Witness Name: Jason Leitch
Statement No.: 1
Exhibits: JL
Dated: 02 November 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF PROFESSOR JASON LEITCH

In relation to the issues raised by the Rule 9 request dated 8 August 2023 in connection with Module 2A, I, Professor Jason Leitch, will say as follows: -

1. I am Jason Leitch of St Andrews House, 2 Regents Road, Edinburgh, EH1 3DG. I am the National Clinical Director (NCD) and Co-Director of the Directorate for Healthcare Quality and Improvement. A position I have held since its inception in 2015. I have worked for Scottish Government since 2007.

2. Throughout this statement I have answered the questions put to me by the Inquiry to the best of my ability. Where I am unable to answer the questions posed, for example because the question falls outside my remit, I have informed the Inquiry of this and the reasons why, in accordance with the instructions outlined in the Rule 9 request. The structure and headings of this statement are those included in the Inquiry's request.

3. In the preparation of this statement, I have referred to records and material provided to me by the Scottish Government. I have also received assistance from the Scottish Government Covid Inquiry Response Directorate and other appropriate assistance to enable the statement to be completed. Due to the significant volume of questions and material that the Inquiry has asked me to consider, I was also assisted in identifying documents and factual information relevant to the questions being asked to assist in the preparation of my statement. However, any views or opinions expressed are my own.

4. Unless stated otherwise, the facts stated in this witness statement are within my own knowledge and are true. Where they are not within my own knowledge, they are derived from sources to which I refer and are true to the best of my knowledge and belief.

5. References to exhibits in this statement are in the form [JL/Number - INQ000000].

Sources of advice; medical and scientific expertise, data, and modelling

Roles and responsibilities

6. I was appointed as NCD in January 2015 to engage with and provide clinical leadership to the NHS in Scotland. This involves working with health boards and other stakeholders to drive service improvement through key programmes like the Scottish Patient Safety Programme. I am also responsible for the delivery of clinical quality and safety within the NHS and to ensure health boards prioritise quality and safety of care. A big part of this means making sure quality and governance are prioritised at board level. Developing collaboration between colleagues working in quality and safety improvement, clinical research, professional regulation, and workforce planning is part of my role. Before the pandemic I had no specific responsibilities relating to pandemic preparedness.

7. Scotland's NCD role developed out of the role of National Clinical Lead for Quality. It came about in 2015 when senior leaders in Health and Social Care (HSC), including the Director General (DG) and the Chief Medical Officer (CMO), decided that a third senior clinician with responsibility for the quality and safety of the delivery system was needed. The intention was to place quality and safety at the highest level of NHS Scotland leadership. While the job title of National Clinical Director is unique to Scotland, the role and functions are not. My counterparts are those in the four nations with clinical responsibility for safety and quality of the system.

8. I was not involved in any pre-pandemic preparations in Scotland prior to March 2020. As set out later in this statement, as the risks around Covid-19 became apparent, my role evolved. Early in the response to Covid-19, following the resignation of the former CMO in April 2020, I became the principal clinical communicator for the Scottish Government. This involved communicating with three groups – the public, the Scottish Parliament, and Scottish Government stakeholders. The stakeholders

were people and organisations who were affected by Covid-19, such as hospitality businesses, education establishments, and faith and belief organisations and institutions.

9. It was recognised in the Scottish Government that there was a need, not just for political leadership, but also for clinical communication, a responsibility I took on as NCD. Though what I did was very high profile in terms of the media platform, I was not writing the guidance or making the decisions on Scotland's response. I viewed my role as translating what had been decided into clear communication to the public, the Scottish Parliament, and stakeholders.

10. While it was an unofficial title, my role as the "principal clinical communicator" was to disseminate – through a variety of communication channels – decisions, information, advice, and guidance during the pandemic. This information was not restricted to health-related matters but included issues like school closures and business restrictions. The thread through everything was Covid-19 and public health.

11. During the Scottish Government's response to Covid-19 I met regularly with Scotland's CMO, the Deputy Chief Medical Officers (DCMOs) and the Chief Scientific Adviser (CSA). I spoke to my Scottish colleagues regularly, often multiple times a day and with the broader UK-wide senior clinicians through the Senior Clinical Advisers' Group, of which I was part. The group was co-ordinated by the UK CMO. This group also included their counterparts in the other UK nations, public health officials and academics. It was instrumental in shaping clinical advice on the response to the pandemic.

12. This group met every Tuesday and Thursday night for approximately one year, and then every Tuesday night for approximately one year after that. It consisted of all four CMOs (Chief Medical Officers), the Chief Nursing Officers (CNOs), and the leads for public health. I attended, as did the English Medical Director.

13. In this group evidence was considered and discussed and efforts to reach a clinical or scientific consensus on how best to respond to the pandemic were made. We discussed how to frame advice to those responsible for decision-making in government.

14. Decisions relating to the response to Covid-19 were made by Scottish Ministers. My role was not as a decision-maker but as one of many advisers who attended meetings and formal groups where advice was formed and then submitted to Scottish Ministers. I would often attend meetings where I was not an active participant but to listen and learn. My job was to communicate the advice, following decisions by Ministers, to the three groups already mentioned. To do that effectively I needed to understand the advice that was being given. Throughout the questions there is frequent reference to what medical/scientific advice was given, why that advice was given and how it was communicated. It is important at the outset to underline that my role focussed on communication. I was not principally involved in giving scientific/medical advice, although I was often present when such discussions were occurring.

NCD advice and medical/scientific advisory bodies

15. Although I was not a member of any of the medical/scientific advisory bodies, I did occasionally attend the Covid-19 Advisory Group (C19AG) to listen to the discussions, particularly around communicating the pandemic response. I attended C19AG meetings on the following dates: 21 January 2021, 4 February 2021, 9 September 2021, and 11 January 2022. I believe that this matter is covered by the Module 2/2A Corporate Statement of the Chair of the C19AG dated 23 June 2023 which provides answers to questions from the Inquiry that I am unable to answer given my remit and limited involvement with C19AG.

16. While I was not party to any political decision-making, I had a general understanding throughout that Ministers wanted to hear the best scientific and expert advice and considered it very carefully.

17. We often referred to "following the science" in public communications. It was true to say that we were following the science. The science was broad and dynamic. It was not just public health science but also behavioural science and other areas impacting on the population. Prior to the introduction of therapeutic treatments, and the vaccine rollout, non-pharmaceutical interventions (NPIs) were the only tool we had to keep R below 1. The polling I have seen showed that our messaging was trusted and effective. It is difficult to draw firm conclusions about the effect of individual NPIs but the reduction of R below 1 is evidence that the guidance and communication worked.

Science changed frequently and the advice and decisions changed with the science. My role was to communicate that changing advice.

18. There are various questions in relation to the policies that underpinned the Scottish Government's approach. I was not involved in these policy matters but I believe that this matter is covered in the Corporate Statement of the Director General Strategy and External Affairs in the Scottish Government, provided 23 June 2023, and the Corporate Statement by the Director General for Health and Social Care, provided 23 June 2023.

19. I am asked to what extent the policy was driven "by the idea that no death from novel coronavirus is acceptable," I do not recall any discussions that there was to be a singular focussed response like this. My impression from the groups I attended was that everyone acknowledged that no approach could avoid all harm. It was a compromise. If we focussed solely on one of the harms, then additional harm may be caused elsewhere.

20. The engagement with Public Health Scotland (PHS), territorial Health Boards, Local Authorities and Independent care providers was constant throughout the pandemic. I spoke to leaders from Public Health Scotland weekly at least. I attended and briefed Board Chief Executives regularly. However as set out already, my role was to communicate the advice being given. I did not have an executive function. The various advisory groups gave their advice to these parties. My interaction with them was principally around explaining when the guidance had changed, or the state of the pandemic had adjusted.

21. The personal and working relationships between medical and scientific advisers in Scotland and across the UK was very good. Many of us knew each other well and had worked together for many years. Other relationships were newer and were formed quickly and effectively. The 4-country senior clinicians' group was essential and worked well, as outlined later within this statement at paragraph 87 onwards, under heading *Intergovernmental Working*. The working relationships between the Scottish Government and medical and scientific advisors was very good.

22. Advice was given regularly to Cabinet, Scottish Government Resilience Room (SGoRR) and the Four Harms group. These three groups were crucial to the Scottish response. The principal adviser to these groups was the CMO. I supported the CMO

and groups and often contributed to the discussions, but I was not a decision maker. I attended Cabinet several times in place of the CMO where they could not attend, communicating the updates on the pandemic they would normally cover. My attendance was an integral part of SgoRR and Four Harms for the reasons already set out.

