

21 **Q.** If we could have a look at the email, at the bottom page  
 22 that you can see there, at the top passage, he says:

23 "The obvious concern (increased by yesterday's not  
 24 unexpected announcement of human-to-human transmission)  
 25 is that this become a pandemic, and therefore will  
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1 affect Scotland. This is not yet certain, but in my  
2 judgement it is likely, certainly sufficiently likely  
3 that we should be prepared for the eventuality. Other  
4 colleagues share this view."

5 There are some instructive parallels with the H1N1  
6 pandemic in 2009-10. Indeed, one possibility is that  
7 this could turn out to be quite similar in some key  
8 respects: a widespread epidemic fuelled by mild cases  
9 but with mortality among vulnerable patients."

10 So at that stage, as you say, Professor Woolhouse's  
11 position in intimating his concerns to Dr Calderwood is  
12 that there are still some uncertainties about the  
13 position, but that he considers that a threat to  
14 Scotland is sufficiently likely; yes?

15 **A.** That's certainly my reading of his email and also the  
16 discussions that I was privy to at that time with  
17 Professor Woolhouse.

18 **Q.** And I think what he has -- a piece of factual  
19 information, if you like, rather than assessment or  
20 opinion, is that evidence had arisen the previous day of  
21 human-to-human transmission, that's referred to in the  
22 email?

23 **A.** So that was at the stage where it was just becoming  
24 evident that there were -- rather than transmission from  
25 an animal source to human, that there were -- there was

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1 identified, particularly if there were mild cases which  
2 could mimic many other diseases.

3 **Q.** And in this email he also raises the possibility of the  
4 severity of any ultimate epidemic in Scotland, were it  
5 to arrive; is that correct?

6 **A.** So I recall both within -- I can read within this email,  
7 but I also recall within other correspondence from Mark  
8 that he rose that it had the potential to do that, but  
9 again emphasised within each of those that there was  
10 great uncertainty about that.

11 **Q.** Yes. It is fair to say that there's a degree of  
12 uncertainty; certain things are expressed at the level  
13 of likelihood and others at the level of possibility.

14 What I would be interested in knowing is what the  
15 response was within your office, if you like, on behalf  
16 of Dr Calderwood, and indeed what advice was provided to  
17 ministers to put this on their radar, if you like?

18 **A.** I would love to be able to answer that question for you  
19 with the degree of detail that I suspect you're looking  
20 for, but I'm afraid that I wasn't sufficiently close to  
21 those discussions that you speak about, what there  
22 existed between Dr Calderwood and ministers, to be able  
23 to give you that with any kind of clarity. What I do  
24 recall from the conversations with Dr Calderwood was the  
25 concern that she had that she was using this information

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1 now evidence of distinct human-to-human transmission, ie  
2 the virus had now been able to evolve to an extent that  
3 it had the potential to certainly cause at the very  
4 least an outbreak, if not an epidemic or even  
5 a pandemic, in human form.

6 **Q.** Thank you for that. What I'm trying to highlight is  
7 that the evidence of human-to-human transmission is very  
8 significant in trying to work out the potential threat,  
9 isn't that right?

10 **A.** That is correct.

11 **Q.** Thank you.

12 He also, and it's fair to say that this is much more  
13 at the state of possibility rather than likelihood, says  
14 that this could be an epidemic fuelled by mild cases,  
15 with mortality amongst vulnerable patients like the H1N1  
16 threat had been.

17 Would this tend to suggest, if the epidemic were to  
18 be fuelled by mild cases, that testing, though  
19 an important part of trying to contain the virus, may  
20 miss cases as mild patients may not report for -- to  
21 undergo a test?

22 **A.** One of the key considerations at this stage would have  
23 been to what degree can viral substance be obtained in  
24 order to develop tests which would identify with  
25 sufficient confidence that the virus itself could be

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1 from Professor Woolhouse to corroborate information  
2 which was coming from other sources and to try to gain  
3 a -- a kind of -- a sense, a better all round picture of  
4 exactly the degree of threat.

5 I think she commits, in this email chain, to kind of  
6 taking that in to further discussion with other CMOs,  
7 where again it was recognised that there was a threat  
8 here which was certainly emerging, and that that threat  
9 was at that stage being fully assessed through the  
10 NERVTAG, which is the appropriate committee for  
11 assessing the threat from emerging respiratory viruses.

12 **Q.** Whilst it might be entirely understandable, as you were  
13 not the CMO at the time, that you're not across the  
14 detail of precisely what might have been said to  
15 ministers, are you at least aware of whether  
16 conversations took place with ministers about this  
17 threat at this time, by --

18 **A.** I'm aware --

19 **Q.** -- Dr Calderwood or others?

20 **A.** I'm aware of the intention that she had, but I'm not  
21 aware of the timing of any of those conversations,  
22 I'm afraid. I'm afraid I would be speculating on those.

23 **Q.** So she intended to convey it but you don't know whether  
24 she did convey these matters, either generally or  
25 specifically?

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1 **A.** What I recall from the discussions was her concern and  
 2 the discussions that she initiated across government  
 3 with fellow health and social care directors and the  
 4 regular dialogue which she was having, even at that  
 5 time, with ministers, particularly the  
 6 Cabinet Secretary, in relation to the degree of threat.  
 7 But what was said in those conversations I'm afraid  
 8 I don't know.

9 **Q.** Are you aware of any information or advice being  
 10 communicated around this period about the possibility of  
 11 asymptomatic transmission?

12 **A.** There's a great deal of uncertainty about asymptomatic  
 13 infection and asymptomatic transmission, two separate  
 14 things and which need to be taken as two very separate  
 15 entities.

16 Certainly by the stage that we were getting towards  
 17 the end of January we recognised that it was possible  
 18 that there was asymptomatic infection. What was very  
 19 unclear at that stage was whether that asymptomatic  
 20 infection could actually lead to asymptomatic  
 21 transmission. And even six months later, in July, we  
 22 still had opinion from the WHO where they were still  
 23 stating at that point that further research was needed  
 24 to establish whether there was asymptomatic transmission  
 25 or not. But asymptomatic infection certainly was

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1 **Q.** But you're aware of the systems which existed for  
 2 providing advice to ministers at that time?

3 **A.** I'm aware that sometimes that advice was given directly  
 4 in conversations and sometimes that advice was given in  
 5 written form.

6 **Q.** So over this period, it's at least possible that advice  
 7 could have been tendered by Dr Calderwood to the  
 8 First Minister or the Cabinet Secretary for Health and  
 9 Sport orally about the matters contained within this  
 10 email?

11 **A.** It is feasible that that could be happened, but, as  
 12 I say, you're asking me to speculate on something which  
 13 I was not directly involved in and I'm afraid I can't  
 14 give you an accurate answer to that.

15 **Q.** In the email Professor Woolhouse points out, again on  
 16 the second page, just below the passage we looked at  
 17 before, he says:

18 "Such an epidemic would be difficult to track. As  
 19 in 2009-2010 what would be needed is an integrated  
 20 surveillance set up that combines clinical surveillance,  
 21 genomic surveillance, and serological surveillance.  
 22 (The latter requiring an appropriate test; we and, I am  
 23 sure, many others are working on this already). This  
 24 should be unexceptionable. My reasons for writing now  
 25 is to emphasise that, that based on experience of

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1 considered a possibility at that stage.

2 **Q.** Are you aware of any advice being tendered to any  
 3 ministers around this time, by Dr Calderwood or others,  
 4 about the possibility of asymptomatic or mildly  
 5 symptomatic transmission?

6 **A.** I am not aware of any discussion in relation to that at  
 7 all, I wasn't privy to that.

8 **Q.** These are potentially very, very significant revelations  
 9 being made by Professor Woolhouse; is that not correct?

10 **A.** These are concerns which have been raised by  
 11 Professor Woolhouse, which were being raised in  
 12 a variety of different areas. You know,  
 13 Professor Woolhouse had taken the time to express his  
 14 concerns directly to the CMO, but I am aware that very  
 15 similar concerns were beginning to be spoken about  
 16 amongst other epidemiologists at that point in time, in  
 17 fact were being reported through some of the discussion,  
 18 even in the early stages of SAGE and NERVTAG, that this  
 19 virus had the potential to be an incredibly significant  
 20 development.

21 **Q.** Given that significance, if advice had been tendered by  
 22 the Chief Medical Officer at that time, Dr Calderwood,  
 23 or others, would that not have been done in writing?

24 **A.** I -- I think you're asking me to speculate on something  
 25 that which I can't answer.

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1 2009-10, that systems needs to be put in place in  
 2 advance of the arrival of the virus, so the sooner the  
 3 better. If we wait until after the virus has arrived  
 4 then we will miss information of public health value and  
 5 our efforts to prevent [or] control the epidemic will be  
 6 compromised."

7 So the general message that Professor Woolhouse at  
 8 least is trying to convey is that his experience of  
 9 dealing with epidemics, pandemics of this nature is that  
 10 one needs to act decisively and quickly otherwise it  
 11 will be too late?

12 **A.** Yeah, I mean, I think everything that  
 13 Professor Woolhouse says there is ... is straight out of  
 14 the health protection playbook. It's surveillance being  
 15 a particularly important part of identifying the  
 16 possibility of cases. To do that you can either try to  
 17 identify them through clinical means, which is  
 18 a syndrome of symptoms which are so specific and  
 19 sensitive to that illness that they're easy to pick up  
 20 clinically, or a testing infrastructure which allows the  
 21 disease to be identified by laboratory means. In this  
 22 case, because the symptoms were relatively non-specific,  
 23 it relies largely on the -- particularly at this time of  
 24 the year, when there's so many respiratory viruses  
 25 circulating, it relies on the development of -- the

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1 identification of material to be able to develop a test  
 2 which can then be used and deployed at scale to be able  
 3 to identify the virus.

4 **Q.** When did a test become available to Scotland?

5 **A.** I don't recall the first available date, but the first  
 6 instances of us being able to test were led by our NHS  
 7 laboratories, with two regional laboratories in Glasgow  
 8 and Edinburgh being able to offer approximately 300 or  
 9 so tests a day between them in order that we try to  
 10 identify those.

11 **Q.** I think you're referring there to facilities that were  
 12 opened up in March in order to provide tests, but what  
 13 I was wanting to know is: obviously one has to go  
 14 through a process of genomic sequencing which leads to  
 15 a test. That test needs to be put together and then it  
 16 gets scaled up. When was the test first available, do  
 17 you remember?

18 **A.** I don't recall the exact date when the test was first  
 19 available. I recall in the very early stages, when the  
 20 first potential cases were identified, testing at that  
 21 time was so limited that samples had to be transported  
 22 through special procedures to reference laboratories,  
 23 public health laboratories. I think there's perhaps  
 24 only one in the United Kingdom who was able to operate  
 25 the test at that time.

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1 **LADY HALLETT:** Right. Sorry, I misunderstood.

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

3 So the position is that you were party to  
 4 discussions, so you know about the discussions, and  
 5 you've outlined some of the content of those, but you  
 6 weren't privy to the actions which Dr Calderwood might  
 7 have taken as a result of those discussions and these  
 8 concerns. I think you mentioned that in your evidence  
 9 earlier, that that was broadly your --

10 **A.** I would love to be able to expand on the detail of that,  
 11 but I think those questions are best directed to  
 12 Dr Calderwood.

13 **Q.** Is it the case that the types of surveillance systems  
 14 which Professor Woolhouse was urging ought to be set up  
 15 as soon as possible to try to get ahead of the virus  
 16 started to be set up from this point or not?

17 **A.** The type of surveillance systems that  
 18 Professor Woolhouse refers to, as I say, they can be  
 19 done in two ways. They can be done by symptom  
 20 surveillance, syndrome surveillance, we still have the  
 21 mechanisms to be able do that. At that point in time,  
 22 though, it was at the time of the year with high  
 23 circulating levels of respiratory virus, so symptom  
 24 surveillance would have added relatively little  
 25 information in terms of the specificity of the threat

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1 **LADY HALLETT:** Sorry, could I just ask a question?  
 2 Could I go back to the email where  
 3 Professor Woolhouse intervened? He raised the  
 4 possibility of a very serious threat to Scotland, and by  
 5 the sounds of it this resonated with both you and your  
 6 predecessor as CMO, because you'd heard similar concerns  
 7 elsewhere. What I don't understand at the moment,  
 8 Professor, and I'm not sure if you're the one to answer  
 9 or whether it should be your predecessor, but why didn't  
 10 the CMO talk to you, her deputy, about this potentially  
 11 serious threat to the country?

12 **A.** She did, my Lady.

13 **LADY HALLETT:** She did?

14 **A.** She spoke to me on a regular basis about it, and we  
 15 discussed Professor Woolhouse's advice and we discussed  
 16 both his advice in the context of advice that she was  
 17 already receiving from other people and from other  
 18 committees at that point in time as well. So it  
 19 shouldn't be misunderstood that this was happening in  
 20 a vacuum at all, this was happening in a way where  
 21 information was being developed from a variety of  
 22 different sources. What I am unable to say is --

23 **LADY HALLETT:** What she then said?

24 **A.** -- is the timing and the exact nature of what she said  
 25 to others.

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1 that was presented to the country.

2 **Q.** But that's not, I think, what Professor Woolhouse was  
 3 suggesting.

4 **A.** The second mechanism at which you could have done that  
 5 would have been to set up a kind of laboratory  
 6 surveillance mechanism. Now, that relies on the  
 7 development of tests which are then scaled to  
 8 a sufficient level that you're able to use and deploy  
 9 that testing in that way, and unfortunately that takes  
 10 time.

11 **Q.** But there are even -- what I think is being urged here,  
 12 Professor Woolhouse recognises that work is being done  
 13 on a test, what he seems to be suggesting is that the  
 14 systems which would go around the test once it becomes  
 15 available could be put into place such that when a test  
 16 does become available, those systems are ready to start  
 17 the scaling up process that you've talked about. Was  
 18 action taken at this time to put those systems in place?

19 **A.** So there are recognised surveillance mechanisms across  
 20 the UK then Scotland and elsewhere in the UK whereby  
 21 that type of surveillance was already used through  
 22 GP practices, what we call sentinel surveillance. And  
 23 once a test was available in sufficient numbers to be  
 24 able to do that, people who presented with symptoms  
 25 which may have been suggestive of the disease could have

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1 been tested for it in order to identify them.

2 The deployment of that test into that environment is  
3 probably a simpler process than the development of the  
4 test to get to sufficient scale that you have got  
5 sufficient capacity in the testing in the laboratories  
6 to be able to test in that manner. And that takes --  
7 that's probably the real limiting step in terms of the  
8 approach here.

9 **Q.** It's been suggested by reference to a notebook provided  
10 by a civil servant called Mr Grieve, whom you will know,  
11 that around this period, although he was attending  
12 various meetings, I think perhaps some of the ones you  
13 were attending as well, of committees, that there was  
14 a general lack of awareness within the department of --  
15 the directorate, sorry, of health and social care, and  
16 indeed more widely within Scottish Government, as to the  
17 urgency of the threat.

18 Would you accept that that was indeed the position,  
19 and would you accept that that is in stark contrast to  
20 what is being urged by Professor Woolhouse?

21 **A.** I am surprised to hear that, because certainly the  
22 conversations that I was party to during that time,  
23 particularly in late January and early February, was  
24 that this was a very urgent threat which had been  
25 identified and which people really needed to turn their

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1 departments in Scotland and the rest of the UK to make  
2 sure that information was being shared between them,  
3 that Scotland was able to kind of -- to be part of any  
4 moves to kind of deploy testing as it became available  
5 at that stage. As I say, first of all through the NHS  
6 laboratory system, then gradually, as it was recognised,  
7 just the degree of capacity that would be required, how  
8 other laboratory systems could come in and assist the  
9 NHS in that testing as well.

10 So a whole series of things which began to take  
11 place in order to try to prepare health and social care  
12 for what was likely to come ahead. And in the meantime  
13 to try to identify when there were cases, potential  
14 cases in Scotland, so that the right health protection  
15 measures could be taken around about them.