Informal Decision Making and communication

23. Responses to these questions have been referred to in previous corporate statements and are I believe covered in the Module 2A Corporate Witness Statement of the Director General for Health and Social Care, provided 23 June 2023.

24. I have subsequently been sent a further 79 questions by the Inquiry in relation to this section, which I will be responding to separately.

25. I was a member of a number of informal messaging groups. These were used, for example, for coordination of meetings and media appearances. I never used them to give advice to Ministers. If advice was required, it was given by email and/or meetings. I would occasionally be contacted on WhatsApp about what the current advice on a particular issue was, and I would give it. However, this was advice that had already been given formally by others and I was helping to ensure this was communicated consistently. I have retained no relevant messages, in line with Scottish Government guidance. I was required to change my government phone in March 2023 after a trip to Israel and a potential security concern. All of its contents were lost at this time. I will provide further information about my personal devices in my responses to the 79 additional questions referred to above. I have retained four sets of Twitter DM messages which relate to discussions about the management of the pandemic and these will be provided to the Inquiry as part of the new Rule 9 79 questions return. I do not have a record of all the groups I was a member of, but they included one for all health and social care directors, clinical advisors, senior four harm advisors, sports advisors, and a group with the CMO and Jim McMenamin from PHS. I used the latter group to receive urgent data prior to media appearances. I had no other involvement, but I believe that these matters are covered in the Corporate Statement of the Director General for Health and Social Care.

26. My role, as described above, was principally to communicate the advice and state of the pandemic to others. The C19AG was a crucial part of the information flow and

advice structure. It was important I understood their advice and was able to translate it for ministers and others. It was not essential I was at the meetings to hear the discussions. I attended when able and when it was crucial to discuss matters relevant to my role such as public communication. I did not consider attendance essential given the broad number of others attending and I believe that the other questions on this matter are covered by the Module 2A Corporate Statements of the Director General Strategy and External Affairs and the Witness Statements of the Director General for Health and Social Care.

Scottish Government Covid-19 Advisory group ("C19AG") and SAGE

27. My role, as described above, was principally to communicate the advice and state of the pandemic to others. The C19AG was a crucial part of the information flow and advice structure. It was important I understood their advice and was able to translate it for ministers and others. It was not essential I was at the meetings to hear the discussions. I attended when able and when it was crucial to discuss matters relevant to my role such as public communication.

28. The Scottish CMO is a member of SAGE, so there was no need for me to be a member too. They shared the information appropriately. We had to divide responsibility and roles. We could not all attend everything and much of my time was spent engaging on communication to the public.

29. The SAGE/ C19AG system and their sub-groups were crucial. They included broad expertise, including behavioural science. They also included a variety of views and the necessity to reach consensus made the advice as good as it could be. Professor Andrew Morris's leadership was crucial. He was trusted by the scientists and by Ministers.

30. In my view C19AG was very effective in the way that it formulated advice to the Scottish Government in its management of the pandemic. I believe that the role of the sub-groups is covered in the Module 2A Corporate Statement of the Chair of C19AG.

31. The C19AG provided advice in writing to the Scottish Government in the form of papers setting out the consensus view of the C19AG. Some of this advice was in response to requests for advice, communicated to the Group via the secretariat.

Other advice was provided on the C19AG's own initiative. The C19AG advice was routinely issued to the:

- First Minister
- Deputy First Minister
- Cabinet Secretary for Health and Sport (subsequently Cabinet Secretary for Health and Social Care)
- DGHSC (Director General for Health and Social Care) and Chief Executive of the NHS
- NCD
- Covid Public Health Director
- Other senior officials involved in the response to Covid-19.

32. Ministers and senior officials would also routinely receive a brief informal report following meetings of the C19AG, noting the issues discussed, in advance of the formal minutes of the meeting. The C19AG secretariat has collated all key materials from the group, including copies of advice issued by the Group, and I understand that these have been provided to the Inquiry.

33. SAGE / C19AG were not the only sources of advice. As described in the corporate statement from Director General for Health and Social Care (DG HSC), advice was obtained from multiple sources for decision-makers including the World Health Organisation (WHO) and PHS. Both SAGE and C19AG were crucial though. The full advice, including economic, educational etc, was broader than the scientific/public health groups. It was given through the Four Harms group, and a variety of groups feeding into that structure, and which is covered in other corporate statements. I am confident the broad advice received by Ministers included advice from SAGE and C19AG as well as other sources.

34. The detail of advice on health, economics, ethics, and education is better known to others and covered elsewhere in corporate statements. I did have a general sense of there being no issues in obtaining expert advice as and when it was required for all relevant subjects.

35. I had no concerns regarding the adequacy or sufficiency of scientific and other expert advice, bearing in mind the nature of the novel virus and disease and the nature of far-reaching population level interventions. Much of the advice was, by necessity, in

real time. My experience was that the subgroups were appropriate and provided timeous advice when asked. For example, I remember the group focussed on schools and education, chaired by Professor Linda Bauld, which looked at specific challenges about re-opening schools. It was very helpful in reviewing and aligning all the advice to allow Ministers to reach informed decisions.

36. I am not familiar with the processes of providing scientific advice between January 2020 and February 2020 as it was not part of my remit, I was unaware of any issues in this regard.

37. My understanding of the transmissibility, infection, mutation, reinfection, the nature of the virus including its severity, and the measures available to limit its spread and how this understanding developed over the course of the pandemic can be found in the four CMO's *Technical report on the Covid-19 pandemic in the UK (*10 January 2023), provided [JL/001 – INQ000130955].

38. In my opinion the C19AG was a well-managed, broad group who looked at issues they were asked to consider as well as other matters. It was chaired by a senior academic. The membership of the group included a broad range of opinions, but in my view that made it better. It provided clear advice during the pandemic.

39. The CMO was the principal clinical adviser, and as NCD I was the principal clinical communicator. Our roles are outlined in the Module 2A Corporate Statement of DG Health and Social Care, provided on 23 June 2023. I understand that all advice given to Ministers has been provided to the Inquiry. That advice was from a series of sources already described. I gave no separate independent advice as that was not my role.

40. Expert medical and scientific advice was sought, carefully considered, and acted upon by Scottish Ministers. The CMO attended Cabinet every week and gave an update on the epidemiology of the pandemic. The CMO sought to explain and 'translate' clinical and scientific advice to enable Ministers to understand it and make their decisions. I attended Cabinet occasionally in a listening capacity and have listed my attendance above.

41. The CSA, CMO and DCMO (Deputy Chief Medical Officers for Scotland) roles are detailed in the Module 2A Corporate Statement from DG Health and Social Care. My

experience was that the working relationships between the CMO, DCMO, the deputy NCD and I were very effective throughout. There were some personnel changes within the CMO's department, and the relationships stayed effective throughout. The deputy NCD worked well with the CMO and DCMOs. We divided responsibility as appropriate. The deputy NCD, for example, was responsible for clinical advice for shielding and later for Long Covid. The role of C19AG is covered elsewhere and their corporate statement covers how they made decisions and communicated advice.

42. I was clear about what the senior decision makers were trying to achieve with their decisions. There was no lack of clarity when decisions were made by Cabinet and the First Minister. It was clear what needed to be communicated and as the principal clinical communicator I was often responsible for communicating the decisions and advice of others and the state of the pandemic. It was important to be clear, as it was crucial that the advice to the public and organisations was clearly understood. It is for others to judge if I managed that, but I tried, in all conversations, to ensure the advice was translatable for public consumption.

43. Data was crucial in advice and communication. The dashboards created and regularly updated by Public Health Scotland (PHS) and the UK public health agencies were crucial. They were publicly available, often updated daily and we referred to them often on press conferences and media appearances. The available improved over time. For example, understandably, at the start data was very limited. However, as time passed more data became available.

44. Advice to core decision-makers was always given openly and truthfully, and in response to the policy options under consideration. The science was constantly changing, and this was always made clear.

45. To the best of my knowledge advice from the WHO, SAGE and C19AG as well as from PHS was never watered down or adapted because it was 'too hard'. The advice and decisions around responding to a global pandemic are, by their nature, hard. Everyone understood this. The First Minister was very clear on the best options in that context.

46. We communicated as clearly as possible in all the advice and communication. Technical terms were used where necessary, and language was then adapted for each audience. I did many media briefings and many Scottish parliamentary

committee appearances. We held daily press conferences for 18 months. I always tried to be completely open and honest, including when I did not know something. While I accept there are undoubtedly learning points for how we communicated advice to people, at all times we were as transparent as we could be.

47. To challenge any medical/scientific advice provided to them, the First Minister and her Cabinet Ministers were able to ask questions throughout the pandemic response both directly in meetings and in response to briefings. This happened regularly in Cabinet, in SGoRR and in other key meetings.

48. I did not give independent advice to Ministers. The principal route for advice was through the Four Harms group, C19AG, and the senior clinicians group. However, from my involvement I know that the advice being given by the various groups developed and matured as our knowledge changed but, even from the beginning, the implications of decisions were expressed, including economic ones.

49. I do not recall any conflicts with medical and scientific information and advice and data modelling communicated by advisers to key decision-makers within the Scottish Government, and it was provided on a basis of consensus. I believe that formation and provision of advice is described in the Module 2A Corporate Statement of the Director General for Health and Social Care, provided 23 June 2023.

50. The advice to the First Minister and Cabinet was broad-based and not from a single individual. It contained advice from SAGE, C19AG, PHS, the CMO, and others. I did not see any evidence of 'groupthink.' The Four Harms process was specifically developed to allow advisors to consider all the implications of the response.

51. To my knowledge, there were no instances where medical or scientific advice or data modelling was provided but not followed, or decisions in relation to which medical and scientific information or advice or data modelling was not sought but which ought to have been sought.

52. It is my understanding that the Four Harms group has been fully covered in corporate statements provided by the Scottish Government and was specifically developed to weigh medical and scientific advice with other considerations. It had broad membership including the Chief Economist.

53. Advice from C19AG was readily available and part of the Four Harms discussion. I was one of the senior clinical leaders on the Four Harms group, along with the CMO, and took a full part in the conversations so that the group could give advice to decision-makers.

54. C19AG advice was provided directly to Ministers and formed part of the advice provided by CMO and others. I am not aware of any times where C19AG participants were not invited to attend C19AG meetings due to concerns that they would disagree with the consensus view. However, it is important to reiterate that I was not a member of C19AG. I would attend if there was something specific I needed to understand to translate and communicate to others. This would help with my own understanding and so I could perform my communicator role. Occasionally I would attend and tell the group what the Ministers' decisions were so they would know for their own media appearances. This was important to ensure consistency of messaging.

55. I spent time with several patient groups as well as other groups across the Scottish public sector including teachers, business owners etc. I attempted to explain the most recent advice and listen to the lived experience of those in the groups. PHS also did a lot of outreach work to communities, schools etc. I spoke regularly to young people, via Young Scot's health panel, to hear from them about their experiences. I also did numerous radio and TV phone-ins, hearing directly from the broader public. All of these engagements allowed me to contribute broad views from stakeholders to the advisory groups I was part of.

56. Advice was requested from the C19AG by the CMO, Ministers and the First Minister. As described in the statement of the Chair of the COVID-19 Advisory Group several deep dives were held to allow the First Minister and others to hear directly from the members. Advice was received from the group in briefings and I believe that this matter is covered in the Module 2A Corporate Statement of the Director General Strategy and External Affairs.

57. There are a number of questions in this section that I cannot answer as the formation and administration of the group was not part of my remit and I am not familiar with any of the details sought as I was not a key participant. I believe that these matters are covered within the Module 2A Corporate Statement of the Director General for

Health and Social Care. I believe that the Inquiry has already been provided with the minutes and papers by the Scottish Government.

Data and modelling

58. Like many sections, much of the background is covered in the already submitted Module 2A Corporate Statements from DG Health and Social Care, CMO/CSA/NCD and DG External Affairs. Particular sections that cover well the questions asked include Module 2/2A CMO/CSA/NCD statement, sections 36, 37 and 38; and the Module 2/2A DG statement, sections 243, 244, 245, 251, 252 and 349.

59. As throughout, my main role was communication and translation of information to three groups – the public, stakeholders, and politicians. Data was crucial and central to this. I often used data in interviews, briefings, and discussions. I used slides with stakeholders to illustrate the state of the pandemic.

60. Key data and modelling information and advice used in the Scottish Government's response to Covid-19 included multiple sources - the WHO, the European Centre for Disease Prevention and Control, the UK Health Security Agency (UKHSA), and the Scottish sources – PHS and HSCA, which I used most often. We had the outputs from SAGE and its specific modelling subgroup, SPI-M. I often used 'Our World in Data' to describe the global position. I believe that additional information on this matter is covered in the Module 2A Corporate Statements of the Director General for Health and Social Care, .

61. I believe the Scottish Government, including those who provided models about the trajectory of the pandemic, had adequate access to reliable data and modelling information. I had adequate access to data to inform advice to core decision-makers throughout the pandemic, and it evolved over time and matured. I do not recall encountering any issues with data sharing, collection, or dissemination during the pandemic. I believe that further information on this matter is covered in the *Technical report on the COVID-19 pandemic in the UK*, provided [JL/001 – INQ000130955].

62. Data visualisation to help core decision-makers understand the advice was helpful, for example dashboards were useful and we used data to communicate with the public. I was often asked about data on TV and radio and in stakeholder meetings. I often used data slides produced by PHS and HSCA to illustrate the state of the

pandemic, particularly to stakeholder groups. I often shared modelling and data with all the groups I spoke with. 'Our World in Data' became a key source for global data to illustrate the state of the pandemic to many groups I spoke to, including parliamentarians. I believe that additional information on this matter is covered in the Module 2A Corporate Statement of the Director General for Health and Social Care and in the *Technical report on the COVID-19 pandemic in the UK*, provided [JL/001 – INQ000130955].

63. Non-pharmaceutical interventions were included in data and modelling as the pandemic progressed. Research was also becoming available gradually to help inform advice. There was data on traffic patterns, and public transport numbers regularly given to assess movement of the population. We were able to see survey data on how many people self-reported following particular guidance such as staying at home etc.

64. The provision of modelling information is described in other statements, but modelling included that from SAGE, SPI-M (Scientific Pandemic Influenza Group on Modelling), and HSCA. Modelling from many sources was considered. I had adequate and timely access to clear, relevant, and reliable modelling. Due to my remit, I was not involved in any discussions about the remit of C19AG.

65. Within the limitations of a novel virus with developing scientific knowledge the modelling was very good. It changed over time as the science developed. We understood modelling was not prediction and always had caveats. Modelling of epidemiological outcomes was as reliable as it could be given the limitations of data available for a novel virus and NPIs that had not been attempted at this scale previously. My recollection is modellers would often present a variety of scenarios. For example, for school returns – all schools, no schools, key workers only. They presented multiple scenarios as well as data and modelling allowed. I did not consider the modelling to be biased towards specific outcomes.

66. My impression is that Ministers and senior advisers understood what modelling was and what it was not. They understood it was part of the information required to inform advice and subsequent decisions.

67. Other factors, such as economic, societal, educational, non-Covid health related, and mental health impacts were often even harder to model but HSCA and other groups did do it when they could.

68. Sufficiently modelling vulnerable and at-risk groups was harder to do because of the novel nature of the virus and the developing nature of the science. When it was possible, it was modelled.

69. The Inquiry have asked me whether there is anything I consider could have been done to improve data collection, sharing and linkage across health and care systems, Scottish Government Directorates and the other nations of the UK, I have provided views and reflections in other responses, to which I have nothing further to add to the information provided at *Section A (e) Data and modelling* above.

Other sources of information and advice

70. I was only peripherally involved in the first three months of 2020 and did not provide any direct advice in that period.

International advice

71. My contribution to the advice given by the various groups included my knowledge from other country's responses and that included conversations with colleagues that I had established relationships pre-Covid. This included colleagues in Sweden, the USA, Canada, Israel, and Denmark.

72. Many of the Scottish and UK sources of advice had established links to international experts. PHS, the C19AG, the UK Senior Clinicians Group, all comprised experts with good global links. These were informal and formal. For example, the UK membership of the WHO is managed by the UK Government, and this allowed a flow of information. UKHSA also has strong international connections. Our academic partners, particularly through the Usher Institute at the University of Edinburgh, were very well connected globally. Members of the C19AG were very active around the world including Professor Devi Sridhar, chair of global public health at the University of Edinburgh, who was able to share information from other countries. I too have a global network of health experts through my work in Healthcare Quality. I was able to speak to them regularly throughout the pandemic.