16 **Q.** It would have been predictable at this stage that if  
17 something of the nature of the threat which  
18 Professor Woolhouse was setting out were to become  
19 reality, there would be a number of logistical things  
20 that would be necessary to put in place to try to  
21 protect not only potential victims but also the  
22 healthcare staff that would be required in hospitals and  
23 in social care settings against the virus so that they  
24 could adequately deliver care to those who were sick.

25 What steps were taken over this period to try to secure

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1 attention to.

2 And I think the evidence of what I saw at that time  
3 was that certainly health and social care directors were  
4 very focused upon this. I can't comment on other parts  
5 of government as to how significantly they took the  
6 threat, but my recollection, my observation from that  
7 time, was that health and social care directors were  
8 incredibly worried about the potential that this threat  
9 had. And let me assure you that Dr Calderwood left  
10 people in no doubt that that was the case. In the  
11 conversations that I was party to with fellow  
12 directors, it was very clear that she saw this as  
13 something which needed to be prioritised.

14 **Q.** But you can speak directly, I think, to conversations to  
15 focus, you've mentioned, to worry, but not to action?

16 **A.** The implication behind my remarks there is that action  
17 would then be taken in terms of getting organised and  
18 preparing, and at that stage --

19 **Q.** What action was taken to prepare? Action not worry,  
20 conversation or focus.

21 **A.** So one of the earliest aspects of this that I remember  
22 was ensuring that we had briefing mechanisms to make  
23 sure that situational awareness of the degree of threat  
24 was understood by aspects of the health service, that  
25 within -- proper links were established between

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1 greater supplies of personal protective equipment for  
2 those people?

3 **A.** I don't recall specifically how that was approached,  
4 I wasn't directly involved in much of that stuff,  
5 although there were points in time when I was asked to  
6 communicate with the system, I think probably towards  
7 late February, early March, about the use of some of the  
8 equipment. But that was overseen by a particular unit  
9 of health and social care called "health resilience",  
10 and I'm afraid I wasn't directly involved in their work  
11 there.

12 **Q.** Thank you.

13 You mentioned earlier some difficulties which you  
14 had experienced with regard to getting access to  
15 information which you were, I think, primarily, and  
16 understandably, deriving from SAGE and NERVTAG at that  
17 stage. Was the type of information that you were trying  
18 to get the type of information that Professor Woolhouse  
19 was giving you on a plate?

20 **A.** No.

21 **Q.** Why?

22 **A.** No.

23 **Q.** What was the information you were having difficulty in  
24 getting?

25 **A.** The type of information which I was trying to glean more

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1 information about was the timing of interventions in  
 2 particular, to try to understand from SAGE and the  
 3 scientists who were engaged there, their best advice as  
 4 to when particular approaches should be implemented in  
 5 order to have their effect. And it seemed, particularly  
 6 through the conversations in the early part of March,  
 7 that it was at that stage less clear as to when some of  
 8 those interventions should be brought into play.

9 **Q.** Okay, let's explore that a little more. Are we talking  
 10 about here what one might call non-pharmaceutical  
 11 interventions?

12 **A.** Yes, we're talking about the NPIs here, and --

13 **Q.** Yes, we have been through an explanation of what that is  
 14 and the various forms that might take.

15 So you mentioned that you had been seeking advice  
 16 about the NPIs and when they might be used profitably,  
 17 in early March. Had you sought information about that  
 18 before that point?

19 **A.** The -- so the -- in terms of the NPIs before that point,  
 20 there was still much discussion about how NPIs should be  
 21 used and what -- whether non-pharmaceutical  
 22 interventions could be used in isolation or whether they  
 23 needed to be used in, if you like, baskets or bundles of  
 24 different approaches together. So much of the  
 25 discussion through SAGE, particularly through the

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1 which was about at what point and what would be the  
 2 triggers for the deployment of societal measures which  
 3 would be deeply unpleasant for society to experience and  
 4 which we would need the significant support of the  
 5 population in order for them to be effective and to be  
 6 able to sustain those for a period long enough that they  
 7 would continue to have their effect.

8 You mentioned earlier the role of behavioural  
 9 science at that stage, and behavioural science was  
 10 an important feature of the discussions at that point in  
 11 time, when many papers were fed in from SPI-B as to what  
 12 we might expect in terms of a response from the  
 13 population to a variety of different approaches.

14 But what I wasn't clear on at that stage yet and  
 15 which -- what I didn't see from SAGE was formal advice  
 16 as to really what the trigger might be for deploying  
 17 those either singular or multiple interventions, and how  
 18 we should watch for that.

19 Eventually it settled, as you know from papers which  
 20 you'll have seen. And there was a variety of triggers  
 21 which were suggested. Most of the data that we were  
 22 using at that point, of course, was unfortunately of  
 23 lagged data, it was health outcome data such as either  
 24 hospital admission, ICU admission or even the  
 25 possibility of the number of deaths that we were likely

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1 modelling groups, with much of it coming from SPI-M, was  
 2 actually how would you achieve the desired effect.

3 Once you began to understand the transmission rate  
 4 particularly of the virus and the R values that were  
 5 associated with it, how you would begin to slow that  
 6 down to the extent that the NPIs could actually have the  
 7 desired effect, or whether that was using one or two  
 8 NPIs in isolation, or whether in fact it needed a much  
 9 broader approach to try to reduce the scale of infection  
 10 at that point in time. There then became the question  
 11 as to when was the best point in time to try to deploy  
 12 those NPIs, and a great deal of discussion through that  
 13 group as to what the likely impacts of deploying those  
 14 NPIs, either in isolation or collectively, would have  
 15 both in halting the virus at that stage but also  
 16 potentially simply saving up more impact and trouble  
 17 with a bigger wave once those were released at a later  
 18 stage. There was still some uncertainty through the  
 19 modelling as to what the impacts would be.

20 **Q.** I think if I heard your evidence correctly that you  
 21 mentioned some difficulty in ascertaining information  
 22 about the best timing in early March. Could you expand  
 23 on that a little? What was the difficulty that you  
 24 experienced?

25 **A.** So what we heard at that stage was a lot of discussion

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1 to see. But that lagged data was one of the things  
 2 which was suggested and proposed as a trigger event for  
 3 the institution of those type of measures.

4 **Q.** What was your understanding of the role of behavioural  
 5 fatigue in the advice and discussion that was taking  
 6 place around that period?

7 **A.** So behavioural fatigue was something which was  
 8 acknowledged. I remember discussions at SAGE at the  
 9 possibility that the deployment of particularly severe  
 10 restrictions on everyday life might lead in some parts  
 11 of the population to behaviours and fatigue in terms of  
 12 compliance with those measures, which could actually  
 13 cause a wave to develop which would be, at that stage,  
 14 fairly significant in terms of the impact on the  
 15 population.

16 **Q.** So was it the case that you were under the impression  
 17 that advice had been received from experts, including  
 18 from SPI-B, relating to behavioural fatigue and that it  
 19 should play a role in determining when and if a lockdown  
 20 should be imposed?

21 **A.** I would characterise advice on behavioural fatigue as  
 22 one of many aspects which were considered in the round  
 23 in terms of the timing for the deployment --

24 **Q.** But did you understand that SPI-B had given such advice?

25 **A.** I understood that SPI-B had raised concerns that

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1 behavioural fatigue may be a consideration in terms of  
2 the approach. What at that stage was unclear was  
3 whether fear of the impact of the virus and the impact  
4 of that on the population, the impact of that fear in  
5 the population would outweigh the fatigue that they may  
6 experience.

- 7 **Q.** I think you also mentioned a moment ago that there was  
8 some consideration around this time that the possibility  
9 of a bigger wave of the virus was playing some part in  
10 the consideration about the timing of the imposition of  
11 restrictions or ultimately a lockdown. What was your  
12 understanding of the position in that regard? How  
13 important was that a factor?
- 14 **A.** I recall discussions through SAGE where what I heard  
15 recounted were concerns through some of the models which  
16 had been developed that actually by reducing the initial  
17 impact and mitigating that, if measures were not  
18 sustained for a long enough time then the release of  
19 those measures, either through non-compliance or because  
20 of the harm it was causing to other parts of  
21 socioeconomic infrastructure within the country, would  
22 release an even bigger wave of infection amongst  
23 a population that was still immune naive to a virus  
24 which was likely to circulate very quickly. A lot of  
25 the initial discussion centred upon how long would it be

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1 verbal advice given, there may have been written advice  
2 given, but I can only speak from my own experience in  
3 relation that rugby match, in that I wasn't asked to  
4 provide advice in relation to that.

- 5 **Q.** Would it have been the sort of thing on which advice  
6 would have been useful? Given the fact that you were  
7 accessing information via SAGE and NERVTAG about these  
8 emerging international cases, would it have been useful  
9 for that to have been communicated, whether it was or  
10 not, in decision-making about whether that match should  
11 have been allowed to go ahead?
- 12 **A.** So my own view is that the whole question of  
13 international travel at that point in time is something  
14 which I think would have been very important to have  
15 a very risk-averse position in relation to at that  
16 stage.
- 17 **Q.** A further international rugby match took place in  
18 Scotland, between Scotland and France, on 8 March.  
19 France, as I understand it, was the first country in  
20 Europe to have a death from coronavirus, and on the day  
21 of the match France reduced the number of people allowed  
22 at mass gatherings to 1,000, and I understand around  
23 67,000 people attended the match at Murrayfield on  
24 8 March. Again, are you aware of any advice having been  
25 tendered to Scottish Government by the Chief Medical

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1 necessary for those measures to stay in place and would  
2 it be necessary to have some degree of braking, if you  
3 like, from spread on a periodic basis until either  
4 sufficient therapeutics were available to intervene or  
5 a vaccine was available to try to give the population  
6 protection.

- 7 **Q.** Evidence emerged of growing infection in Italy in late  
8 February, I think. Do you recall that?
- 9 **A.** I do, yes.
- 10 **Q.** Scotland's international rugby team played rugby in Rome  
11 on 22 February, and the international women's team had  
12 been due to play in Legnano just outside Milan in the  
13 Lombardy region the 23rd, that match having been  
14 cancelled due to local concerns about Covid. Do you  
15 recall the Chief Medical Officer or anyone in the  
16 department of which you were part being asked to give  
17 any advice about the advisability of that match  
18 continuing given concerns about infection rates in that  
19 very part of Italy?
- 20 **A.** I guess in the -- that's -- all I can speak for is that  
21 I wasn't approached for advice myself. That's all  
22 I was --
- 23 **Q.** If such advice had been provided, would it have been  
24 provided in writing?
- 25 **A.** I would -- in a situation like that there may have been

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1 Officer or your directorate about the advisability of  
2 that match being allowed to proceed on Scottish soil?

- 3 **A.** Again, I can only speak from my perspective, and I was  
4 neither approached nor did I give advice in relation to  
5 that rugby match.
- 6 **Q.** And again, would one have expected that advice, if  
7 given, to have been provided in writing?
- 8 **A.** Again, I think I have to say that that advice may have  
9 been given in writing but it may also have been given  
10 verbally. I'm afraid I don't know whether that was  
11 sought or given.
- 12 **Q.** Thank you.

13 Could I ask to have INQ000371227 put up on the  
14 screen, please. I'm looking at page 77.

(Pause)

Excuse me just one second.

(Pause)

18 Sorry, I'm looking, as it appears, at the top left  
19 corner where it says "CMO CALL", just focus in on that.  
20 No, the top left-hand corner, "CMO CALL".

21 We think that this entry comes from 16 March 20 --  
22 this is from your handwritten notebook, Professor. We  
23 think it comes from 16 March, where it says:

24 "WHO -- general view that WHO been unhelpful; Test  
25 Test Test being a particular example of

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1 misrepresentation."

2 Is that -- could you explain what it is that you  
3 felt had been a misrepresentation of the "test, test,  
4 test" message?  
5 **A.** So testing was an incredibly important aspect of the  
6 response and testing had to be ramped up really as  
7 quickly as we possibly could, both in terms of the  
8 infrastructure to be able to conduct testing but also  
9 during that period, while the capacity for testing was  
10 available, was to use it in a prioritised way, and it  
11 was the view of the CMOs that testing at that stage was  
12 most important in identifying people for clinical  
13 purposes to know whether they had Covid or not, to  
14 differentiate it from other forms of illness which may  
15 need treatment, but also then to isolate them in a way  
16 that tried to reduce that transmission to other people  
17 as well. And testing should be prioritised in that  
18 sense in order -- whilst the capacity to test was  
19 increasing. And WHO certainly viewed testing as being  
20 very important, but perhaps in the messaging around  
21 about testing they were not perhaps as nuanced in their  
22 messaging in terms of how it should be used.

23 **Q.** Right. So that was what you considered to be  
24 a misrepresentation?

25 **A.** Yep. Testing -- there was a strong clinical view, not  
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1 involved to try to increase the capacity around testing  
2 as quickly as possible. That involved using not only  
3 the NHS laboratory infrastructure but also in linking  
4 with other public health laboratory infrastructure and  
5 university infrastructure to try to kind of develop  
6 sufficient number of tests across the country using all  
7 means possible.

8 You'll recall that at this particular stage there  
9 were all sorts of difficulties with even getting the  
10 testing reagents from around the world and procuring  
11 testing reagents that were necessary. But what  
12 I witnessed was incredible efforts from the teams  
13 involved in testing to try to make sure that Scotland  
14 and the UK were positioned as importantly as possible.  
15 I don't think anyone ever underestimated the importance  
16 of testing, but it certainly wasn't easy for these teams  
17 in developing it at that time. And I think one of  
18 the -- one of the major lessons which certainly I would  
19 want to see carried through following this, and I'm very  
20 glad it's been captured within the report of the  
21 Standing Committee on Pandemic Preparedness, is to make  
22 sure that we've got an infrastructure which is  
23 sufficiently agile enough, particularly around about  
24 testing, and a public health reference laboratory  
25 testing infrastructure would, for me, be ideal for it to  
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1 just held by the CMOs but held across the profession,  
2 that testing was incredibly important to -- so that when  
3 faced with a patient who had the potential to have Covid  
4 in front of them, first and foremost we had the ability  
5 to be able to determine whether it was Covid or whether  
6 it was another treatable disease. And then of course if  
7 it was Covid that takes you down a whole pathway of  
8 treatment which necessitates a different -- a wholly  
9 different approach both in terms of isolation, contact  
10 tracing, et cetera.

11 **Q.** Was what was unhelpful about the WHO's message that  
12 although it set out a clear priority that testing was  
13 necessary to try to combat this disease, that Scotland  
14 was simply not practically ready to undertake that  
15 testing? Was that what was unhelpful about this  
16 message?

17 **A.** One of the things that I think was misrepresented here  
18 by WHO in those early stages was actually the  
19 difficulties in trying to increase the capacity  
20 sufficiently quickly to develop a testing at scale.

21 **Q.** So they were saying "You should test, test, test", and  
22 Scotland said "We couldn't, couldn't, couldn't"?

23 **A.** I think that is perhaps a characterisation which is  
24 unfair. I think Scotland recognised the need for  
25 testing, and great efforts were made by the teams  
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1 be able to turn its attention to emerging threats as  
2 they were identified in a way which was different from  
3 our experience in February and March of 2020.

4 **Q.** So for future pandemic preparedness, you think it's  
5 extremely important that the infrastructure is  
6 maintained to enable all of the testing that's required  
7 to be put into action as quickly as possible?

8 **A.** That's one of the major pieces of learning that I would  
9 certainly want to single out from this, is that there  
10 are particular parts of infrastructure which were put in  
11 place that, whilst we could never maintain at the levels  
12 that existed during the height of the pandemic,  
13 certainly need to be there in a way where we could pivot  
14 in as agile a way as possible --

15 **Q.** So one might say the core of that existing  
16 infrastructure needs to be maintained for future  
17 pandemics?