73. International evidence and data were a crucial part of the advice shared with decision-makers. We learned a great deal from other countries. I have no specific knowledge of how the formal scientific advisory structures were adapted. It came from many sources including the WHO, SAGE and the C19AG.

74. I do not recall being at the meeting of C19AG on 13 April 2020 attended by Andreas Poensgen. I did attend the meeting with David Nabarro from the WHO. Questions regarding these meetings are better directed at C19AG as due to my remit, I was not involved with invitations to C19AG meetings, but my understanding is that the intention was to get as broad a global perspective as possible, to gather the best advice from around the world. David Nabarro was giving advice to over 200 member nations of WHO.

75. The WHO advice was crucial in the UK and Scotland. We monitored it and received regular updates from them. Their advice is global, and it is for almost 200 member countries, each of which has a different context and a different health and care system. It is inevitable, and acknowledged by the WHO, that their advice will of course be adapted for local context, which is what Scotland did.

76. As the pandemic was ongoing, we did learn from other countries. Three years later it remains important to reflect and learn from other country's responses. This is an ongoing exercise, as inquiries are reporting globally. The WHO continues to learn lessons and advise.

77. International Comparators Joint Unit was a UK Government initiative. I had no direct dealings with it.

Other sources of information and advice

78. I had no concerns about the adequacy of the evidence sources on which our advice to core decision-makers was based throughout the pandemic.

79. Consulting with interest groups was not part of my remit. As outlined elsewhere, I did engage with a wide range of interest groups to communicate the latest guidance around Covid-19, and this was continually developed and updated. I spent time with stakeholders and talked to them about the state of the pandemic and what the

Government wanted to do. This also allowed me to hear from them about their experiences. I would feed that knowledge back into the advisory groups to try to make the advice as rounded as it could be. I do not consider there was information overload. The organisation was divided in such a way that there were people in charge of different areas such as business, faith and belief, sport. Each sector managed their information groups and provided key information up the chain. I was cross-sector and that allowed me to hear from a cross-section of groups.

80. Ministers and Scottish Government officials would meet regularly with core stakeholder groups. Meetings would be recorded and shared as appropriate with those with an interest, including in Cabinet discussions as relevant.

81. Scottish Government sought to take account of issues around nosocomial infections, and higher rates in care homes, including through the work of the Covid-19 Nosocomial Review Group. I do not recall any representations from Scottish Covid Bereaved to the then Cabinet Secretary Humza Yousaf MSP, or Scottish Government Groups, although given my remit this may have been received at any number of meetings, I was not present at. I do not know if the percentage of nosocomial deaths were significantly higher than care home deaths.

82. There was a particular discussion in 2021 about extending the symptom profile. This was a carefully balanced debate to capture as many Covid cases as possible while also not capturing false positives. All infectious diseases face this diagnostic dilemma, particularly when symptoms are very general, such as headache. The UK senior clinicians group discussed this regularly and decided not to extend the symptom profile based on the evidence available at the time.

83. Advice was available to Ministers through groups such as the Scientific Advisory Group for Emergencies (SAGE), the Covid-19 Advisory Group (C19AG), the Joint Committee on Vaccination and Immunisation (JCVI) and the Joint Biosecurity Centre (JBC). As outlined in the Module 2A Corporate Statement of the Director General Strategy and External Affairs provided 23 June 2023, at paragraphs 72-75, the pandemic, and measures in response to it, were assessed against the 'Four Harms' identified as:

    - direct Covid-19 health harms: primarily, the mortality and morbidity associated with contracting the disease;

- broader health harms: primarily, the impact on the effective operation of the NHS and social care services associated with large numbers of patients with Covid-19, and its knock-on effects on the treatment of illness;
- social harms: the harms to wider society, in terms (for example) of education attainment because of school closures; and
- economic harms: for example, through the closure of businesses.

84. The Scottish Government's strategic aim was to minimise the overall harm of the pandemic. In April 2020 it published the way it would take future decisions on its pandemic response in the *Framework for Decision Making* [JL/002 – INQ000131025]. A published update, *Framework for Decision Making – Further Information* (5 May 2020), provided: [JL/003 - INQ000131026] explained how the Scottish Government's approach to NPIs was developing in light of epidemiological conditions.

85. The medical and scientific advice, evidence and data made available to key decision makers increased in line with the growth in scientific understanding as the virus evolved.

86. I believe that additional information on these matters is covered in the Module 2A Corporate Statements of the Director General Strategy and External Affairs and the Director General for Health and Social Care provided on 23 June 2023.

Intergovernmental working

87. I witnessed effective cross-country collaboration and discussions. The 4-country Health Ministers met regularly, and I often accompanied the Scottish Health Cabinet Secretary. These meetings were open and constructive. They were organised by the UK Government. Clinically, the 4-country response was good. This was evidenced by the 4-country clinicians' group, convened by CMO England twice weekly initially, and then once a week. There are more details about this in the corporate statements. I regularly attended the 4-country Health Ministers' meeting accompanying the Scottish Cabinet Secretary. These meetings were open, professional, and functional. I occasionally attended COBR in a listening capacity.

88. Meetings of the "Senior Clinical Advisers' Group" and "UK Senior Clinicians Group" are the same meetings. I agree these meetings were essential to the response. It

brought together the senior clinical advisers of the four nations and allowed a free and frank discussion of the state of the pandemic and advice being given to the respective decision-makers. It met regularly and often. A note of discussions and outcomes was shared from the meetings from the UK CMOs office. It was not a formal decision-making group, but they were crucial in the response.

89. The responses from the other UK countries were well understood in the main. There were some occasions when the timing of announcements was inevitably fast and perhaps all countries could have been better at informing each other. My role was to communicate the Scottish guidance and try to prevent confusion. I did some UK-wide media in which I was always clear there were four countries and four governments.

90. I had no working relationship with the Office of the Secretary of State for Scotland. I believe that formal links are covered in Scottish Government Corporate Statements. I have previously explained the role of the NCD in Scotland. I cannot answer whether there should have been counterparts to my role in the other nations as that is a matter for them. Much of the NCD role is covered by other people in the other nations. For example, the English Medical Director did a lot of the communication in England.

91. I believe that additional information on four nations cooperation is covered in the Module 2A Corporate Statement of the Director General Strategy and External Affairs.

Funding and competence

92. I did not encounter any issues faced by the medical/scientific advisory structures in relation to resources and funding during the pandemic that impacted on the quality of advice we were able to provide. I was not aware of there being limits to what could be achieved in our pandemic response based on funding constraints...

93. The nature of devolved Government and decision-making are covered fully in the Director General Corporate Statement. Public health advice was always given on the basis of what was best for the Scottish population. This was balanced by the Four Harms approach, including economics. Clearly the funding available to the Scottish Government and the funding of the Covid response had to be factored into decisions. Whether this limited the decision makers is a matter for them.

Conclusions and lessons learned

94. The processes for gathering advice and for communicating it to the public, stakeholders and parliamentarians worked well. My role was principally communication and others should judge how successful that was.

95. All advice was subject to considerable scrutiny. Both C19AG and SAGE have a broad range of expertise. C19AG is an external group. Advice from these bodies was public and many of their members appeared regularly in the media. The First Minister met the chair of the C19AG regularly and occasionally met the whole group for deep dives on particular subjects.

96. Our advice was published, I appeared on TV and radio almost daily for two years explaining it. I endeavoured, in my specific role, to be as transparent and open as possible.

97. I believe those leading the pandemic response had a good understanding of the medical and scientific advice and I had no concerns about the performance of any individuals in that regard. I did not have any concerns regarding the performance of any of our counterparts in the UK Government or the devolved administrations.

Initial understanding and responses to Covid-19 in the period from January to March 2020

98. Fuller responses to the questions in this area are detailed in the *Technical Report* of the four CMOs, provided [JL/001 – INQ000130955]; it would not be in my remit to answer a question on behalf of the UK CMOs I had almost no responsibility for the Covid-19 response in the period from January to March 2020. I was not involved in any pre-pandemic planning, nor was I involved in communications to the First Minister.

Initial understanding of the nature and extent of the threat

99. I became aware of Covid from early media reports and early WHO announcements. I was in India from 5 January 2020 to 23 January 2020 leading a clinical team to a children's home and orphanage. The first Covid labelled meeting in my diary was the

following Sunday, 26 January. This was my first Government meeting on the pandemic. I was in Nazareth at a Board meeting from 3 to 8 March 2020. Israel restricted international travel during that week, and I flew home early. My first media interviews were on 13 March, with multiple interviews in the following two weeks.

100. I was not involved in early advice about the implications of Covid-19 to or from the then CMO in early 2020. I was not involved in the advice to First Minister or Cabinet in these early months.

101. In the period between January and March 2020 I spoke to some international contacts. I had no direct dealings with the WHO, PHS or UKHSA; the CMOs were the key connections.

102. It was impossible to form an evidenced view of the threat posed to Scotland by Covid-19 as there was not enough evidence then. However, the alerts from the WHO and early data suggested a very serious disease and fast spread was likely. I was not provided with any information from China in January and February 2020. No scientific articles and reports published in January or February 2020 were brought to my attention, and I cannot personally speak to what information and advice was brought to the First Minister's or Cabinet's attention.

103. I do not have specific notes or recollection of my understanding for each of the specific characteristics of Covid-19 that are detailed in question 145, many of which were in constant evolution. My more general understanding is covered well in the *Technical Report on the Covid-19 pandemic in the UK* [JL/001 – INQ000130955].

104. I was involved in the early meetings of Health and Social Care Directors from February 2020 onwards and in the early response. I was also involved in SGoRR. The first I attended was 6 March 2020. I did not "*ascertain the state of Scotland's preparedness*," it was not my role to do so. In my view, however, Scotland was well prepared. It was impossible to be fully prepared, no country could be or was.

105. The essential features of the virus and disease could not be properly understood at that time. We still do not understand the virus and disease fully. The scientific community worked at pace to gather as much data and evidence as

possible. It was impossible to fully understand the implications of a novel virus in three months.

106. I do consider that we reacted appropriately in January 2020 to the news of the epidemic in China and news of its spread to European countries. The reaction of the First Minister, Cabinet, and other Departments in January 2020 to news of the epidemic is a matter for them. As far as anyone could at that point, I appreciated the seriousness of the spreading virus.

107. There was not an understanding that this virus was akin to flu. There was an understanding it was a poorly understood novel coronavirus.

108. I had no direct contact with the WHO. Any contact was via PHS and UKHSA. Scotland is not a member nation of WHO. The UK is a member. As stated previously, the WHO advice applies across almost 200 member countries. It is as relevant to Scotland as elsewhere. However, it always requires local adaptation to demographics, the state of the pandemic and a country's health and care system. Different countries had different challenges - we were no different.

109. Tests were relatively few due to insufficient testing capacity globally. The testing and laboratory capacity that was available in January 2020 was a relatively small offer, not on the scale required to deal with a pandemic of this nature. I think this is one of the key points of learning in the pandemic. Diagnostic tests became available when science and production enabled it. A mass testing programme was not in place in February 2020 because the science was not available. Mass testing could not have been made available before the nature of the virus had been established, a test designed and mass produced.

110. The timeline of scientific knowledge is covered fully in the *Technical Report* of the four CMOs, provided [JL/001 – INQ000130955]. The first UK case was in late January 2020. I was not directly involved in Scotland's response until later in March 2020 so cannot answer questions about this period.

111. From January to March 2020, concerns grew within the Scottish Government (SG) about the nature and scale of the threat from the pandemic, arising from the information coming from China, and then the spread of the virus to Italy. As evidence became clearer about the spread, Scottish Ministers increasingly engaged with

clinical and scientific advisers and began to consider what steps would need to be taken. I believe Ministers took the threat seriously and began to prepare accordingly. CMO input was crucial in the early briefings and Cabinet papers detailed her discussions with the other three UK CMOs to make shared recommendations at a national level arising from WHO advice. These briefings, and the wider knowledge being acquired at the time, helped Ministers and officials recognise that the situation was increasingly serious, and this was reflected in the priorities of SG. The Government had set out to the Scottish Parliament in September 2019 its Programme for Government – but there was a realisation that the programme would have to adapt to address this growing threat. The adaptation of policy programmes was not a new factor in that the SG had had to reprioritise policy on previous occasions - such as the financial crash in 2008, and Brexit. The scale of change to the policy programme required to deal with Covid-19 was however on a different scale

112. I believe that additional information on these matters is covered in the *Technical report on the COVID-19 pandemic in the UK* [JL/001 – INQ000130955].

Pre-lockdown response – questions 162 – 173

113. I was only peripherally involved in the early response as outlined previously. I wasn't involved in the preparations. I was involved in communicating the guidance to the public from March 2020. I did some early media appearances to explain the situation to the public beginning in the week of 9 March 2020. The guidance I was communicating changed as we all learned more. As outlined, advice was received from the WHO, UKHSA, PHS etc. That advice was up to date and based on the knowledge at that moment. It is impossible to say if guidance was 'adequate' or not. I know that the best advice was given at the time based on the knowledge we had.

114. Divergence or otherwise across the four countries is covered extensively in corporate statements. Divergence and alignment had different causes including legal, geographic, and demographic. Crucially the health services are structured and led differently, it was necessary to adapt to these circumstances. The basic public health information at the start of the pandemic was the same.

115. I cannot answer questions about the measures the Scottish Government took to carry out surveillance of Covid-19 in the UK during the period January to March 2020. This predates my detailed involvement.

116. I understand that COBR agreed to increase planning for a reasonable worst-case scenario using the flu assumptions on 29 January 2020. The Cabinet Secretary for Health and CMO were present at this meeting. I was not. A read-out of actions from this meeting is provided [JL/004 – INQ000101310].

117. As the risk became clearer the Scottish Government, along with governments everywhere, ramped up preparations appropriately. The First Minister and then CMO undertook regular press briefings. PHS gave advice appropriate for the stage of the pandemic and their chronology is contained in their corporate statements. My role in public communication became clearer at this point and I began to appear widely on TV and radio across Scotland and the UK, attempting to explain to the public what was happening and what to do.

118. I am not aware of differing views among advisers. My views correspond with those contained in the *Technical Report* of the CMOs from early 2022, provided [JL/001 – INQ000130955].

119. I did not provide advice to core decision-makers about the nature of the general guidance to be given to health and social care providers.

120. I had no contact with Iran, South Korea, Italy, or China in this period, but we received advice from the WHO, UKHSA and PHS who were able to use global networks to keep as up to date as possible. Knowledge of the virus and its characteristics changed very quickly throughout this period.

121. I did not give any advice to core decision-makers in February and March 2020 on whether to advise the public to use face coverings.

Flattening the curve

122. The extent of cooperation in relation to the UK Coronavirus Action Plan is described in corporate statements, I had no role personally. I do think the plan was appropriate at that point in time.

123. ‘Flattening the curve’ was not a strategy, it was a way of illustrating to the public and others why reducing infection numbers was so important. It was principally about not overwhelming the NHS. Smoothing out the number of people infected, and therefore the number needing admission and intensive care, would allow the NHS infrastructure to cope, unlike what we were seeing in Italy. I described ‘flattening the curve’ on media and at press briefings as a way of explaining to the public why they were being asked to restrict their movements and chances of spreading the infections.

124. Even early on we had estimates of the conversion rates of cases to admissions to intensive care. This allowed estimates of how many intensive care beds and ventilators would be required. All countries were making this calculation. The modelling suggested we could be overwhelmed very quickly. Hence, ‘flattening the curve,’ or delaying the infections to allow the NHS to cope. This proved to be the case and the NHS was not overwhelmed. ICU coped and we never ran out of intensive care beds.

125. I believe that additional information on these matters is covered in the Module 2A Corporate Statement of the Director General for Health and Social Care.

Herd immunity

126. Herd immunity or population immunity occurs when a sufficient percentage of a population has become immune to an infection, whether through previous infections or vaccination, thereby reducing the likelihood of infection for individuals who lack immunity. It is the most likely way to manage a fast-spreading infectious disease such as measles, chickenpox or Covid. Population immunity was never the aim of the Scottish Government to my knowledge, but it was always going to be the end point once we had vaccination. There was never any suggestion that our advice or decisions should be about getting to herd immunity by allowing a certain number of infections in certain groups Scotland now has over 95% of the population with antibodies – reaching temporary population immunity. This wanes over time. There was never any suggestion that advice or decisions should be about getting to herd immunity by allowing a certain number of infections in certain groups.

127. I have responded fully to all the questions that relate to matters that did fall within my remit. I believe that additional information on these matters is covered in the Module 2A Corporate Statements of the Director General Strategy and External Affairs and the Director General for Health and Social Care provided June 2023.