18 **A.** And some of that might be laboratory space and some of  
19 that might be laboratory expertise and resource in  
20 individuals, but I do think that it's really important  
21 that as a country we have a laboratory system which is  
22 preserved and invested in in the coming years. But  
23 that's one of the things I would like to see --

24 **Q.** I have one other question about testing but before we go  
25 off what's on the screen, just at the same point there  
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1 you make a note relating -- I think it says:  
 2 "SAGE -- masks  
 3 "-- likely to recommend."  
 4 Was it your understanding at that stage that SAGE  
 5 was likely to recommend something to do with face masks?  
 6 Is that what that's referring to?  
 7 **A.** Yeah, at this stage it was very unclear just exactly how  
 8 advice was going to be developed around about masks and  
 9 coverings, face coverings, noting that there's  
 10 a distinction between the two. And eventually the  
 11 recommendation from SAGE was that it was face coverings  
 12 rather than face masks. But I think those are two  
 13 separate items which you see on screen there, the two  
 14 dashes.  
 15 **Q.** I see. So they were discussing masks but they were  
 16 likely to recommend something else?  
 17 **A.** You know, with the passage of time I can't speak with  
 18 accuracy as to exactly what that annotated comment  
 19 means, but I do remember there being discussion in SAGE  
 20 in relation to -- and debate as to whether face masks or  
 21 face coverings were likely to be the preferred option.  
 22 **Q.** Right.  
 23 Just on testing again, could I take you, please,  
 24 to -- we mentioned Professor Crossman earlier, to his  
 25 statement, which is INQ000273976. I'm looking at  
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1 Scottish Government's response ..."  
 2 Could it be taken from that, do you think, that the  
 3 Scottish Government had no strategy for testing until  
 4 Professor Crossman helpfully offered his services?  
 5 **A.** I think that could be one reading of what  
 6 Professor Crossman has said in his statement.  
 7 **Q.** If that were the case, would that be a fair reflection  
 8 of the reality?  
 9 **A.** I think at that stage the Scottish approach to testing  
 10 was very much mirroring those which were happening in  
 11 other the UK nations in terms of the prioritisation of  
 12 testing. However, I think what Professor Crossman and  
 13 his colleagues did very successfully was to take what  
 14 was a rather informal approach and to formalise that  
 15 within a written strategy so that people could be very  
 16 clear as to how testing was going to be developed and  
 17 prioritised for different purposes.  
 18 **Q.** I think he describes it as the absence of a testing  
 19 strategy. That doesn't tend to suggest that there was  
 20 one at all.  
 21 **A.** I think you would have to ask Professor Crossman in  
 22 greater detail, but what I would take from that is that  
 23 there wasn't a written strategy.  
 24 **Q.** Thank you.  
 25 **LADY HALLETT:** Except he contrasts it with the position in  
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1 paragraph 10.  
 2 Professor Crossman played a significant role in the  
 3 testing side of things; is that correct?  
 4 **A.** He did.  
 5 **Q.** Yes, thank you. He says there:  
 6 "From January until around the middle of March 2020,  
 7 I was not involved in pandemic management. I could see  
 8 that individuals with governmental advisory function in  
 9 the other nations were having some role in pandemic  
 10 response and I was aware that some strategies were  
 11 emerging for example in testing for [I think it's meant  
 12 to be SARS-CoV-2] infection. I was not formally asked  
 13 to expand my role but it was the absence of a SARS-CoV-2  
 14 testing strategy in Scotland when there was one in  
 15 England and Wales that caused me to contact  
 16 Catherine Calderwood (then CMO) and bring this to her  
 17 attention as I was concerned that without the ability to  
 18 test for the causative agent the pandemic would be  
 19 unmanageable. At that stage I offered my services to  
 20 the CMO to help with the response. The CMO responded  
 21 that it would be helpful to have a strategy but if I was  
 22 going to do this it needed to be done quickly.  
 23 I responded and delivered the first strategy with a  
 24 civil servant (Mary Stewart ...) by the 28th March and  
 25 this seemed to establish me as a useful adviser to the  
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1 England and Wales where there was one, and you said that  
 2 Scotland was then mirroring the rest of the UK.  
 3 **A.** That was my recollection of it, was that the discussion  
 4 there that certainly happened in clinical circles at  
 5 that point in time was that Scotland was taking  
 6 a similar approach to other countries in the UK, but  
 7 there was no written strategy that backed that up.  
 8 **LADY HALLETT:** Well, we'll check with Professor Crossman.  
 9 **MR DAWSON:** Thank you.  
 10 Moving on to a slightly different area but in the  
 11 same time period, we've heard some evidence already from  
 12 Dr McMenamin and Professor Phin about the well known  
 13 Nike conference. I only want to focus with you on one  
 14 aspect of that.  
 15 Could we go to INQ000225995, please.  
 16 This is an exchange concerning this very thing. It  
 17 mentions you, I think, having some involvement. Do you  
 18 recall discussion around this early period to do with  
 19 the -- what should be said about concerns that were  
 20 arising around the Nike conference at this time?  
 21 **A.** Yeah, I mean, I recall coming into this at a kind of  
 22 latter stage. I think by this point in time the first  
 23 cases had already been identified and an incident  
 24 management team was up and running in relation to it,  
 25 and my recollection is that the CMO fed into that  
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1 process. I came into it, as I say, at probably a later  
2 stage when there was beginning to be a little bit of  
3 concern as to what was being said --

4 **Q.** I think broadly what this is showing is this is the  
5 chief of staff of the First Minister, Nicola Sturgeon,  
6 looking for some advice about what should be said around  
7 it, because I think you've identified by this point,  
8 which is towards the beginning of March, there had been  
9 some efforts in connection with this event to try to --

10 **A.** Yeah.

11 **Q.** -- we heard from Dr McMenamin -- to try to trace cases  
12 and to try to work out what was going on.

13 **A.** Yeah.

14 **Q.** I think he described those as local efforts to try to  
15 deal with the situation.

16 There was, I think it fair to say, a question mark  
17 as to whether this should be publicised in particular.

18 If we go back to page 1, please, I think we see  
19 Dr Calderwood's response, relating to this. She  
20 suggests towards the bottom that her "strong advice  
21 would be not to say anything here specifically" and that  
22 "naming the conference risks breaching patient  
23 confidentiality as a delegate list will be available".

24 So it seems that the chief of staff on behalf of the  
25 First Minister had been seeking some guidance, and that

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1 actually you remove a patient's right to confidentiality  
2 in the illness which they might be experiencing.

3 So Dr Calderwood's concerns here are something which  
4 we see and encounter regularly when managing outbreaks  
5 across the country. And different clinicians will have  
6 different levels of risk tolerance in order to that, and  
7 I know that Dr Calderwood in particular was very against  
8 any circumstances whereby she may be responsible for the  
9 release of confidential patient information, and  
10 a particularly high level of -- a high risk threshold in  
11 relation to that.

12 I think when you speak to other clinicians they  
13 might have different levels of risk tolerance in  
14 relation to that. My own view in this case was that,  
15 and it's probably recorded in some of the email systems,  
16 I suspect, is that whilst it was really important to  
17 maintain patient confidentiality at all times, that  
18 there was -- in this case there was an interest,  
19 a legitimate public interest that meant that some  
20 information, some form of information --

21 **Q.** That's precisely what I was getting at.

22 **A.** -- could be released. But it had to be very, very  
23 carefully thought through, the implications of that, so  
24 as not -- particularly when there's such small numbers  
25 at this early stage of the outbreak being identified.

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1 there is a medical aspect to this in Dr Calderwood's  
2 view which connects to patient confidentiality and that  
3 her view is that, as a result of that, this shouldn't be  
4 released publicly, what has happened and what is going  
5 on to try and control it.

6 What was the issue about patient confidentiality, in  
7 the sense that could information not have been released  
8 with any patient details completely anonymised in order  
9 to keep the public informed about this potential  
10 significant threat?

11 **A.** There was a great deal of concern in those early stages  
12 about the welfare for people who had been identified as  
13 having Covid-19 and a process, a well recognised process  
14 in outbreak management, which we call deductive  
15 disclosure which is about managing the tension that  
16 exists between not giving information which could lead  
17 to the deductive disclosure or identification of  
18 a person associated with that outbreak and fulfilling  
19 legitimate public interest in terms of public messaging  
20 and transparency about any outbreak as well. And that  
21 is a tension that exists not just in relation to the  
22 response which we saw during Covid terms but it exists  
23 with every public health health protection response  
24 which exists and a real fear amongst clinicians that  
25 inadvertently by issuing particular types of advice

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1 Another word on the Nike conference, if I can,  
2 because I think it's really important that when we're  
3 speaking about the Nike conference we commend and  
4 recognise the efforts of the health protection teams  
5 that were involved in dealing with this conference,  
6 because their actions at that point in time probably --  
7 well, we now know from the evidence from the genomic  
8 sampling --

9 **Q.** We went through that, although your tribute is --

10 **A.** Yeah, handled this outbreak so thoroughly that actually  
11 we were able to -- there was no further examples of that  
12 lineage, that lineage died out in Scotland as  
13 a consequence.

14 **Q.** There were though, I think, in the same report, between  
15 290 and 310 other incursions of Covid into Scotland over  
16 this period.

17 **A.** I think this is really important to understand, when you  
18 look at the way Covid was introduced to Scotland, and  
19 this is not just in the period probably February and  
20 March of 2020 but also later on that summer when  
21 international travel began to open up, what we saw the  
22 evidence for, particularly through this relatively new  
23 discipline of genomic sampling, which was a wonderful  
24 innovation used extensively during the early part of  
25 this response to understand transmission dynamics of the

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1 virus, but what we saw was that, as you say, there were  
 2 several hundred incursions of the virus of different  
 3 types across Scotland at that point in time. So rather  
 4 than, if you like, a ground zero which occurred in  
 5 Scotland, actually that multiple seeding through  
 6 international travel that there was at that event made  
 7 it very difficult to control the virus in those early  
 8 stages.

9 **Q.** Dr McMenamin when we discussed this on Friday was at  
 10 pains to -- I'd suggested to him that perhaps a number  
 11 of these strains had come from Spain and he was at pains  
 12 to say that it came from a number of the major European  
 13 countries, including Italy and France. And of course  
 14 the Scotland rugby teams, international rugby teams,  
 15 played rugby in Italy in late February, didn't they, or  
 16 one of them did?

17 **A.** And many people from Scotland visited for skiing in  
 18 those kind of areas as well. And -- and, you know,  
 19 international tourism being as it is just now, there  
 20 will always be a risk that as infection of one sort of  
 21 another begins to show itself globally, is that there  
 22 will be further and further incursions as a consequence  
 23 of that.

24 **Q.** Equally, a number of people from France came to Scotland  
 25 to watch Scotland play France on 8 March as well?

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1 definition was removed. It also heralded the move to  
 2 delay phase of the response."

3 Furthermore -- so this gives some background --  
 4 I understand on 13 March, an announcement was made by  
 5 your predecessor -- we can take that down, thank you --  
 6 an announcement was made by your predecessor about the  
 7 first death in Scotland from Covid, and what was said at  
 8 that time by Dr Calderwood was:

9 "I am saddened to report that a patient in Scotland  
 10 who has tested positive for Coronavirus has died in  
 11 hospital. I offer my deepest sympathy to their friends  
 12 and family at this difficult time.

13 "The patient, who was being treated by Lothian  
 14 Health Board was an older person who had underlying  
 15 health conditions. No further information will be  
 16 available to protect patient confidentiality."

17 It was subsequently suggested in the press that the  
 18 person who had died was in fact a Frenchman who had  
 19 attended the Scotland rugby game. That does not feature  
 20 in the analysis given by Dr Calderwood. Is it your  
 21 understanding that that is in fact correct and why did  
 22 that not appear in Dr Calderwood's announcement?

23 **A.** I have to say to you I have no knowledge of that  
 24 whatsoever.

25 **Q.** I'd like to ask you some questions, please, about the

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1 **A.** And as you say, there were tourists come to Scotland,  
 2 and Scottish people visit other countries for a number  
 3 of different reasons.

4 **Q.** But those events were predictable and might have been  
 5 able to have been controlled?

6 **A.** I think that those are events that, with the benefit of  
 7 hindsight, you're right, they could have had an impact,  
 8 but the degree to which they've had an impact is, at  
 9 this stage, I'm afraid --

10 **Q.** Whether it's necessary to rely on hindsight will be  
 11 a matter for your Ladyship in due course. But as  
 12 regards this very matter, I wonder if I could take you  
 13 to your witness statement INQ000273978, to page 71,  
 14 paragraph 280, where you give us some useful information  
 15 about an important event. You're talking here about the  
 16 first person to test positive for Covid in Scotland and  
 17 you say:

18 "The first person to test positive for Covid-19 in  
 19 Scotland was on 1 March 2020. This person was a  
 20 returning traveller. Subsequently, the first person to  
 21 test positive through evidence of community transmission  
 22 (ie no exposure to known contact or returning traveller)  
 23 was 11 March 2020. This was significant because it  
 24 implied that Covid-19 was already spreading within  
 25 communities and so the geographic element of the case

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1 circumstances in which you came to take on the post  
 2 initially of interim CMO and subsequently as CMO in  
 3 December.

4 Could I just ask you, before we get into the detail  
 5 of that, why was it that you were appointed interim CMO  
 6 for such a lengthy period and then took over as the full  
 7 CMO, if you like, and did that have any practical  
 8 significance at all?

9 **A.** So the reason I was interim CMO for, oh, that must have  
 10 been approximately six months or so, was partly because  
 11 I was managing a pandemic at that point in time and the  
 12 appointments process to an office such as the CMO is  
 13 a fairly rigorous one and one which is overseen by civil  
 14 service commissioners, so it's a competitive process  
 15 through -- with different stages, and I think in order  
 16 to make sure that both -- usually the appointment of  
 17 a CMO is a process which takes several months from the  
 18 point of identification of potential candidates, through  
 19 advertisement, through to assessment centres which  
 20 people participate in, and then interview. And, as  
 21 I say, subsequently it was decided that sufficient  
 22 stabilisation had occurred within the system by late  
 23 2020 that that process could be begun, and still at that  
 24 point it probably took three to four months from  
 25 advertisement through to appointment.

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1 Q. But to all intents and purposes, am I correct in  
2 thinking you performed the role of the CMO, whether you  
3 were interim --

4 A. So the role of -- I guess it's important to point out at  
5 this stage that I wasn't the first interim CMO that  
6 Scotland has had, there have been instances before, from  
7 the handing of one CMO to the next, whether an interim  
8 has been appointed. In fact before Dr Calderwood took  
9 office --

10 Q. What I'm trying to get at, Professor Smith, is I just  
11 want to know whether from 5 April 2020, irrespective of  
12 the title and the various procedures, which I understand  
13 need to be followed, you were the principal medical  
14 adviser to the Scottish Government on matters relating  
15 to --

16 A. So it was exactly the same.

17 Q. Thank you.

18 You were asked in your statement whether the  
19 resignation of Dr Calderwood had had an effect on  
20 Scotland's response. You've already told us that she  
21 had been a pivotal figure, understandably, in the  
22 response up till that point. You say in your statement  
23 that:

24 "The resignation of Dr Calderwood did not affect  
25 Scotland's pandemic response and [that] the CMOD

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1 point in time.

2 Q. Is it correct to say that Dr Calderwood had  
3 a particularly close relationship, as you said, with the  
4 former First Minister, Ms Sturgeon, and the  
5 Cabinet Secretary for Health and Sport, Ms Freeman?

6 A. I think my observation would be that she had a good  
7 relationship with the former First Minister and with the  
8 Cabinet Secretary, and indeed with other ministers that  
9 she had contact with as well. She was an important  
10 figure and she was trusted, I think, by them.

11 Q. You presumably required to build a relationship, as  
12 you've described, with those two important figures in  
13 the pandemic response?