Pre-lockdown developments in March 2020

128. It is my understanding that a detailed explanation regarding these matters is provided in the Corporate Statements of the Director General Strategy and External Affairs and the Director General for Health and Social Care, and in the *Technical Report* of the CMOs [JL/001 – INQ000130955]. I was only peripherally involved at this stage and not involved in any preparations.

129. A broad range of options were considered before the first lockdown. Advice was received from PHS. Ministers made the decisions and aligned this across the four countries. This is covered in corporate statements.

Super-spreader events

130. The advisory structure described elsewhere including CMO and PHS were responsible for advice on mass events. I was not involved at this early stage.

131. I think these strategies around organised events were, inevitably, partly successful. Mass events were stopped when the infection numbers were very low and stopped earlier in Scotland than elsewhere. Advice and decisions are always a balance across the four harms and personal freedoms. Restrictions and lockdown were never taken lightly in any of the discussions I witnessed.

132. We became aware of positive cases at the Nike conference when the PHS Infection Management Team (IMT) reported to Government. The IMT managed these outbreaks effectively and timeously.

133. We announced cases daily to the public, along with mortality numbers. We also gave daily advice at these same press briefings about how to stay safe and what the latest guidance was.

Testing

134. My role in testing and tracing was to communicate the guidance as it developed rather than direct involvement. The details of how the strategy was developed and led is contained within the Corporate Statement of DG HSC.

135. Testing for infectious disease is an essential part of surveillance and clinical treatment to assess the scale of the challenge and, crucially, to allow appropriate treatment to be followed. It was clear immediately that testing for this novel infectious agent would be crucial, which is why the global scientific community worked so hard to develop testing as fast as they could.

136. I was aware of the WHO advice on testing. WHO advice is for the member countries, including the UK, and must be adapted for local context. For example, a testing strategy in Malawi will look very different from a testing strategy in Scotland. Our advice aligned with that of the WHO. It is also important to realise that both the science and the global production capacity was developing continuously. There simply was not a large supply of tests for the world in the early stages. Lateral flow tests did not exist. On a practical level, you cannot start producing tests until you know the agent against which you are testing.

137. My role around surveillance and tracing was in the communication of the guidance to external audiences.

138. Testing was crucial at every stage. It evolved as the science and capacity changed. Testing capacity was initially low. This was inevitable. PCR testing is complex and slow. The whole world was looking for testing capacity. As capacity developed testing became more widely available, culminating in regular home tests provided free to the whole population at scale. This was impossible at the beginning; as set out above, as tests could not be produced until sufficient information was known about the virus.

139. Testing was a huge logistical exercise and largely successful. My role was to communicate the role of testing, how to test and why to test. We made TV adverts and online videos explaining lateral flow tests and how to use them. The communications worked well and were watched extensively. With any infection, you want fast, accurate testing. The sooner in an outbreak testing is available the better. I

think the global scientific community worked remarkably well to discover and distribute tests.

140. I believe that additional information on these matters is covered in the Module 2A Corporate Statement of the Director General for Health and Social Care.

Decisions in relation to non-pharmaceutical interventions ("NPIs")

Overview

141. My main role was around communicating the latest guidance to the public and to stakeholders. I did this through media interviews, which included TV, radio, and print, through TV advertisements and through regular media briefings with the First Minister and others. I was part of the Four Harms group and the Senior Clinicians Group which provided broad advice on issues relating to NPIs such as the type and nature of NPIs to propose, public compliance, and behavioural science perspectives.

General questions about NPIs

142. I do not recall who first introduced the work of Tomás Pueyo to me or to Scotland. His work is a metaphor for how to deal with a fast-spreading deadly disease and is basically mainstream science explained well. I had no direct dealings with him. The idea of population restrictions to reduce the R number below one and then gradual reopening of society to keep it below one is sensible and worked well. I do not recall anyone in Government suggesting Scotland should do anything different.

143. In the period between March and May 2020, monitoring of data was crucial. We could measure cases, admissions, and deaths daily. We shared these figures with the population daily. PHS was the main source of public health advice and, when numbers fell to such an extent that the R number was below one and therefore the pandemic was reducing, decision-makers were advised that gradual reopening was sensible. Those groups providing advice, of which I was a part, understood that we could not stay in severe restrictions indefinitely. While severe restrictions limited direct harm from the virus, they could lead to other harms.

144. As above, in the period between March and May 2020, we had thorough monitoring of case numbers and admissions.

145. We had regular contact via PHS with the WHO, the ECDC (European Centre for Disease Prevention and Control) and other individual countries. I had personal relationships in Israel, Denmark, Sweden, Canada, and the US that I could speak to and hear their experience. Everyone was dealing with the same basic challenge, when to reopen, who to test, etc.

146. I believe that additional information on these matters is covered in the Module 2A Corporate Statements of the Director General Strategy and External Affairs and the Director General for Health and Social Care.

Long-Covid

147. Long Covid, by its very nature, only became apparent after the virus had infected people over a prolonged period. The definition has changed but, roughly, symptoms remaining after 12 weeks is now considered a post-Covid syndrome. Even three years in, it is still poorly understood. I do not recall when I specifically heard the phrase, but it became gradually known to the clinical community throughout 2021 and 2022.

148. DNCD Dr John Harden was the clinical lead for Long Covid and is best placed to provide the Inquiry with information on this matter. The advice given to decision-makers included reducing the risk of Covid and its long-term effects at every stage as the science developed.

Specific measures

149. The rationale for NPIs is covered in the *Technical Report* of the CMOs [JL/001 – INQ000130955] and I agree with it. I am asked specifically about NPIs in relation to religious worship. Every sector, including faith and belief, was asked to adapt appropriately for each stage of the disease and the guidance in place. I spent a lot of time with Scotland's faith and belief leaders explaining the state of the pandemic and the latest advice. I also spent a lot of time hearing from them and supporting communications with their members. The faith groups were fully engaged and very compliant. They argued their specific cases well, but I always found them

inquiring and very keen to protect lives. It was not always straightforward. The Christian and Jewish communities were very concerned about face coverings and singing, the Muslim community was very concerned about social distancing. I endeavoured to explain why we were suggesting specific guidance and what that guidance was.

150. The face-covering science is covered in the *Technical Report* of the CMOs [JL/001 – INQ000130955], with which I agree.

NHS capacity

151. Decision-making was influenced by the possibility of the NHS in Scotland becoming overwhelmed and this was a crucial consideration throughout. This was why the NHS Louisa Jordan temporary emergency critical care hospital was developed. It was necessary to plan extra capacity. It was not, in the end, required for Covid cases, fortunately. It was used for outpatient clinics to release capacity elsewhere and to allow safe care. It was used for training and subsequently as a mass vaccination centre. Managing capacity in the NHS, particularly acute capacity, was a crucial consideration. Northern Italy very quickly ran out of ICU beds. We knew that could happen in Scotland.

152. Modelling of the potential number of cases requiring hospitalisation was used to determine the risk to NHS capacity in the absence of a vaccination or the application of effective NPIs. The decision to apply NPIs was effective in protecting the NHS, which at no stage reached a point where it could not provide the care that individuals required. The issue of NHS capacity was a regular part of the information monitoring carried out by Scottish Ministers. The NHS was stretched like never before and the staff were astonishing, but Scotland never ran out of capacity in ICU or hospitals generally.

153. The issue of NHS capacity was a regular part of the information monitoring carried out by Scottish Ministers which led to the decision to construct additional bed capacity at the NHS Louisa Jordan at the Scottish Exhibition Centre. Although this facility was not required to provide hospital care, it provided an essential resource in the event of a greater impact of the pandemic and was utilised as a location for delivery of the vaccination programme. Although there were pressures on the availability of ICU beds, there was an adequate supply during the pandemic. The

concern to ensure the NHS remained sustainable throughout the pandemic informed the public messaging that was taken forward by the Scottish Government and featured in the encouragement to the public to comply with the regulations and guidance put in place to counter the effect of the virus.

154. Scotland did not run out of PPE but there were early distribution challenges. These were resolved quickly, particularly to care settings. There was no shortage of PPE. PPE procurement and distribution was a challenge and a massive logistical exercise, but we never ran out. 'Protect the NHS' messaging was never because we had a shortage of PPE. Prioritisation of ICU beds was a local clinical decision. There was never a national approach to admission decisions.

155. "Protect the NHS" was a key part of the public messaging, and I used it often, particularly at times of high infection rates. ICU capacity and bed capacity were crucial in managing the effects of Covid. Asking the public to play their part was important and it worked.

156. I believe that additional information on these matters is covered in the Module 2A Corporate Statement of the Director General for Health and Social Care.

Schools

157. The core decisions around schools are covered in the Module 2A Corporate Statement of the Director General Strategy and the Director General Education and Justice provided 23 June 2023. My principal role was in communicating with stakeholders. I met with education stakeholders regularly to explain guidance. I wrote to parents several times. I met policy leaders, unions and staff and did several evening open events with parents. I also wrote on several occasions to every Scottish parent of a school pupil via their schools. I have sent those letters with this statement.

158. It is difficult to be certain if school closures were effective in reducing transmission of the virus. Lockdown reduced the R number below one and this included schools. It is impossible to pull out individual elements of lockdown to assess their role.

Vulnerable and at-risk groups

159. The DNCD Dr John Harden led on this clinically and I would refer you to him for further detail. I was involved in communicating the guidance publicly.

160. Implementation of NPIs, and vulnerable or at-risk groups, were well covered in the technical report of the CMOs [JL/001 – INQ000130955], with which I agree. The nature of who was most at risk changed and continues to change. Researchers worked fast to establish risk profiles and continue to do so. The advice given to Ministers was always based on the most up-to-date data available at the time. The DNCD was responsible for the clinical advice in this area.

161. As data became available, it became apparent this infectious disease, as with all others, disproportionately affected certain groups including the poor and ethnic minorities. I do not remember a specific date I became aware of these data. The nature and extent of disparities in relation to Covid-19 for certain groups, including ethnic minorities, is still only partly answered. Poverty is a risk factor for infectious disease and Covid is no different. Inequalities make infectious disease worse.

162. Understanding disparities in infection risk, disease severity, mortality, and long-term sequelae for different groups in relation to Covid-19 is covered in the *Technical Report* provided [JL/001 – INQ000130955]. From my involvement I was acutely aware of the 'at risk' and vulnerable groups being fully considered and included. The 'at risk' group was not a fixed group. It changed as the science changed.

163. Health inequalities within ethnic minority populations and other vulnerable groups, resulting in disparities in risks and outcomes, was reasonably foreseeable and was foreseen. We endeavoured to protect all of society, including those more vulnerable. My role in communicating to the population included speaking to third sector groups including those working in harder to reach areas. I spoke with many groups advising the ethnic minority communities including Gypsy travellers, the Scottish African diaspora, and others. I appeared on multiple radio stations reaching speakers of other languages and spoke regularly to community leaders.

164. I believe that clinical advisors in the Scottish Government gave sufficient consideration throughout the pandemic to the impact of NPIs on 'at risk' and other vulnerable groups considering existing inequalities.

165. Public facing roles that were likely to be put at higher risk of exposure to Covid-19 are covered in the *Technical Report* [JL/001 – INQ000130955]. The advice was adapted for location and risk. Those working in ICU had a different risk profile to those working at home and received different advice. We also tried to give appropriate advice to other groups of key workers such as teachers, police officers, and others. I spoke to these groups often, including their unions. We also spoke with transport providers and their unions regularly.

166. Where I was able, my role in communications prioritised certain groups, including ethnic minority healthcare workers and frontline workers. I spoke to any group who wanted us to speak to them. We sought opportunities to speak to the prison population, third sector organisations, and specific population groups via radio, Q&As, podcasts and other media.

167. Advice given to protect workers in the front line was as up-to-date and as clear as possible based on the science available.

168. To protect those who may be more vulnerable or at risk in any future pandemic, early assessment of risk and mitigation is crucial, as it was in this pandemic. We continue to give the best advice we can for the present position. The standing committee for pandemic preparedness is working on preparations for the future. It is important to remember, as set out in the CMOs' *Technical Report* [JL/001 – INQ000130955], that in whatever pandemic comes next the vulnerable groups could be different. It is important to ensure they are core to the decision-making.

169. Regarding advice given to core decision-makers, there is nothing specific beyond what has already been said. I did not, as an individual, provide advice to decision makers. I believe that additional information on these matters is covered in the Module 2A Corporate Statement of the Director General for Health and Social Care, and in the *Technical report on the COVID-19 pandemic in the UK* [JL/001 – INQ000130955].

Vulnerabilities relating to pre-existing health conditions

170. Regarding our understanding of the way in which those who were medically vulnerable to Covid-19 should be defined, the DNCD John Harden was responsible

for clinical advice in this area. It is also widely covered in the CMOs' *Technical Report* [JL/001 – INQ000130955]. It is an ongoing piece of work based on developing understanding of the science. Protection of those most at risk from Covid was always at the centre of decision-making. I believe that additional information on these matters is covered in the Module 2A Corporate Statements of the Director General Strategy and External Affairs and the Director General for Health and Social Care.

Decisions relating to the first lockdown

171. I supported the decision to impose a national lockdown, based on the broad advice at the time. I believed then and now it was the right thing to do. Details of the clinical advice at the time are contained in the CMOs' *Technical Report* [JL/001 – INQ000130955].

172. There was not, and can never be, a perfect time for what became the national lockdown. It was always going to be a very hard decision for decision-makers around the world. The national lockdown could not have been avoided. The nature of the virus and the necessity to drive the R number below one to avoid direct harm and the NHS being overwhelmed was critical.

173. My own opinion is that national lockdown could not have been avoided. For the first lockdown, the advice was based on knowledge of the virus at the time, case numbers, admissions, and mortality. It was also influenced by WHO advice, Italy's experience, and a legitimate fear that the NHS in Scotland, and across the UK, would be overwhelmed. I do not believe the decision should have been made earlier though it was not a decision that I made.

174. As soon as the scale of the challenge became clear, researchers worldwide began to work on therapeutics and vaccines. There was not, initially, any great hope for therapeutics or a vaccine. There were no existing vaccines for coronaviruses or any good therapies. The UK was at the forefront of both discovery pathways. The RECOVERY trial became crucial and was the first to prove steroids were helpful, which was not the expected result. My recollection is the scientific community did not expect a fast vaccine. MRNA technology was new and only because of enormous global cooperation and financing did researchers manage to develop a safe and effective vaccine so quickly.

175. The likelihood and timing of an effective treatment for Covid-19 infection becoming available has been otherwise covered. I believe that additional information on these matters is covered in the Module 2A Corporate Statement of the Director General Strategy and External Affairs.

Continuation of the first lockdown

176. I agree that a 'Zero Covid' strategy in Scotland would have been unlikely to be sustainable. For obvious reasons, a 'Zero Covid' approach in one country on a landmass containing three countries would be impossible.

177. The clinical rationale for the "*Covid-19: A Framework for Decision-Making*" [JL/002 – INQ000131025] strategy is in the CMOs' Technical Report [JL/001 – INQ000130955]. Reducing the R number below one meant the infection rate would fall. Holding it below one, while gradually opening sectors of society and allowing some mixing, was essential to keep infections down but allow a return to some normality. I communicated this to the public, stakeholders, and parliamentarians regularly. Information on the Four Harms can be found in the Module 2A Corporate Statements of the Director General Strategy and External Affairs and the Director General for Health and Social Care.

Effectiveness of the first lockdown

178. I believe that information on these matters is covered in the Module 2A Corporate Statement of the Director General Strategy and External Affairs and the Director General for Health and Social Care.

Conclusions and lessons learned

179. I believe that information on these matters is covered in the Module 2A Corporate Statements of the Director General Strategy and External Affairs and the Director General for Health and Social Care.

Decisions relating to easing the first lockdown in the period from 29 May 2020 to 7 September 2020

180. I believe that information on these matters is covered in the Module 2A Corporate Statements submitted by Chair of COVID-19 Advisory Group, and the Director General Strategy and External Affairs, and the Director General for Health and Social Care.

The steps taken to ease the first lockdown

181. It was important to try to do two things following the decision to change our "stay at home" message to "stay safe"": keep R below one and allow some return to normality such as for faith groups and family gatherings. The core clinical advice is contained in the *Technical Report* of the CMOs [JL/001 – INQ000130955] and additional information on these matters is covered in the Module 2A Corporate Statement of the Director General Strategy and External Affairs. The message and messaging were effective. Public opinion polling shows the message was trusted and complied with.

Eat Out to Help Out

182. I was not involved in any discussion or advice about introducing the Eat Out to Help Out scheme. It was a UK Government initiative. We did not receive any information or medical/scientific advice about Eat Out to Help Out, to my knowledge, and I am unaware of any such advice in respect of the Eat Out to Help Out scheme. The first I knew of the initiative was when it was announced.