14 A. I believe that I had a trusted relationship and  
15 benefitted from a lot of contact with the  
16 Cabinet Secretary before that point in time, but  
17 I didn't have quite the level of contact or relationship  
18 that Dr Calderwood had with the former First Minister.

19 Q. I think you suggested a moment ago that the course for  
20 the Covid response had already been set by that point.  
21 Did that mean that you inherited a plan that had been  
22 devised by someone else?

23 A. At that point of time we were, ultimately I would have  
24 thought, two weeks into what later became known as  
25 lockdown. Much of the discussion was about what impact

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1 continued to provide advice to policy colleagues and the  
2 Scottish Cabinet."

3 In light of what you have already told us about the  
4 significance of her response, are you seriously  
5 suggesting this had little or no impact?

6 A. The biggest impact I had was in the workload for the  
7 rest of the directorate at that point in time. We  
8 suddenly found ourselves with an important trusted  
9 colleague who was no longer available there, who had  
10 developed relationships with ministers, and if there was  
11 any detrimental aspect of it at that point in time was  
12 that I -- during that immediate period, it was about  
13 building relationships with those ministers in order  
14 that I could provide them with advice that they were  
15 seeking from me. Over the latter course of March, my  
16 time with ministers began to increase a little bit.  
17 I had conversations with the former First Minister on  
18 several occasions, I knew the Cabinet Secretary for  
19 Health well at that stage as well. And so by that point  
20 in time I was able to slip into the role without too  
21 much detriment.

22 You'll recall that in that period the course was  
23 already set in terms of the approach, and it was -- it  
24 was very much about being able to kind of give advice,  
25 develop advice as new evidence was coming in at that

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1 was that lockdown having and how was it stabilising the  
2 drastic situation that we saw across the country, and we  
3 began to turn our attention at that stage to: if it was  
4 beginning to stabilise, then for how long did those  
5 drastic measures that we all experienced have to stay in  
6 place for and how would we begin to kind of gradually  
7 over time reduce that in as safe a way as possible?

8 Q. At the very moment of her resignation, a few days before  
9 on 1 April, Scotland's confirmed cases of Covid-19 had  
10 passed 2,000, with 76 deaths in hospital that day, the  
11 Scottish Government had just announced its ambition to  
12 deliver 3,500 tests by the end of the month,  
13 construction had just started on the SEC in Glasgow to  
14 become the NHS Louisa Jordan, and the day after her  
15 resignation the Coronavirus Act was introduced, gaining  
16 Royal Assent on 31 March.

17 In light of these very, very important developments  
18 with regard to the strategy, it's true to say, isn't it,  
19 that this was the worst moment that one could possibly  
20 find for Dr Calderwood to depart the scene?

21 A. In the management of a pandemic, particularly in the  
22 early management of a pandemic, I don't think there was  
23 any good time to lose an adviser, particularly  
24 an adviser who has built that level of trust and  
25 relationships across the system. So I don't think that

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1 there is any good time at all.

2 **Q.** Is it correct to say that there were attempts made  
3 within the Scottish Government to keep Dr Calderwood in  
4 post despite the events which led to her resignation?

5 **A.** I wouldn't be party to that, I wouldn't know.

6 **Q.** Do you know when it was that the Scottish Government  
7 became aware of the matters which led to her resignation  
8 compared to when it was that she eventually resigned?

9 **A.** I can only tell you when I became aware, and I became  
10 aware on the Saturday evening, which I think would be  
11 April 4, perhaps.

12 **Q.** I think that's right. I checked this earlier. I think  
13 April 5, the day of her resignation, she resigned late  
14 in the evening, that was a Sunday, so I think you're  
15 absolutely right.

16 **A.** So I think it would be late afternoon, early evening on  
17 the -- on Saturday the 4th that I became --

18 **Q.** The reason I ask is that there are -- I won't go into  
19 the detail, but that you will no doubt remember that  
20 obviously this was a difficult time for you and the rest  
21 of your team to have to take over responsibility, and  
22 there is some mention in some messages of the focus on  
23 Dr Calderwood being slightly difficult for the team, who  
24 was trying to keep the show on the road, understandably,  
25 and that there is a suggestion in those messages that --

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1 elsewhere at that point in time. And I already knew  
2 many of the personalities who were involved in that  
3 group, I had established relationships with them, the  
4 chair in particular I had a very trusted relationship  
5 with, and we were able to use that trusted relationship  
6 to provide advice back and forward and for me to be able  
7 to get a full recount of the meeting from. And whenever  
8 I wasn't able to attend a meeting itself I had one of my  
9 deputies delegating for me at that meeting. But really  
10 the relationships were already largely established with  
11 members of that group.

12 **Q.** Although no doubt these very eminent professionals were  
13 very well known to you, in this specific context, the  
14 context of a new group being set up to provide advice  
15 through you to ministers, which had been set up  
16 originally under the auspices of your predecessor, was  
17 it not very significant -- was it not very important for  
18 you to attend these initial meetings to try to set up  
19 the way in which the group was going to function and to  
20 establish those relationships in that particular  
21 context?

22 **A.** That type of information was conveyed through the  
23 conversations that I had with the chair at that point in  
24 time. Unfortunately it just wasn't possible for me to  
25 be everywhere at once and there were many, many calls on

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1 you refer to "the team who have been giving advice over  
2 the course of the week". It tends to suggest,  
3 therefore, that perhaps the focus on having to deal with  
4 Dr Calderwood, in a more pastoral sense, which is also  
5 suggested, had been going on for some time before her  
6 resignation, through the course of that week, which then  
7 culminated on Sunday the 5th?

8 **A.** No, that's an incorrect interpretation of that.

9 **Q.** Okay, thank you. But your first intimation of it was on  
10 the Saturday?

11 **A.** Yeah.

12 **Q.** Thank you.

13 I've asked you some questions already about your  
14 role on the Scottish Covid Advisory Group. One matter  
15 which has come up in our analysis of the group's minutes  
16 is that you did not attend the third meeting, which took  
17 place on 2 April 2020, the fourth meeting on  
18 6 April 2020, the fifth meeting on 9 April 2020, the  
19 sixth meeting on 13 April 2020, nor the seventh on  
20 16 April, nor the eighth on 20 April.

21 You mentioned a moment ago the importance of  
22 creating relationships with your ministerial and indeed  
23 other civil service colleagues. Why was it that you  
24 failed to attend these meetings?

25 **A.** Because I would have had duties or priorities that sat

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1 my time at that point in time, which just -- I couldn't  
2 be in two places at the one time.

3 **Q.** Thank you.

4 I'd like to ask you some questions -- we've covered  
5 this area with a number of other witnesses including  
6 Dr McMenamin and Professor Phin -- about the position  
7 with regard to the Chief Medical Officer's office and  
8 the minimisation of infections within care homes.

9 We've looked in some detail, and I won't take you to  
10 all the detail, Professor, with other witnesses,  
11 including Dr McMenamin particularly, at the report that  
12 was done by PHS in this regard which came out in  
13 October 2020, which helpfully sets out the pieces of  
14 published guidance that emanated from PHS with regard to  
15 the management of infection in care homes, and we've  
16 looked at the particulars of that, which I don't intend  
17 to take you to.

18 What I would be interested to know is the extent to  
19 which the Chief Medical Officer's office, because this  
20 was before you became Chief Medical Officer, was  
21 involved in the compilation and publication of the  
22 advices -- of the guidance that emanated principally  
23 from PHS on 13 March and then later in the month,  
24 I think the 26th was the other date.

25 **A.** So I don't recall any involvement. There was a separate

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1 structure which was set up to provide advice through  
 2 that to develop that guidance. I know that Public  
 3 Health Scotland and some advisers within Scottish  
 4 Government worked closely together in relation to that  
 5 guidance but I didn't have any direct involvement in  
 6 that.

7 **Q.** Right.

8 We've heard evidence or we have evidence that there  
 9 were a number of versions of the guidance created,  
 10 I think two were ultimately issued, but a number of  
 11 versions existed. It creates an impression of  
 12 a slightly chaotic picture in terms of the allocation of  
 13 responsibilities for who is meant to put together and  
 14 compile this guidance, whether it's a government CMO  
 15 type of exercise or whether it's PHS or both.

16 Do you have any recollection of that  
 17 characterisation being an accurate one over that period?

18 **A.** As I say, I wasn't directly involved, so I couldn't even  
 19 comment as to how many iterations there were.

20 **Q.** Thank you, but there were other individuals effectively  
 21 from within your directorate who were engaged in that  
 22 process, along with Dr McMenamin and others?

23 **A.** There were other government clinical advisers. Whether  
 24 they were within the directorate or not at that stage  
 25 I cannot recall.

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1 Professor Phin had suggested, there was a need as  
 2 regards testing for there to be a degree of  
 3 prioritisation amongst groups who might be tested.  
 4 Ms Lamb gave evidence to the effect that that  
 5 prioritisation was a matter on which advice was given by  
 6 the Chief Medical Officer or the Chief Medical Officer's  
 7 directorate. Do you have any knowledge of that advice  
 8 and the basis upon which it was given as regards who  
 9 should receive tests by way of priority over other  
 10 groups?

11 **A.** So the only prioritisation that I recall at that point  
 12 in time, particularly in those early stages, was that  
 13 testing, where it was available, should be particularly  
 14 prioritised for those with a clinical need, so to  
 15 determine what illness they had, whether it was Covid or  
 16 not, whether it was another treatable illness and how  
 17 those patients should be managed. Beyond that as  
 18 a first priority I wouldn't be able to comment.

19 **MR DAWSON:** Thank you for that.

20 My Lady, if that's a convenient moment, I'd be happy  
 21 to break.

22 **LADY HALLETT:** Certainly.

23 **MR DAWSON:** Thank you.

24 **LADY HALLETT:** I shall return at 3.15.  
 25 **(2.58 pm)**

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1 **Q.** We've heard evidence as regards this care home situation  
 2 that there is a kind of cultural issue which exists  
 3 within Scottish Government as regards its healthcare  
 4 provision, that there is an instinct to look after  
 5 hospitals and then to look after care homes, and, last,  
 6 to look after those who are in residential care in their  
 7 own homes. Is that a cultural issue which you recognise  
 8 to any extent, and in particular relating to this very  
 9 significant period?

10 **A.** So I have to say to you that I don't recognise that as  
 11 being a scenario which I ever saw play out, certainly in  
 12 my presence. I think that there was -- in the  
 13 conversations that I recall from that period, there was  
 14 general concern about the potential for the spread of  
 15 infection in any closed setting, and I would put it as  
 16 broadly as that. So I would also include in that not  
 17 just hospitals, care homes, residential homes, but also  
 18 prisons, places like that, where -- any closed setting  
 19 where actually there was a population who may be at  
 20 greater risk and that the virus could spread within.  
 21 And we'd already seen some of that play out in other  
 22 countries, particularly Italy at that time, about the  
 23 potential for them.

24 **Q.** Ms Lamb, who you will know, who gave evidence earlier,  
 25 suggested that in this regard, as Dr McMenamin and

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1 **(A short break)**

2 **(3.15 pm)**

3 **LADY HALLETT:** Mr Dawson.

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

5 Could I start by returning to an area we were  
 6 looking at earlier and ask a question I forgot to ask  
 7 you. You were giving some evidence about your  
 8 involvement, albeit limited, in the advice that was  
 9 provided to Scottish Government over the initial few  
 10 months before the first lockdown, and you told us  
 11 of course that the principal adviser in that regard was  
 12 the Chief Medical Officer, Dr Calderwood, and you were  
 13 not privy to a lot of the discussions, but you certainly  
 14 discussed matters with her as her deputy. Would that be  
 15 broadly correct?

16 **A.** Yes.

17 **Q.** I was interested to know whether, at that time, your  
 18 understanding was that the Scottish Government had the  
 19 legal power to impose restrictions on members of  
 20 Scottish society or whether in having these discussions  
 21 and providing advice you were under the impression that  
 22 that legal power was something they did not have, which  
 23 would later, of course, come through  
 24 the Coronavirus Act. What was your understanding of the  
 25 position?

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1 A. So what I recall from that time is that there was --  
 2 there was discussion between policy teams at that point  
 3 to what extent Scotland had both the powers and the  
 4 capabilities to support the population should an event  
 5 like that begin to happen. I probably became more privy  
 6 towards those conversations during the period of March  
 7 than earlier than that. But as we were exploring what  
 8 the possible responses could be, from the output of  
 9 SAGE, it was becoming more and more evident that  
 10 actually Scotland, although they had the powers to be  
 11 able to kind of take that course of action, one of the  
 12 difficulties in doing that was to be able to identify  
 13 particularly the financial support for people -- to  
 14 support them during that period.

15 Q. The reason I ask is, of course, if one were in the  
 16 position of Dr Calderwood at the time, giving advice  
 17 about what options might exist, and you weren't privy to  
 18 the precise advice that was given, it would be important  
 19 to know, would it not, what the range of legal options  
 20 actually were, because you might wish to suggest  
 21 something which simply couldn't be done and therefore it  
 22 would be a waste of time, whereas if the impression was  
 23 that you did have the legal power to impose restrictions  
 24 in the nature of a lockdown or something short of  
 25 a lockdown, that would inform the matters on which

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1 admissions when positive cases, it'll need additional  
 2 staff to care ... for isolated patients and use  
 3 associated IPC processes."

4 Should that be CMOD?

5 A. No. CNOD --

6 Q. The Chief Nursing Officer --

7 A. So this looks -- in this case, it's information that  
 8 I have jotted down that has been provided by potentially  
 9 the Chief Nursing Officer or one of her staff in  
 10 relation to their view who -- the Chief Nursing  
 11 Officer's directorate is the lead directorate for  
 12 infection prevention and control measures, and really  
 13 was -- provided significant clinical input into the  
 14 development of approach to care homes.

15 Q. Well, can you tell us what you understand this to mean  
 16 as being the CNOD view, rather than me suggesting to you  
 17 what it ...

18 A. What I read from this short passage which I've written  
 19 down here which says -- I suspect has been jotted down  
 20 from a meeting at some point -- that if admissions to  
 21 care homes are contemplated when there are already  
 22 positive cases within that care home, then we need to  
 23 almost separate streams of staff, additional staff, just  
 24 to look after the isolated patients and to take care of  
 25 the infection prevention and control processes. I think

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1 advice from a medical perspective might be tendered,  
 2 isn't that right?

3 A. So within that context, I guess it's understanding what  
 4 powers were immediately available at that point in time  
 5 and what powers could be developed through emergency  
 6 legislation, and my understanding is that those areas  
 7 were explored. But, as I say, not being privy to those  
 8 conversations directly, I can't give you --

9 Q. Of course we take your evidence in regard with that  
 10 caveat, as I set out at the beginning.

11 To return then to where we were, which was  
 12 discussing again an area you had a certain amount of  
 13 involvement in, which was care homes, could I take you  
 14 to INQ000371227. This, again, is one of your notebooks.  
 15 Page 45, and I'm looking ...

(Pause)

17 Yes, it's on the left-hand side there, you make  
 18 a note -- we think, from the previous entry, that this  
 19 is dated -- you can see on the right-hand side, there,  
 20 there's an entry of March -- this is 2020 -- on the  
 21 left-hand side -- we think this is dated 23 March 2020.  
 22 So this shows some level of involvement or information  
 23 that you have in the care homes issue at that time and  
 24 you've written:

25 "CNOD view -- if move to opening care homes to

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1 these were ideas which were being bandied about round  
 2 about capacity rather than any kind of definitive  
 3 position in relation --

4 Q. Yes, I understand the context, but this seems to  
 5 contemplate the possibility that there will be positive  
 6 cases in care homes; yes?

7 A. I think it was always recognised that there would be the  
 8 potential for positive cases in care homes. I think  
 9 that we realised that it was -- with ingress and egress  
 10 from care homes, just with staff, with visitors, with  
 11 other sorts, that it was always a possibility that  
 12 someone could take infection into that environment, or  
 13 it could come from other sources as well.

14 Q. Are you aware of the particular issue, I think,  
 15 highlighted, as the Chief Nursing Officer Directorate is  
 16 pointing out, that if positive cases did get into  
 17 care homes then it would need additional staff in order  
 18 to care for the isolated patients, because there would  
 19 need to be a degree of isolation and -- with various  
 20 processes, infection control I think processes? Was  
 21 anything done to try to address the fact that additional  
 22 staff in care homes would be needed as had been  
 23 highlighted, as far as you're aware, over this period?

24 A. I'm afraid I wouldn't be able to answer that question.  
 25 I think that's a question for people who were more

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1 closely involved in that work.

2 **Q.** Thank you very much.

3 If I could go on to some -- a different area.

4 I would like to ask you some -- broadly some questions  
5 about various parts of the strategy for the Scottish  
6 Government's fight against coronavirus and the various  
7 different phases that it went through.

8 Could I go to your statement, please, to paragraph  
9 506 and page 126.

10 It's INQ000273978, paragraph 506, please, page 126.

11 Thank you.

12 This is a section of your lengthy report in which  
13 you are telling us -- it's a broad reflection, although  
14 in a particular context, about the differences in  
15 approach which emerged between the -- in particular  
16 the UK Government's response and the Scottish Government  
17 response. We heard some evidence about specific  
18 meetings around about the beginning to middle of May  
19 from Mr Thomson be the other day, leading to a COBR  
20 meeting which took place on 10 May, which he identified  
21 as being effectively a point at which you could  
22 recognise a significant -- he didn't like the word  
23 "divergence", but divergence in the approaches.

24 You are comparing and contrasting, I think, here, at  
25 a general level the reasons why you think that those

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1 surveys.

2 Can you tell us, please, precisely where it is that  
3 this "national tolerance of risk", and the impression of  
4 it, in particular around this time, from May onwards,  
5 where that emanates from, as it seems to be a rather  
6 abstract concept which is hard to grasp hold of.

7 **A.** I agree that the whole concept of risk is sometimes  
8 difficult to grasp, and I guess the starting point for  
9 this is to understand --

10 **Q.** Just to be clear, Professor, it's more the national  
11 tolerance element I'm interested in.

12 **A.** But I think that the concept of risk is also difficult  
13 to grasp in this context as well.

14 I think perhaps I'd best start with the clinical  
15 aspects of this, if I may, and that's to explain why  
16 I think this is important, because Scotland does have  
17 an older population than other parts of the UK, and we  
18 knew even by this stage that it was very clear that  
19 older groups of people were at greater risk from the  
20 effects of the coronavirus. But not only is it an older  
21 population but it's a sicker population, and it's  
22 a sicker population for many reasons, but the  
23 development of what we call multimorbidity -- that is  
24 the people having multiple medical conditions, chronic  
25 medical conditions that impact on their health -- is

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1 differences emerged and you say:

2 "It is my view that the differences in approach  
3 between UK nations were in part influenced by clinical  
4 and demographic considerations (Scotland has an older  
5 population, with greater levels of multimorbidity and  
6 therefore greater risk of harm from Covid-19) and in  
7 part by national tolerance of risk and harm in each of  
8 the four harm domains. This national tolerance of risk,  
9 in my view, is not as simple as saying Scottish  
10 Government's tolerance of risk, as population polling  
11 and attitude surveys were used extensively alongside  
12 other sources of information to inform that  
13 understanding more fully."

14 There is a consistent theme amongst the evidence in  
15 written form given to this Inquiry about this issue,  
16 that Scotland had a different tolerance to risk, and I'd  
17 like to explore that with you a little bit.

18 First of all, there seemed to be two major  
19 components of what you're saying here, is that there  
20 were clinical and demographic reasons why a different  
21 tolerance might be applied, and I'll ask you about that  
22 in a moment, but there was also some additional factor,  
23 which you describe as there being some different  
24 national tolerance of risk, which I think you're  
25 suggesting is evidenced by polling and attitudes

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1 more evident in Scotland than in other parts, and not  
2 only is it more evident but it also tends to occur at  
3 a slightly earlier age. And a lot of that is influenced  
4 by the health inequalities that we see across the nation  
5 as well. So, again, a piece of -- strong piece of  
6 learning is about -- one of the ways to make a country  
7 more resilient against any pandemic is to improve the  
8 general health of the population, but particularly those  
9 who experience inequalities.

10 **Q.** Is it correct to say, Professor -- we've heard quite  
11 a lot of evidence about the health inequalities, and  
12 some specific characteristics of that, as well as the  
13 fact that Scotland has an older population and  
14 particularly from our statistical witnesses. You are  
15 saying here, I think, that the different approach taken  
16 from May onwards was driven in part by the different  
17 morbidity levels, the health inequalities. Was it the  
18 case that Scotland had greater health inequalities,  
19 worse wealth and an older population throughout the  
20 pandemic?

21 **A.** So we had worse health and greater inequalities leading  
22 into the pandemic --

23 **Q.** Yes.

24 **A.** -- which was perpetuated through the pandemic.

25 **Q.** Yes.

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1 A. So what it does is it places our population at a much  
2 greater risk --

3 Q. Yes, I understand. What I'm trying to establish is  
4 whether these factors remained a constant such that  
5 Scotland had these factors to take into account which  
6 were not as great a factor in other nations of the  
7 United Kingdom; is that correct?

8 A. So, yes, and one of the reasons for spending some time  
9 just to explain this is because I think that that begins  
10 to -- you begin to explain and understand why the risk  
11 thresholds in Scotland was perhaps set slightly higher,  
12 because of the perceived additional risk to the  
13 population because of these increasing burden -- or  
14 increased burden of disease that existed within the  
15 population.

16 Q. Was it your advice to the Scottish Government, based on  
17 these considerations, in May 2020 that it ought to ease  
18 the lockdown more slowly, thereby diverging from the  
19 UK Government's approach, because of this higher level  
20 of multimorbidity and the older population?

21 A. So my advice, you'll recall, at that point in time,  
22 would be taken in the context of the four harms, which  
23 was already established at that point, so --

24 Q. But as far as the harms you covered.

25 A. But my advice in terms of the health-related harms was

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1 isn't that right?

2 A. It is.

3 Q. From summer 2021, when infection rates were the highest  
4 in the UK due to the Delta wave, and no lockdown took  
5 place, these considerations were also part of the  
6 picture?

7 A. It is.

8 Q. And in late --

9 A. What we should recall --

10 Q. Sorry.

11 A. If I may, what we should recall is that risk is dynamic,  
12 and over that period which you are describing with a we  
13 saw, very importantly, was also the introduction of  
14 additional therapeutic interventions and, most  
15 importantly, a vaccination programme which began to  
16 reduce the level of direct risk from the virus as  
17 a consequence. So it is not true -- whilst the risk --  
18 or whilst the burden of disease and the elderliness of  
19 the population was a fairly constant during that time,  
20 the degree of risk that they faced was altered and  
21 influenced by the therapeutics and the vaccine which  
22 came into play at that time.

23 Q. This difference remained in late 2021 into 2022 when the  
24 infection rates in Scotland were the highest in the UK  
25 due to Delta and Omicron, and no national lockdown took

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1 that -- was that actually the risk to the Scottish  
2 population was greater because of the demographics and  
3 the burden of disease that existed within the country.

4 Q. The Scottish population had these different  
5 characteristics at the time of the first lockdown, but  
6 no earlier restrictions were imposed; isn't that  
7 correct?

8 A. That is correct.

9 Q. They had -- the Scottish population had these  
10 characteristics in the summer of 2020 when the borders  
11 were opened to allow tourists to go to Spain and return,  
12 eventually causing these older sicker people  
13 considerable harm, isn't that right?

14 A. That is correct.

15 Q. At the time of the circuit-breaker lockdowns in Wales  
16 and Northern Ireland and England between September and  
17 November 2020, when no Scottish national lockdown  
18 occurred, these factors also existed?

19 A. These factors existed throughout that time. The  
20 Scottish population has continually, as I say,  
21 demonstrated that it's been a little bit older than  
22 other parts of the UK and has this heavier burden of  
23 disease.

24 Q. These factors existed when Scotland went into its second  
25 lockdown, no earlier than England's second lockdown,

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1 place; is that not right?

2 A. As I explained, risk is dynamic.

3 Q. But these factors still existed at that time?

4 A. The elderliness of the population and the burden of  
5 disease, which by that point was influenced -- the risk  
6 associated with them was influenced by the protective  
7 nature of the vaccines and also the therapeutics that  
8 were available.

9 Q. How were you able to measure the level of protection  
10 that was given by the vaccines over those later periods?

11 A. So the type of protection which the vaccine offered was  
12 monitored through what was, I think, one of the most  
13 important developments in terms of data over the course  
14 of the pandemic response: what became known as the  
15 EAVE II platform. Led by the Usher Institute in  
16 Edinburgh but really a kind of a collaboration between  
17 a number of institutes, including Public Health Scotland  
18 and Strathclyde University as well. But really the data  
19 which they were able to produce looking at the degree of  
20 risk to the population from a variety of different  
21 sources, whether that be new variants or the protection  
22 which was offered by the vaccine, became an incredibly  
23 important part of the information which was used to kind  
24 of associate risk within the country.

25 Q. What we're trying to do here is work out why it is that

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1 Scotland took the same approach at certain times but  
2 a different approach in May 2020. You've introduced the  
3 concept of the vaccines offering a protection and the  
4 EAVE II study, again which we've heard about from other  
5 witnesses, but that protection was afforded to the  
6 people in the other nations of the UK equally, wasn't  
7 it?

8 **A.** It was, yes.

9 **Q.** So that was a factor, as regards to the comparison,  
10 which was consistent, although the inconsistent factor  
11 remained Scotland's multimorbidity and elderly  
12 population?

13 **A.** So again -- just to emphasise again, risk is dynamic.  
14 Over that point in time we would see the same level --  
15 risk is dynamic in other countries as well, but if there  
16 is an approach to risk within this country it would be  
17 influenced by the confidence that the protections that  
18 the population was having from these other sources was  
19 going to have the desired effect and could replace some  
20 of the non-pharmaceutical interventions which were in  
21 play.

22 **Q.** Thank you.

23 The second component, you've taken them quite  
24 rightly, I think, the other way around, with the  
25 clinical and demographic considerations first, but I was  
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1 that actually the Scottish -- there was a significant  
2 aspect of the Scottish public that was very cautious and  
3 fearful in their approach and was perhaps more  
4 risk-averse than we were seeing in other places, and  
5 I think that was reflected in attitudes of some of the  
6 decision-makers as well.

7 **Q.** Was that not the case then at the other times that I've  
8 mentioned when Scotland didn't take greater  
9 restrictions? So, for example, you mentioned the  
10 shielding category. Was it not the case that people who  
11 were shielding were concerned about the virus when cases  
12 started to rise in August 2020 at exactly the same time  
13 that the shielding restrictions were lifted on 1 August  
14 by the Scottish Government?

15 **A.** And I think what we saw there was increasing confidence  
16 that actually the level of harm which was likely to be  
17 experienced by anyone had dropped to a level because  
18 of -- although case levels were rising at that point,  
19 they were still at a very, very low level compared to  
20 before.

21 **Q.** But in essence, whether people in the public's attitude  
22 to risk was one thing or another is not really the most  
23 important thing to weigh in the balance, is it, it's  
24 what the science tells you about what the risk is. And  
25 of course members of the public didn't get the SGORR  
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1 also interested in trying to explore with you what you  
2 mean by what appears to be the other component of the  
3 decision-making process, which is the national tolerance  
4 of risk and harm, which I think you are suggesting is  
5 demonstrable through population polling and attitudes  
6 surveys. If I may say so, Professor, that seems like  
7 a rather unscientific concept. Could you help us with  
8 that?

9 **A.** Yeah, what we saw was the level of fear and anxiety  
10 through some of polling and attitudes survey was really  
11 quite significant and fear of the virus in particular  
12 was evident through that. We also heard it very clearly  
13 and strongly from many public groups as well who were  
14 expressing concern. There was, I think it's fair to  
15 say, a real anxiety, concern, particularly for those who  
16 had been identified as the highest risk groups, so the  
17 group which, at the beginning of the pandemic, would  
18 have been known as the shielding group, but those at  
19 greatest risk. There was a particular anxiety that they  
20 would be left behind and that some of their needs would  
21 not be particularly catered for. And I heard some very  
22 compelling stories from some of those people in groups  
23 when either they wrote to me or spoke to me about their  
24 experience as well.

25 And so all of that begins to create an impression  
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1 sitrep with all of its information in it. So whether  
2 people have a certain attitude, what your job is to give  
3 advice as to how they should be protected, whatever  
4 their attitude was; isn't that right?

5 **A.** Which I continued to do, but I didn't make decisions --  
6 **Q.** Of course.

7 **A.** -- (inaudible), and so the -- whilst the advice that  
8 I may have given during that time remained fairly  
9 constant, and -- it was always influenced for the  
10 decision-makers by advice which was coming from other  
11 areas of government and particularly took into account  
12 the impact on the other harms.

13 **Q.** I see. So in the period where one might say there is  
14 a closer alignment after having been a period of  
15 divergence, to use the phrase Mr Thomson doesn't like,  
16 over, say, May to August, one sees these phenomena such  
17 as shielding being lifted across the United Kingdom on  
18 1 August, that's a common thing that happens, and then  
19 from then on the various things that happen tend to  
20 suggest that Scotland's restrictions are either less  
21 than or equal to the rest of the UK. In that period, is  
22 your position that you continued to give advice that one  
23 needed to be focused in particular on the first harm but  
24 decision-makers made decisions with more regard to the  
25 other harms?  
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1 **A.** So my role was consistent during that time. As we've  
2 explored before, my role was to give the best advice  
3 that I could in terms of preventing harm 1 and harm 2  
4 and that advice had to be taken and integrated into the  
5 advice that was being received from other parts of the  
6 government as well and other advisers within government,  
7 and I think what we can see in the decision-making there  
8 is a changing approach to the relative importance of  
9 each one of those harms, as time went on.

10 We should remember that whilst the harms relating to  
11 Covid changed over time as well, because of the  
12 influence of vaccines and therapeutics, the harms which  
13 people suffered economically also changed over time as  
14 well. So whilst some people might be able to cope,  
15 albeit with difficulty, with a short period of economic  
16 instability and difficulty, the longer that that goes on  
17 the greater the impact that that has as well. So the  
18 whole concept of risk, whether we're talking about  
19 health harms, whether we're talking about the society  
20 harms or whether we're talking about the economic harms,  
21 none of that is static and constant. That is all  
22 dynamic.

23 **Q.** Thank you.

24 You mentioned earlier, I think, somewhat in passing,  
25 the position with regard to borders. I was interested

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1 to the JBC before, and they produced really helpful  
2 evidence packs where they would be examining the  
3 information that was available in relation to certain  
4 countries and either their levels of infection,  
5 hospitalisation, or the emergence of potential variants  
6 within those, and I would be involved in giving advice  
7 to ministers with teams from both health policy but also  
8 from travel policy, in relation to those countries, and  
9 participated in ministerial calls across the  
10 four nations in relation to that as well. And again  
11 I think what you see in terms of the occasional  
12 divergence of the -- and it didn't happen terribly  
13 often, but occasionally, there was a divergence in  
14 approach between the four UK nations where risk appetite  
15 probably influenced the -- how quickly the response was  
16 made.

17 **Q.** But if the evidence base was the same, what was the  
18 reason why these divergences started to occur?

19 **A.** I can only assume that in the decision-makers and  
20 perhaps even in the advice that was given, that is --  
21 the tolerance for risk was greater in some countries  
22 than others. Certainly from my perspective I was always  
23 very, very aware and cognisant of the evidence that had  
24 been produced about the multiple incursions that there  
25 had been both in the early part of the pandemic but then

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1 to know -- we heard some information, again from  
2 Mr Thomson, helpfully, about the way in which borders  
3 were controlled and although he insisted that the  
4 distinction was not a blurry one, there was a slight  
5 complexity with regard to the way that borders were  
6 operated because borders were a reserved matter for the  
7 purposes of immigration and nationality but, as far as  
8 the pandemic was concerned, it was a devolved matter  
9 because the control of borders pertain to a matter of  
10 public health, which of course, as you know, is  
11 a devolved matter.

12 When there were significant and frequent changes to  
13 the rules about which countries -- what the countries  
14 were from which people would be allowed to enter  
15 Scotland or vice versa, over the period in particular  
16 for a period in 2020 and again in 2021, when advice was  
17 being tendered in this regard, was advice sought from  
18 you about whether you thought countries were too risky  
19 or not, or was advice sought from elsewhere? Because  
20 there were divergences in the approach, but our  
21 understanding from other evidence we heard last week is  
22 that the evidence base as to what the risk was in any  
23 given country was the same as between Scotland and the  
24 United Kingdom.

25 **A.** So the evidence was produced by the JBC, we've referred

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1 again in the late summer of 2020 and which had caused  
2 rising cases from some countries with greater levels of  
3 infection than we had. And whilst I think it would have  
4 been impossible to kind of keep infection out of this  
5 country completely from other sources, because of  
6 a reliance on goods coming in from other countries, my  
7 view was that where there was clear evidence of  
8 an increased risk in a particular country, and the  
9 ability for that country to then amplify what was  
10 already happening here, is that we should take action  
11 against that.

12 **Q.** Okay, thank you.

13 I'd like to go briefly to something I think we'll  
14 cover with other witnesses but upon which you make  
15 a very helpful -- that's the concept of zero Covid  
16 around this time. This is the -- this is a fairly  
17 well known concept that around the time, I think  
18 probably the summer of 2020 --

19 **A.** Yeah.

20 **Q.** -- the cases had come very significantly down in  
21 Scotland and the narrative, certainly from the Scottish  
22 Government, is that that is associated with this  
23 strategy of easing the lockdown more slowly, which was  
24 successful in that it got cases down to a much lower  
25 level, and there was -- there were a number of

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1 statements made, including by the First Minister, and  
 2 indeed by other academics who were involved in advising  
 3 the government, that zero Covid elimination was  
 4 a feasible option and was indeed a laudable goal.

5 One of the things that we have struggled with is  
 6 whether this was actually ever a policy. It may be  
 7 a matter of semantics, but in your witness statement at  
 8 paragraph 479 you helpfully say that your position on  
 9 the matter is that:

10 "In my view it would have been impossible to achieve  
 11 a 'Zero COVID' strategy without strict controls of every  
 12 land, sea and air border alongside quarantine and high  
 13 levels of co-operation of the public in adhering to  
 14 restrictions in place. Regional co-operation in trying  
 15 to achieve this aim (and most likely a wider degree of  
 16 co-operation than UK nations alone) may have made this  
 17 slightly more likely, but with a high dependency on  
 18 these borders for essential goods and materials it would  
 19 have been very difficult even with this."

20 So, for the reasons we were just exploring to  
 21 an extent, and I assume also the land border with  
 22 England is a part of this, your view was that although  
 23 elimination as an ultimate goal was a good thing,  
 24 because it would mean suppression of the virus down to  
 25 low levels at the very least, elimination was not

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1 an island nation and are so reliant on things coming  
 2 from outside. But with greater level of regional  
 3 co-operation, and probably at a European level, I do  
 4 believe that we could have sustained lower levels of  
 5 Covid, perhaps not eliminated but certainly got very  
 6 close to that, and dealt with sporadic cases much as we  
 7 do with other diseases such as measles.

8 **Q.** Was your view on the matter, which I have set out and  
 9 you've helpfully added to, a matter on which you  
 10 provided advice to the First Minister and other  
 11 ministers at that time?

12 **A.** It was a discussion that we had on a regular basis.

13 **Q.** Yes, that was your position?

14 **A.** And I think it was well recognised that that was my  
 15 position, and I wrote one or two pieces on it, some of  
 16 which appeared in popular media as well.

17 **Q.** Was there an appreciation at that time that the use of  
 18 the concept of "zero Covid" or "elimination" in public  
 19 pronouncements may as other witnesses, including  
 20 Professor Stephen Reicher, are suggesting (their  
 21 evidence to the Inquiry), create the impression amongst  
 22 the public that, effectively, "Covid is over and we can  
 23 go about our business as normal"?

24 **A.** I'm not sure that the public would ever have believed  
 25 that that was ever a possibility at that stage in time,

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1 something that could ever have been achieved; is that  
 2 right, broadly?

3 **A.** So I think "elimination" was used as a term sometimes  
 4 colloquially rather than scientifically, and certainly  
 5 from a scientific perspective --

6 **Q.** Yes.

7 **A.** -- looking at epidemiology, I didn't think that  
 8 elimination of the virus was a feasible option.  
 9 However, if it led to an approach which tried to keep  
 10 the numbers as low as possible, then I think that that  
 11 was something which was useful --

12 **Q.** Yes?

13 **A.** -- and something which was worth pursuing.

14 Zero Covid, as far as I'm concerned, was never  
 15 a formal policy of the Scottish Government, but keeping  
 16 the cases and the harm which was caused by those cases  
 17 to as low a level as possible was something which we've  
 18 stated in many documents. If we touch upon the  
 19 environment, the circumstances that would have been  
 20 necessary to achieve zero Covid, I really do think that  
 21 it would have been almost impossible for Scotland to be  
 22 able to achieve that as a country by itself. Even on  
 23 a UK level I think that that would have been a very  
 24 difficult thing to try and achieve, despite the fact  
 25 we're an island nation, but perhaps because we're

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1 given the kind of feeling of anxiety that existed within  
 2 the general population, and I think everybody certainly  
 3 that I knew of was constantly watching both the UK and  
 4 international picture to see where the next threat might  
 5 arrive from. But I do think it was useful in terms of  
 6 achieving a collective response from society with an aim  
 7 to try to reduce the harm as much as possible across  
 8 society.

9 It touches upon the point that Mr Reicher has spoken  
 10 about on several occasions, which is actually appealing  
 11 to the altruistic nature of humans and that collective  
 12 societal response, and I think one of the things that it  
 13 was helpful in doing in that respect was actually giving  
 14 them an aim round about which we could try to coalesce.

15 **Q.** But it was a scientifically unachievable aim, isn't that  
 16 right?

17 **A.** I think that elimination, as it's defined  
 18 scientifically, is something which would have been  
 19 almost impossible to achieve.

20 **Q.** Thank you.

21 I'd like to ask you about some brief questions,  
 22 I hope, about the slightly later period. Obviously as  
 23 we've discussed, evidence suggested, which we've  
 24 analysed with statisticians, that cases started to go up  
 25 in August. We have talked about the reasons for that.

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1 On 7 September the First Minister announced that there  
2 would be a slowing down of the easing of restrictions  
3 because of this, and consideration was given, in light  
4 of advice that had been tendered by SAGE, about which we  
5 are already heard evidence in Module 2, that there might  
6 be, by the time of September, a circuit-breaker or  
7 firebreak lockdown to try to break this increasing  
8 trend.

9 In around -- on 18 September, you submitted  
10 an advice paper along with the Chief Nursing Officer and  
11 Professor Leitch, the National Clinical Director, which  
12 can be found at INQ000326427. I'm looking at page 4,  
13 paragraphs 21 and 22.

14 So this was an example of a situation in which you  
15 appear to be providing written advice, but along with  
16 your colleagues, who are providing a sort of joint  
17 opinion, if you like.

18 Just as we're getting that up, this was  
19 a suggestion, this was effectively -- you were looking  
20 at various options, various things that you might do,  
21 and the conclusion I think is reasonably expressed in  
22 these paragraphs where you say:

23 "However, we do not believe that these measures are  
24 sufficient."

25 You've listed a whole load of potential measures  
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1 tightening travel restrictions further during that  
2 period to reduce circulation of virus."

3 So it looks like an advice was given that there  
4 should be a firebreak and then later on a shorter advice  
5 was tendered the same day by the same three people which  
6 moves the position slightly. We're interested in  
7 exploring with you why it was that the advice that was  
8 being tendered had changed in that apparently  
9 significant fashion over the course of that day?

10 **A.** So the only reason that that might have happened is in  
11 terms of drafting and the strength of the recommendation  
12 that all three advisers were content with. It's the  
13 only way that I could assume that that would happen.

14 **Q.** It does look like there's a significant change. You say  
15 there's decisive action, quite forceful, and you  
16 recognise that it might be resisted, I think, and then  
17 your position becomes that you're no longer recommending  
18 within the course of it. So it's not just a tweak. So  
19 are you saying that the first advice didn't reflect your  
20 opinion and the second advice did, or what happened over  
21 the course of --

22 **A.** What I'm saying is that it appears that in that -- if  
23 that is the order, I actually don't know -- I don't  
24 particularly remember this submission that went up, but  
25 occasionally the process of drafting those submissions  
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1 immediately before that in a bullet point list.

2 "Therefore, we recommend that we introduce a general  
3 'stay at home' order for 14 days from 12 October. We  
4 fully acknowledge the seriousness of this and we have  
5 discussed at some length whether we could recommend  
6 a less stringent 'fire break'. Ministers will decide  
7 whether there should be specific exceptions from  
8 a four harms ..."

9 Could we just have that back down to the original  
10 thing, and over the page:

11 "... perspective; from a public health perspective,  
12 to have the fire break effect, we require the most  
13 decisive action."

14 Could I take you to another document, please, which  
15 is INQ000326426. I'm looking on page 1 at paragraph 6.  
16 This is an advice again by the three of you which was  
17 issued, it appears, later that very same day where you  
18 say:

19 "We remain of the view that a 'fire break' amounting  
20 to a general stay at home order may be required to be  
21 implemented quickly if our recommended measures do not  
22 have the desired effect. We do not propose at this  
23 stage a planned 'fire break' during the October school  
24 holidays but such a step may be required. With or  
25 without a 'fire break' we may have to consider  
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1 would be drafted by other people and we would comment on  
2 them, on the language that was used, and if we were  
3 unhappy at the language that was used in them we would  
4 change them.

5 **Q.** So you changed it from --

6 **A.** -- that reflected our position on them.

7 **Q.** So you changed it from "You should have a firebreak  
8 lockdown" to "You should not have a firebreak lockdown"?

9 **A.** I don't think that's what it says.

10 **Q.** Well, what is the change?

11 **A.** It says --

12 **Q.** "We do not" --

13 **A.** -- "school holidays". So it's the timing of it rather  
14 than whether it might be necessary.

15 **Q.** Are you suggesting it continued to be the position that  
16 there should be a firebreak lockdown?

17 **A.** But such a state may be required.

18 **Q.** But not at that time?

19 **A.** But not immediately at that time.

20 **Q.** But decisive action had been required, in accordance  
21 with the previous advice?

22 **A.** So, as I say, I'd -- the only reason that that may have  
23 been included would have been in the drafting of the  
24 submission from whichever source, which clearly the  
25 three advisers have not agreed to.  
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1 **LADY HALLETT:** So did the first advice go to ministers?  
 2 **A.** It doesn't seem so. I wouldn't have thought so.  
 3 **LADY HALLETT:** So the first advice is drafted and you say  
 4 that somebody, one of your number, decided that they  
 5 didn't like the advice as it was drafted. What was your  
 6 opinion? Did you recommend a firebreak at that stage or  
 7 didn't you?  
 8 **A.** So what I recall at that stage was that it was --  
 9 I don't remember the exact dates, but I remember the  
 10 discussions around about we were heading towards  
 11 requiring some sort of firmer action and the timing of  
 12 that firmer action was to be determined, some of it was  
 13 determined by the modelling and there was still hope  
 14 that the October school holidays might influence and  
 15 bring down things naturally. We very often found that  
 16 during periods when schools were not in session is that  
 17 that influenced ...  
 18 **LADY HALLETT:** Did you advise a firebreak or was it one of  
 19 your colleagues who advised a firebreak in the first  
 20 advice?  
 21 **A.** I ... I have to say to you that I don't know where that  
 22 first advice came from. So what I'm saying to you is  
 23 I can only assume that that's how it's been drafted and  
 24 that it has been altered when the three chief advisers  
 25 have looked at it.

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1 the page -- some of the things which you recommend with  
 2 your colleagues should be done are accepted and some are  
 3 not, and it's -- the basic question is: in circumstances  
 4 where, having come to the view that there should not be  
 5 a firebreak lockdown by this point, and then having come  
 6 up with what I assume is quite a carefully planned  
 7 series of things to try and work out, well, what's the  
 8 best thing, where is the virus coming from, what do we  
 9 need to do, and in the circumstances where what  
 10 eventually happens is some of them are accepted and some  
 11 of them are not, in these sorts of circumstances, would  
 12 you ever have the opportunity, having tendered this  
 13 written advice, to discuss with the ultimate  
 14 decision-makers which bits they really should keep in  
 15 and which bits they should jettison?

16 Of course they are, as you have said on a number of  
 17 occasions taking into account a number of different  
 18 factors and harms, but to what extent is there a system  
 19 whereby in that list you're able to say to them, "But if  
 20 you're going to do anything, you absolutely have to do  
 21 that; but if you're going to not do that, that's okay,  
 22 that's not going to make much difference"?

23 Because it seemed to us to be slightly odd that some  
 24 of the things are accepted and some are not without, as  
 25 far as we can tell from the paperwork, any further

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1 The process of drafting submissions was very often  
 2 done by policy officials who interpreted our position  
 3 and -- from -- just in the conversations that we had.

4 **LADY HALLETT:** You can't interpret "We say we need  
 5 a firebreak now". That's not interpretation, Professor,  
 6 is it? That's straightforward. Either that's what they  
 7 understood you were saying. It's not an interpretation,  
 8 it's quite a dramatic change.

9 **A.** It's the only way that I can think that that has  
 10 happened, but ...

11 **LADY HALLETT:** Sorry for interrupting, Mr Dawson.

12 **MR DAWSON:** Not at all.

13 This is potentially quite complicated, this, but  
 14 what we did was we looked at the advice and then we  
 15 compared and contrasted what the advice was with what we  
 16 thought the actual outcome was, and this was quite  
 17 an interesting illustration where you then go on to tell  
 18 us, in this advice, having said "We now" -- well, "We do  
 19 not [I should say] recommend a firebreak lockdown", that  
 20 various things should in fact happen to try to reduce  
 21 R below zero, strengthen FACTS, et cetera, et cetera.

22 So we did a comparison here, I won't go through the  
 23 detail of it obviously, but as a broad proposition what  
 24 appears then to happen is that in this list -- which  
 25 goes on a bit further than one can see there and over

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1 discussion about what the most important elements from  
 2 a harm 1 perspective actually are.

3 **A.** So there are probably two things I would want to kind of  
 4 emphasise in this. The first of all is that there's  
 5 a full realisation that the role of an adviser, whether  
 6 it be a health adviser, an economic adviser or so forth  
 7 is simply that: it's to provide advice, and that that  
 8 advice is received and acted upon according to how the  
 9 decision-maker wants, so that's the first aspect.

10 The second aspect was my experience, whenever one of  
 11 these submissions was sent to the decision-makers, to  
 12 the ministers, to speak about, they would -- they would  
 13 then organise a call, either in person or at the very  
 14 least using a video platform to discuss the advice that  
 15 was contained within it, and there would then be a back  
 16 and forwards in relation, just as you describe, about  
 17 what were the particularly important elements of it, or  
 18 to explore some of the reasoning behind the proposal in  
 19 further detail; and that was a process which we became  
 20 very used to, all the way through the pandemic, but  
 21 very, very regularly a submission such as this would  
 22 then provoke a kind of call of some sort or a meeting of  
 23 some sort to discuss the advice further.

24 **Q.** Did that happen on this occasion?

25 **A.** I don't recall any occasions when it didn't happen.

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1 **Q.** There's no document -- this is very clearly set out as  
 2 to what your position was. We're not aware of there  
 3 being any documentation we've seen about that process,  
 4 so you're saying that's an oral process or a meeting  
 5 takes place and --

6 **A.** Yeah, it was an oral process, yep.

7 **Q.** Right. Because, for example, just to look at these  
 8 things, for example, the "Strengthen FACTS" message, we  
 9 think that did happen, but "limit unnecessary domestic  
 10 and foreign travel" didn't.

11 So other things like non-essential car sharing did  
 12 come in, but restricting non-essential travel to  
 13 30 miles limit did not.

14 Other measures that did not included a message to  
 15 underline the seriousness of the situation, protecting  
 16 the NHS, preserving care; that did not happen.

17 So would you have sat down with the decision-maker  
 18 and gone through every element to make sure that they  
 19 were pushing the emphasis on the right parts? And how  
 20 does the public know what that process involved?

21 **A.** So I don't remember the particular conversation that  
 22 relates to this paper, because there were so many  
 23 conversations which happened which were similar to this,  
 24 but generally what it would involve is looking at the  
 25 proposals which were contained within the submission and

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1 third.

2 Over that period, that period might be said to be  
 3 characterised by very much less stringent restrictions,  
 4 the main protection, it would appear, against the virus  
 5 being the vaccine, as you have said earlier, and in  
 6 particular the vaccine passport system, although it had  
 7 a different name in Scotland, that was what Ms Lamb told  
 8 us it subsequently became known as.

9 Over that period, given your predominant  
 10 responsibility for providing advice on harms 1 and 2, to  
 11 what extent were you providing advice that more needed  
 12 to be done to address harm 1, greater restrictions  
 13 needed to be applied, and that the vaccine and the  
 14 vaccine passport were clearly not protecting the people  
 15 of Scotland?

16 **A.** So during that period one of the most important things  
 17 was, as you say, was that we had a greater level of  
 18 protection from both vaccine and therapeutics, so there  
 19 were multiple medications that we could now use to treat  
 20 people who had become ill, and the vaccine was proving  
 21 that it was able to offer particular protection against  
 22 the most severe consequences of Covid, particularly  
 23 against mortality and serious illness.

24 What it was able to do less well was to reduce  
 25 transmission, although it did have an impact on

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1 walking through them as to what we thought that they  
 2 would achieve, and again taking into account the advice  
 3 from other parts of government as well as to what  
 4 potential harms they might cause as well.

5 I think I have to convey that this was all part of  
 6 that four harms approach we were looking at, the impacts  
 7 on society as a whole rather than simply just as  
 8 a health impact.

9 **Q.** Thank you.

10 So moving into a different later period, I would  
 11 just like to ask you broadly about one, really, area.  
 12 We've seen in the evidence that from around  
 13 August 2021 -- sorry, from around July 2021, there was  
 14 a significant increase in cases in Scotland, I think  
 15 associated with the Delta variant, and that because the  
 16 Omicron variant then arrived towards the end of the year  
 17 and then quickly became the dominant stream, effectively  
 18 Scottish infection cases remained very high over that  
 19 period.

20 We have also explored that over that third wave  
 21 period there was very nearly as much mortality in  
 22 Scotland -- despite the impression that Omicron is  
 23 a less virulent strain of Covid -- as there had been in  
 24 both waves 1 and 2, there was roughly 5,000 deaths in  
 25 the first, 5,000 in the second and about 4,000 in the

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1 transmission as well. And in terms of the vaccine  
 2 certification or passport, as it became known as, whilst  
 3 I was supportive generally of the approach, I would have  
 4 preferred to have seen a slightly more stringent  
 5 approach which was deployed in relation to it, and  
 6 I gave advice that actually vaccination by itself wasn't  
 7 sufficient to render an environment safe, and that --  
 8 but that vaccination plus testing in combination would  
 9 certainly give an additional degree of protection.

10 **Q.** So were there measures that you suggested should be  
 11 imposed, further restrictions, over that period that  
 12 were not?

13 **A.** I don't recall the specific detail, but I remember  
 14 during that period there were times when I would have  
 15 been more content if a stronger position had been  
 16 adopted to protect some of the environments where we  
 17 knew that transmission was likely to take place. So by  
 18 that point it was very well established that indoor  
 19 places with poor ventilation where people were coming  
 20 together were likely to be places where transmission was  
 21 much more likely to occur, and if we were going to kind  
 22 of use vaccine certification in that environment also  
 23 testing at the same time as relying on vaccination would  
 24 have given an additional degree of protection.

25 **Q.** But there wasn't that level of testing; is that what

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1 you're suggesting?

2 **A.** Yeah.

3 **Q.** So given your responsibility in that position, you would  
4 have provided advice that that was necessary?

5 **A.** I recall doing that.

6 **Q.** Thank you.

7 Could I just ask you one final question, it's about  
8 one of the helpful lessons learned and recommendations  
9 that you've set out. In paragraph 720 of the report,  
10 you talk about:

11 "This pandemic, in common with many others,  
12 reflected and in many cases exacerbated existing  
13 inequalities. Research on where the disparities were,  
14 what their causes were and how best to reduce them  
15 needed to begin from the outset of the pandemic. A wide  
16 range of qualitative and quantitative research methods  
17 were needed to understand disparities. Continual  
18 dialogue with local communities was important in  
19 understanding risks and vulnerabilities, and to  
20 co-design effective responses at a hyper-local level  
21 that might not be picked up in larger, national  
22 data sets or research."

23 So I think here you're addressing a theme about  
24 which we have heard a considerable amount of evidence.

25 Is it correct to say that you're accepting there  
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1 trying to address some of those health inequalities and  
2 we should be very, very clear that the way that we  
3 address those is not through a healthcare-related model  
4 but actually is through a kind of cross-government,  
5 all-society approach in terms of what we understand by  
6 inequality across society. And if we can do that, if we  
7 can improve both the economic and social capital of  
8 communities, that leads to a kind of better level of  
9 health within all these communities, I think that we'll  
10 be in a far stronger position to be able to meet  
11 Disease X when it appears in the next pandemic.

12 **Q.** That's a very laudable aim, if I may say so, Professor,  
13 but is your position that that did not happen  
14 sufficiently during the pandemic?

15 **A.** I think attempts were made to do that, and it was often  
16 very difficult to get the right data and information to  
17 understand exactly how it impacted on particular  
18 communities. I think changes were made during the  
19 course of the pandemic which helped us to understand  
20 better. I think it's worth singling out the huge  
21 efforts which were made, albeit slower than I think  
22 people would have liked to have seen it, to understand  
23 the impact on particular BAME communities and those who  
24 had lived with disabilities of one sort or another.  
25 I think although strides were made during the course of

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1 that there wasn't enough done to understand the way in  
2 which the pandemic was exacerbating existing  
3 inequalities, and that that is a matter which not only  
4 could have been done better during the pandemic but must  
5 be done better in future?

6 **A.** So the whole issue of health inequalities is one which  
7 I think is worth exploring in quite a bit of detail,  
8 because just in terms of lessons learned, one of the  
9 most important things that we as a nation could do in  
10 order to prepare ourselves for the inevitable next  
11 pandemic which we face is to raise the health of all the  
12 population, to make it a much more health resilient  
13 nation and population in terms of meeting whichever  
14 disease comes to us in pandemic form in the future.

15 Now, to do that we need to understand the nature of  
16 health inequalities and we need to prioritise action  
17 against health inequalities that exists within our  
18 society. So both during the pandemic and outside the  
19 pandemic, spending as much time and research as possible  
20 to understand the impact on people's lives of those  
21 inequalities that they face and how that impacts on  
22 their health is something which I think is incredibly  
23 important. We see it in society even before the  
24 pandemic came, is that health inequalities were stark.  
25 I see a renewed focus since the pandemic in terms of

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1 the pandemic to understand that better, preparing  
2 ourselves so that we've got much better data resources  
3 that relate to some of these communities and  
4 characteristics is going to be really important for us  
5 to --

6 **Q.** Were those data sources at least lacking in the  
7 pandemic?

8 **A.** I think they were lacking at the beginning of the  
9 pandemic, yes. I think they were developed over the  
10 course of the pandemic, but certainly at the beginning  
11 I don't think they were as strong as they subsequently  
12 became.

13 **MR DAWSON:** Thank you very much. Excuse me just one second.

14 Those are my questions, and there are no  
15 core participant questions, as I understand it.

16 **LADY HALLETT:** Thank you very much indeed, Professor.  
17 Thank you for your help and for being here virtually all  
18 day.

19 **THE WITNESS:** Thank you.

20 **(The witness withdrew)**

21 **MR DAWSON:** The next witness is Professor Sheila Rowan, and  
22 my learned friend Ms Arlidge will be asking the  
23 questions.

24 **LADY HALLETT:** More musical chairs.

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1 **PROFESSOR SHEILA ROWAN (affirmed)**  
 2 **Questions from COUNSEL TO THE INQUIRY**  
 3 **LADY HALLETT:** Sorry you have been kept waiting for so long.  
 4 **THE WITNESS:** It's okay.  
 5 **MS ARLIDGE:** You're Professor Sheila Rowan?  
 6 **A.** I am.  
 7 **Q.** I'm going to ask you, please -- sorry, I'm not going to  
 8 ask you to turn to it. I'm going to ask for your  
 9 witness statement dated 14 November. Someone's already  
 10 ahead of me. It's INQ000274012. Hopefully that comes  
 11 up on your screen.  
 12 **A.** It does.  
 13 **Q.** Is that a familiar document to you?  
 14 **A.** It is.  
 15 **Q.** You, between 2016 and June 2021, were the Chief  
 16 Scientific Adviser to the Scottish Government; is that  
 17 correct?  
 18 **A.** That's correct.  
 19 **Q.** And you were -- your successor in that role was  
 20 Julie Fitzpatrick from the date of you leaving.  
 21 I should say, my Lady, that there is a witness  
 22 statement from Ms Fitzpatrick, Professor Fitzpatrick,  
 23 which is INQ000352847. I'm not going to bring it up on  
 24 screen, but that's for reference.  
 25 You were seconded, Professor Rowan, from the  
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1 figurehead point to bring those matters together; is  
 2 that right?  
 3 **A.** Yes, as Chief Scientific Adviser one of the  
 4 prerequisites for the role is to be able to access  
 5 scientific expertise across all domains in science, so  
 6 coming in with a very wide network of contacts enables  
 7 ministers and officials to use the CSA across  
 8 cross-cutting science areas.  
 9 **Q.** And it's about effectively knowing the right people to  
 10 ask the right questions of, at the right time, because  
 11 of your expertise in that cross-cutting role?  
 12 **A.** Absolutely, utilising those wide networks.  
 13 **Q.** And presumably those wide networks are across the  
 14 research world, it's not simply limited to, for  
 15 instance, the University of Glasgow or whichever  
 16 university you happen to be employed with at that  
 17 particular time?  
 18 **A.** No, indeed, they're very wide networks. They cross, as  
 19 I say, all scientific disciplines, certainly not  
 20 institution specific nor discipline specific, so a very,  
 21 very wide range of areas.  
 22 **Q.** And it's not a dissimilar role in that respect to the  
 23 Chief Scientific Adviser in Westminster, in terms of --  
 24 the Inquiry's already heard evidence about his  
 25 particular expertise, but that was simply he happened to  
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1 University of Glasgow for three days a week to carry out  
 2 the Chief Scientific Adviser role for Scottish  
 3 Government; is that right?  
 4 **A.** That's correct.  
 5 **Q.** You hold the chair of, I think still do, natural  
 6 philosophy at that university?  
 7 **A.** I do.  
 8 **Q.** And in fact during your time of secondment you remained  
 9 an employee of the University of Glasgow rather than  
 10 an employee of the Scottish Government; is that right?  
 11 **A.** That's correct, yes.  
 12 **Q.** Just in terms of clarifying the position, is it right  
 13 that your role -- it's not a criticism -- as chair of  
 14 philosophy doesn't have any direct relevance in terms of  
 15 scientific knowledge about the pandemic, for instance?  
 16 **A.** So, my professional background is that indeed I'm  
 17 a professor of physics. However, I would add that  
 18 I bring with that 20 years of experience in working in  
 19 and leading interdisciplinary teams to solve difficult  
 20 scientific challenges and, importantly for the CSA role,  
 21 a very wide range of professional networks across all  
 22 scientific areas.  
 23 **Q.** Because your role is to bring together, as the Chief  
 24 Scientific Adviser, is to bring in knowledge from  
 25 different sources and act as a sort of central  
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1 be that person in the role at that particular time, he's  
 2 not appointed to be the scientific adviser who gives all  
 3 of the advice about everything, he brings that thing  
 4 together, he brings that data together and the expertise  
 5 together; so in that respect your role is not dissimilar  
 6 from the UK Chief Scientific Adviser?  
 7 **A.** So there are both similarities and differences to the  
 8 role, and the similarities are certainly -- and I think  
 9 this is quite important -- that there is no requirement  
 10 for either of the UK Government Chief Science Adviser or  
 11 the Scottish Government Chief Science Adviser to come  
 12 from a particular discipline. They can be from any  
 13 discipline, and in both nations historically have come  
 14 from a wide variety of backgrounds.  
 15 **Q.** You mentioned the cross-cutting role that you play. By  
 16 that do you mean that it's part of your role to have  
 17 eyes on the science across Scottish Government and  
 18 across the country and your areas of science across the  
 19 system, rather than focusing and drilling into one  
 20 specific area every day?  
 21 **A.** So it's about being there to be a resource who can be  
 22 consulted on any particular science area and then  
 23 knowing where to access the expertise to draw out the  
 24 evidence, to draw out the information such that  
 25 government can use that.  
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1 Q. Now, one difference is you -- your secondment is  
 2 three days a week.  
 3 A. Yeah.  
 4 Q. It was three days a week. Was that the case throughout  
 5 the pandemic as well as in normal times?  
 6 A. So, it was formally the case throughout the pandemic,  
 7 although obviously during that time I prioritised  
 8 matters for Scottish Government and reorganised my time  
 9 accordingly. So although that was formally the case,  
 10 I did during that time spend more time on pandemic  
 11 matters than other things.  
 12 Q. Because the reality is that it was a fast-moving  
 13 situation and --  
 14 A. Yeah.  
 15 Q. -- asking the right questions at the right time of the  
 16 right people was no doubt a full-time job?  
 17 A. Correct. It was of course a fast-moving time, and  
 18 I prioritised my efforts accordingly.  
 19 Q. Your role as the Chief Scientific Adviser sat, at the  
 20 time of your role, I understand, within the directorate  
 21 for education, communities and justice, and then  
 22 subsequently the director education and justice; is that  
 23 right?  
 24 A. That's correct.  
 25 Q. It was subsequently, I think, transferred to the  
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1 across Scottish Government?  
 2 A. That's so. When I took up the role, I did indeed work  
 3 with colleagues in my support team, and indeed reached  
 4 out across to government to understand its scientific  
 5 advisory needs, and together we put together as  
 6 framework, as you say, which gave a guide to the  
 7 principles that policy officials can use to access  
 8 scientific advice in government.  
 9 Q. Because if there's already a source of science within  
 10 government, for instance, there's already a scientist  
 11 dealing with a particular issue, it probably doesn't  
 12 require so much outside engagement or outside research  
 13 if there's already a framework in place, but equally  
 14 there will be elements that are not covered by,  
 15 effectively, embedded scientists in various departments?  
 16 A. That's right. So what the principles of that framework  
 17 say are: if there is a domain specific need and there is  
 18 a domain expert, a topic expert in Scottish Government,  
 19 they would be a good first port of call to refer to. In  
 20 addition to that, they also say, quite clearly, where  
 21 there is no expert in an area in Scottish Government,  
 22 you can use the CSA to help source scientific advice  
 23 based on the cross-cutting nature of the CSA role and  
 24 its ability to reach out widely across topic areas.  
 25 Q. In doing so, was part of your role to advise on the  
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1 directorate of economy. Do you have any insight into  
 2 why the role sat where it did and why it was moved?  
 3 A. So I think there's a certain -- so I don't know, first  
 4 of all, the reasons why the CSA role or who made the  
 5 decision to position it in Education and Justice during  
 6 my tenure, that was a decision made before I took up the  
 7 role. I would say there's a certain logic to having it  
 8 there in that it's adjacent to the higher education and  
 9 science part of Scottish Government. Understandably  
 10 that science and research area is one in which the CSA  
 11 has interest. But I don't know if there are specific  
 12 reasons for why it was there, nor why it was moved.  
 13 Q. When you took up the role -- dealing very briefly,  
 14 appreciating you took up the role in 2016 -- but when  
 15 you took up the role at that time, I think you say in  
 16 your statement that the post had been vacant for about  
 17 18 months beforehand; is that right?  
 18 A. That's correct.  
 19 Q. I think you accept that, as a result, that did mean  
 20 there were gaps in the advisory system that existed and  
 21 was set up. Of course by the time the pandemic came  
 22 along you'd been in post for some time. You've set up,  
 23 I think, a scientific advisory -- advice framework as  
 24 well to sort of -- is that -- is it right to say that  
 25 it's sort of codifying how science should be accessed  
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1 right questions to ask when people were coming to you  
 2 for: where do I go and ask this question? Was it also  
 3 part and parcel of the role to help formulate the  
 4 questions that were being put?  
 5 A. I would say less to help formulate the questions being  
 6 put, but to help people understand what a constructive  
 7 question looks like in terms of scientific advice, so  
 8 that they could get useful answers back.  
 9 Q. And then did your role also involve interpreting the  
 10 answers that came back as necessary?  
 11 A. Can I check, do you mean answers back ...?  
 12 Q. So when the questions had been given to whichever  
 13 adviser, whichever scientist, whichever group --  
 14 A. Sure.  
 15 Q. -- and a paper comes back, were you involved in the  
 16 interpretation, assisting in the interpretation of that  
 17 paper where necessary?  
 18 A. When necessary, again, that -- and specifically during  
 19 the pandemic, I would say as CSA I had two key roles,  
 20 one of which was indeed in attending SAGE, potentially  
 21 being a point of contact between the Scottish system and  
 22 SAGE, in terms of SAGE advice and how that might feed  
 23 into the Scottish system and have the Scottish lines  
 24 applied to it, and the other one was again the ability  
 25 to, if needed, identify who an expert might be to help.  
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1 Q. Turning to sort of more specific experience of the  
2 pandemic and your role therein, we learn from your  
3 witness statement, paragraph 36 on page 11, that you  
4 were brought into the room, as it were, in terms of  
5 Covid-19, January 2020, as a result of that SAGE meeting  
6 in January 2022 -- sorry, 22 January 2020. Too many 2s.

7 And you attended that meeting, you were invited to that  
8 meeting, as CSA for Scotland?

9 A. No, that's not correct. So the meeting on  
10 22 January 2020 was a precautionary SAGE meeting with  
11 a very small, limited number of attendees, and that  
12 pre-dated my attendance at SAGE.

13 Q. So is it right, then, to say that you went to the first  
14 formal SAGE meeting, as it were, rather than the  
15 precautionary SAGE meeting?

16 A. No, there were a series of SAGE meetings between  
17 January, throughout February, March onwards, and the  
18 first SAGE meeting at which I was a formal attendee was  
19 in April.

20 Q. Why the gap?

21 A. Sure. So, as we've discussed, the role of -- the  
22 framework for science advice in Scottish Government  
23 indicates that when there is a topic relevant need -- in  
24 this case, associated with the pandemic, that would be  
25 for public health advice, medical and clinical advice --

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1 reviewed the SAGE minutes, it was only by sort of March  
2 and then into April that it became clear that the scale  
3 and kind of response needed was going to be wider than  
4 strictly public health, virology, epidemiology, and that  
5 wider expertise could be needed, and that's the point at  
6 which I started to attend SAGE.

7 Q. So March/April time was the first time that the sort of  
8 cross-cutting element of your role came to the fore; is  
9 that fair?

10 A. That's correct. And, again, to help understand that, if  
11 you look at the SAGE attendees, I think in April  
12 Professor Cath Noakes started as a SAGE attendee, she's  
13 a mechanical engineer. That's a topic that might not  
14 naturally come to mind when considering pandemic  
15 response, but the recognition was surfacing that wider  
16 expertise, cross-cutting expertise could well be  
17 important in the response, and so that's where my role  
18 can serve.

19 Q. Because Professor Noakes was a mechanical engineer, was  
20 talking about like aerosolisation or the risk of  
21 particles and what -- how matters -- how the virus might  
22 be spread through the air, and obviously others were  
23 talking about how the virus might be spread through  
24 touchpoints and the like, and that brings together --  
25 that's a good example, is it, of a mechanical engineer

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1 the first port of call, the person who would take the  
2 lead on that advice would be the Chief Medical Officer,  
3 not the Chief Scientific Adviser. So I did have a role  
4 during that time, but it was not to lead on the public  
5 health advice.

6 Q. Did that run the risk, at least, of you not having  
7 sufficient eyes across that cross-cutting element in the  
8 early days of the pandemic in terms of emerging  
9 knowledge and the fast-moving pace and the various  
10 threads that had to be pulled together?

11 A. So I would say no, what -- the way the system works is  
12 that the SAGE advice formally comes to the Chief  
13 Scientific Adviser, as I was then, and my office, so  
14 we're sighted on each of the SAGE minutes, the minutes  
15 formed the advice, so that sight was there, and my role  
16 was to ensure that those were passed quickly to SGoRR,  
17 the Scottish Government Resilience Room, who have the  
18 formal responsibility of co-ordinating emergency  
19 response, so that they could access the relevant topic  
20 experts, which in this case, as I say, would be the  
21 Chief Medical Officer and colleagues in Health  
22 Resilience.

23 So -- and during that time, the predominant need was  
24 for public health advice during the January, February,  
25 March period. I would say, having seen and indeed

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1 being able to look at it from a slightly different  
2 angle, perhaps?

3 A. Bring her expertise in fluid dynamics in the built  
4 environment, in the engineering of buildings, to bring  
5 that expertise to bear, and she played an important  
6 role.

7 Q. When you became more involved in the cross-cutting role,  
8 March/April time, what discussions were you having, both  
9 at that time and before that, with the then Chief  
10 Medical Officer about the focus, what could be brought  
11 to bear from other aspects in Scottish Government away  
12 from just the pure CMO approach?

13 A. So I would say up until March/April the response was  
14 very focused on, you know, clinical, medical,  
15 epidemiological needs, and so I did discuss with the  
16 then CMO, Catherine Calderwood, the expertise that she  
17 wished to draw on in putting together the Covid-19  
18 Advisory Group, which through its terms of reference is  
19 constituted -- it's still mostly in that response space,  
20 because that was still, the primary need was the public  
21 health response and associated areas, but she requested  
22 that I attend the, and was a member of the Covid-19  
23 Advisory Group, and that brought that ability to reach  
24 out further if needed. But the terms of reference of  
25 that group were still mostly in the public health area;

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1 I performed the link to wider expertise.

2 **Q.** And when -- I think in your statement, paragraph 24, you  
3 talk about this being set up even before the pandemic,  
4 but you also had this -- had CSA, four nations CSA  
5 discussions and meetings and ... when did they start to  
6 ramp up in the context of pandemic matters?

7 **A.** So the CSAs met weekly actually throughout the entire  
8 tenure of my time as CSA, so that pre-dated anything to  
9 do with the pandemic, and those particular four nations  
10 CSA meetings -- so that's the CSAs of the UK Government  
11 departments, plus the UK Government CSA, plus the -- me  
12 as the Scottish, and also the Welsh CSA -- the topic of  
13 those meetings was wide. That's the ability to have  
14 cross-cutting discussions, not actually necessarily  
15 about pandemic response, those could be about  
16 cross-cutting topics. So they were not focused on  
17 developing advice for the pandemic.

18 The CSAs could receive updates on the progress of  
19 the pandemic, but they served a different purpose, and  
20 I would say were extremely effective in building and  
21 maintaining contacts between the CSAs across, again,  
22 a wide range of backgrounds and formed one of the  
23 networks of expertise that we could all access.

24 **Q.** In terms of -- so you spoke about SCAG, and setting that  
25 up, and your role in that. You attended SCAG, didn't  
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1 If the universities subgroup wasn't set up until  
2 May 2021, who was giving advice to the Scottish  
3 Government about those sorts of very specific but quite  
4 high profile matters that were feeding into Scottish  
5 Government decision-making?

6 **A.** So I think it's an important point to realise that SAGE  
7 performs an advisory role for the whole of the UK, and  
8 throughout the pandemic SAGE remained the core source of  
9 scientific advice for all of the nations. The Scottish  
10 Government Covid Advisory Group was not re-doing SAGE's  
11 work, not duplicating SAGE's work, it was simply  
12 applying a Scottish lens to the advice that was coming  
13 from SAGE and adding in local information to help advise  
14 Scottish Government. So even without the formation of  
15 an education -- universities and further education  
16 subgroup, SAGE could provide a core source of scientific  
17 advice for all the nations.

18 **Q.** So what then prompted the subgroup to be set up in  
19 May 2021?

20 **A.** So I'm afraid the setting up of the subgroup would  
21 really be a matter for the CMO to answer, because each  
22 of these subgroups, when they formed, fed in through the  
23 Scottish Government Covid Advisory Group to then provide  
24 a source of advice for the CMO.

25 **Q.** You also attended the schools and education group, so  
211

1 you?

2 **A.** I did.

3 **Q.** And you then also attended a series of subgroups.  
4 The Inquiry's heard and will hear, continue to hear,  
5 lots of evidence about SCAG more broadly. So what  
6 I would like to do right now is very briefly drill down  
7 into some of the detail of the subgroups that you were  
8 on.

9 **A.** Sure.

10 **Q.** You were on the education and children's Issues  
11 subgroup?

12 **A.** That's correct.

13 **Q.** And you were also on the university and colleges  
14 subgroup?

15 **A.** That's correct, very briefly. It formed only shortly  
16 before I came to the end of my time as CSA.

17 **Q.** That's exactly the sort of question I was going to come  
18 to. It formed May 2021, somewhere around then.  
19 The Inquiry has heard and will no doubt continue to hear  
20 evidence about issues surrounding university students in  
21 late 2020 and the concern that the return of students to  
22 university and close quarters in university halls of  
23 residence and the like were driving pandemic figures in  
24 late 2020 as the term returned, students returned to  
25 school -- to university.

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1 were you the only person to be on all three -- attending  
2 SCAG main -- the main SCAG and those two subgroups?

3 **A.** No, I think Professor Carol Tannahill, who chaired the  
4 education subgroup, and I think subsequently originally  
5 the university subgroup, also then attended the main  
6 Scottish Government Covid Advisory Group to maintain  
7 links between those entities. I was, however, the only  
8 attendee on the education and children's subgroup who  
9 also attended SAGE.

10 **Q.** So, again, was this an example of your cross-cutting  
11 function as well and the links that you can build up in  
12 your role?

13 **A.** Exactly. So, again, this is an area where the CSA can  
14 act to perform a role in linking different science  
15 areas, in attending SAGE, then be able to help that  
16 subgroup access the underlying evidence from SAGE, or  
17 indeed elsewhere in my network, to inform the  
18 discussions of the subject experts on that group.

19 **Q.** A different element of your cross-cutting role, I think,  
20 the chiefs group from May 20 -- from mid-2020.

21 If we can have your statement up, please, at page 3.  
22 It might even be page 4, because it's paragraph 10.13,  
23 my apologies.

(Pause)

24 We can do it without the statement, don't worry.

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1           There comes a point in mid-2020 --

2 **A.** Yeah.

3 **Q.** -- when you say it was recognised that there was no --

4           although there were all these different groups

5           available, what there wasn't necessarily was a single

6           area or single forum for the Scottish Government

7           advisers to collectively come together and communicate

8           each of their own individual expertise in a small group

9           setting. Is that right?

10 **A.** That's correct.

11 **Q.** And is that what sort of prompted the institution of

12           what's known as the chiefs group?

13 **A.** Yes. So there were fora in which combinations of the

14           chief advisers would be present, be understanding the

15           different roles that one another were performing and

16           discuss that. There was no forum, no one forum where

17           all the chief advisers met and could share information

18           about ongoing commissions, take a strategic look at what

19           future advice might be needed, and then collectively

20           have that understanding of what one another were doing.

21           So, you know, science advice certainly was

22           proceeding strongly. I would say the most useful role

23           of that group was simply information sharing so that

24           each adviser then could go off and do their own job.

25 **Q.** Was there a concern or potential concern that

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1           subgroups should be established and advise on their

2           membership.

3           Is it right that, as time moved on, this ended up --

4           instead of it being a body that the idea of ministers

5           coming to the group and sort of commissioning further

6           advice, commissioning further investigations or studies

7           or policy papers to be provided, is it right that in

8           fact what happened in reality was it just gave a more

9           focal point, a visibility? I think you say in your

10           statement that it created a sort of -- it helped to

11           increase the visibility of the sources of information

12           across Scottish Government, rather than being a direct

13           sort of advisory body in itself; is that fair?

14 **A.** So the group could have been commissioned to directly

15           provide advice to ministers. It did not, in my time,

16           operate in that way. As I've said, essentially it

17           allowed internal visibility and information sharing of

18           the activities of the different chief advisers with one

19           another.

20 **Q.** Would it have improved the group, would it have improved

21           access to information across government had it had more

22           of a commissioning -- had more involved in the role that

23           it could have had?

24 **A.** So I'm afraid that that's a question I don't have the

25           insight to answer for you.

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1           effectively, because different groups were meeting

2           separately, that there was a risk that information might

3           fall between the gaps, as it were, because of the

4           fast-moving nature of the pandemic?

5 **A.** So I'd no reason to believe that anything was falling

6           between the gaps. However, you can always make things

7           better, and so putting that group in place just put in

8           place an additional forum in which we could all be

9           sighted on one another's activity, and the utility of

10           that exercise was such that I believe some form of that

11           group continues.

12 **Q.** If we just very briefly have up on screen INQ000321345,

13           I think this is the original proposal, as it were, for

14           setting up the chiefs group.

15 **A.** So this is a document that I have not seen in

16           preparation.

17 **Q.** I'm not going to ask you any detail of the granularity

18           about it, and I can apologise -- I apologise for that.

19           Can I just -- if we look at page 3, this is,

20           I think, sort of summing up what you've just said in

21           many ways, but paragraph 10: bringing together small

22           body of groups of advisers to lead the forward planning

23           to ensure that advice can be delivered, liaising with

24           colleagues in the government as appropriate, and this

25           would help to identify where new thematic sectoral

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1           **MS ARLIDGE:** Fair enough. Then I have nothing further for

2           you. Let me just bend over and see if there's anything.

3           My Lady, do you have anything further?

4           **LADY HALLETT:** Thank you very much, Ms Arlidge.

5           Thank you very much, Professor. I hope you have

6           a safe journey back to Glasgow. I hope the trains are

7           running again, are they?

8           **THE WITNESS:** I hope so too.

9           **(The witness withdrew)**

10           **LADY HALLETT:** Thank you very much. 10 o'clock tomorrow,

11           please.

12           **MS ARLIDGE:** I'm grateful, thank you, my Lady.

13           **(4.40 pm)**

14           **(The hearing adjourned until 10 am**

15           **on Tuesday, 23 January 2024)**

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141/19 186/5 186/18	<b>occur [4]</b> 37/25 164/2	45/6 60/10 74/6 77/1	32/17 49/6 50/9 51/11	101/6 103/25 105/19
191/19 194/15 201/1	175/18 192/21	78/22 175/13 185/15	55/11 65/11 84/12	106/4 108/19 108/24
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10/20 12/14 16/15	90/24 91/6 152/13	164/13 164/19 165/20	<b>onwards [5]</b> 48/23	129/13 130/5 133/20
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