183. The timeline of COVID-19 infections dated 7th October 2020, provided [JL/005 – INQ000323667] includes the case numbers at the time of the launch of the initiative.

184. After the Eat Out to Help Out initiative was announced by the UK Government, I recall discussing it with the First Minister and trying to ensure we gave public health advice to the population who were going to take advantage of the scheme. I also spoke to business owners to advise them about keeping their premises as safe as possible. I did not discuss the scheme with UK Government ministers.

Conclusions and lessons learned

185. There was constant learning throughout the pandemic. Advisory groups and others responded quickly to any new evidence. We advised the public, Ministers, stakeholders, and parliamentarians regularly. The whole pandemic response was agile and responsive, as it had to be.

186. Decision-makers, as throughout the pandemic, considered the scientific and medical evidence available to make judgements about our ongoing response and restrictions effected. The science was fed into the advisory groups including senior clinical advisors and the Four Harms Group, and that helped to form the advice that was given to Ministers. That process continues today.

187. I believe that additional information on these matters is covered in the Module 2A Corporate Statements of the Director General Strategy and External Affairs and the Director General for Health and Social Care.

Decisions relating to the period between 7 September 2020 and the end of 2020

188. The easing of restrictions such as visiting other households were always a balance of the Four Harms. They were based on rounded advice and included consideration of cases, admissions, and mortality as well as R number modelling. We had to adapt depending on the state of the pandemic and the number of cases we were seeing. There was no vaccination by this point though there were the beginnings of therapeutics that could help. At this point in time there was no way of reducing the infection spread other than severe restrictions on the population's movements.

189. The Alpha/Kent and Delta variants are covered in the *Technical Report* [JL/001 – INQ000130955].

190. The 'circuit breaker' and a further lockdown is covered in corporate statements and the *Technical Report* [JL/001 – INQ000130955]. I gave no separate advice on these topics but was present at discussions, and in meetings, as it was important I understood the position so I could then communicate Ministers' decisions.

191. We learned continuously. C19AG, PHS, and government clinicians attempted to give rounded, balanced advice in the context of the broader Four Harms advice.

My role was to communicate these decisions to the public, stakeholders, and parliamentarians.

192. I believe that additional information on these matters is covered in the Module 2A Corporate Statement of the Director General Strategy and External Affairs, as well as public statements made by the First Minister.

The 5-tier Covid management system

193. The development of the response at this time is covered in the Module 2A Corporate Statement of the Director General Strategy and External Affairs. I was part of the Four Harms Group and was involved in discussion around how to balance restrictions around public health, economics, and social policy.

194. I believe the system was effective. Advice and decisions sought to find a way through the Four Harms that I previously described. The tier system was an attempt to open society while still protecting people and keeping R below one as far as possible to allow science to develop medicines and vaccines.

195. It was impossible to know if the creation of the 5-tier system would be successful in avoiding the need for a second lockdown. Every country was in uncharted territory.

196. I did not have any concerns over the public understanding and communications surrounding the tier system. I spent a lot of time explaining the system to the public, stakeholders, and parliamentarians. This was my main role.

Conclusions and lessons learned

197. Throughout the first lockdown, we made a constant effort to explain guidance and the state of the pandemic to the public. The “why” and the “what” were always the key messages. The tier system was a stage along a three-year journey, so the communication was no different. I believe that additional information on these matters is covered in the Module 2A Corporate Statements of the Director General Strategy and External Affairs, and the Director General for Health and Social Care.

Decisions relating to the second lockdown (January 2021 to 2 April 2021)

Background to the second lockdown

198. Like all decisions and advice, restrictions being relaxed for Christmas Day was a balance between the risk of the virus spreading and personal freedoms. This was never taken lightly. Christmas is a particularly important time in the year for families and it was decided that some mixing and travel was appropriate. I explained this often but always discussed the risk and often used my personal decisions to illustrate the challenge. I did not mix with my family at Christmas 2020.

199. The timing of level four restrictions is explained in corporate statements. Case numbers warranted further restrictions. There was no vaccine, few treatments and R was above one. This was communicated first by a parliamentary statement followed by a press conference. I then recall making multiple media appearances.

The second lockdown

200. I was part of the advisory groups as stated above. I was part of the Four Harms Group. Advice was regularly received from PHS and C19AG. My role was to communicate the decisions. The rationale for the second lockdown is explained in corporate statements provided by the Scottish Government.

201. The second lockdown was necessary, timely and effective. There is no perfect time, and, on reflection, the timing was correct. It was a challenging time for communication. I attempted to explain to the public, stakeholders, and parliament why and what Ministers were advising.

202. Timings of the second lockdown are covered elsewhere. Simply, the risk of cases was too high. The NHS would have been overwhelmed and more lives would have been lost.

203. I believe that additional information on these matters is covered in the Module 2A Corporate Statements of the Director General Strategy and External Affairs, the Director General for Health and Social Care, General Education and Justice, and the Cabinet Paper – Additional Emergency Measures in Level 4 – 4 January 2021, provided [JL/006 - INQ000232688].

The easing of the second lockdown

204. The timing and decision-making around lockdown restrictions are covered elsewhere. As cases eased because of lockdown it was possible, and necessary, to gradually allow restrictions to be lifted. The updated decision-making framework was communicated in the manner as other decisions. It was first set out in a parliamentary statement, followed by a press conferences and further media appearances.

205. The "stay at home" restriction was lifted in Scotland and replaced with a three-week "stay local" restriction as it was possible and necessary to ease restrictions. This was how Ministers decided to do it after listening to the advice. The aim was to keep R below one and allow some mixing and society to return to some form of normal. It was communicated to the public openly and often, frequently by me.

206. The timing of secondary school pupils returning full-time to the classroom is covered elsewhere. This advice and decisions Ministers made were again a balance across the Four Harms. It was important to get children back to school but to do it as safely as possible. There was still no vaccine and few medicines. We were learning that young people were, in the main, at less risk. Schools were better at mitigations as science developed.

207. I believe that additional information on these matters is covered in the Module 2A Corporate Statement of the Director General Education and Justice.

Conclusions and lessons learned

208. The purpose of the second lockdown was to keep R below one and save lives. It achieved that purpose.

209. To ensure that those lessons were acted upon in the subsequent management of the pandemic, there was constant feedback from PHS, C19AG and others. Data analysis was at the core of the response at all stages.

210. No analysis was carried out on earlier decisions relating to the management of the pandemic in the period around the time of the second lockdown.

211. I believe that additional information on these matters is covered in the Module 2A Corporate Statements of the Director General Strategy and External Affairs, the Director General for Health and Social Care, the Director General for Communities EIHRD provided 23 June 2023, the Scottish Government *Framework for decision making - Assessing the four harms* provided [JL/007 - INQ000131028], and at page 5 the Cabinet Paper - Additional Emergency Measures provided [JL/006 - INQ000232688].

Decisions relating to the period between April 2021 and April 2022

212. I understand that the stay local rule was a balance of the Four Harms - allowing more freedom while limiting the spread of the virus. The restrictions needed to be geographically managed and local authority areas were a convenient way of communicating to the public since everyone knows where they live. It was a simpler way to communicate. I did not make the decision to introduce the stay local rule, but I communicated it.

213. The levels system allowed different restrictions depending on local conditions, based on their specific circumstances and risks of Covid. It is explained fully elsewhere. I explained it often to the public and in my experience, people found it simple to understand. High cases meant more restrictions. Lower cases meant lower-level restrictions.

214. I am asked about audits. There were two sources of data: infection data and polling data. The relevant groups continually monitored both sources.

215. I believe that additional information on these matters is covered in the Module 2A Corporate Statement of the Director General Strategy and External Affairs.

The move to level zero

216. As described elsewhere, the guidance at any point was a balance of the state of the pandemic, scientific progress, protection of the public, protection of the NHS and the restoration of personal freedoms. This period in July 2021 was no different.

217. As above, the science had changed, as it always did. Vaccines, therapeutics, and a greater understanding of risk allowed different advice and different decisions. The timetable is explained fully in the CMOs' Technical Report [JL/001 – INQ000130955].

218. Regarding COVID tests for returning travellers, this was a balance of risk and is covered in corporate statements by those in charge of travel policy.

219. COP 26 and its safety was an enormous undertaking. PHS, Glasgow public health leaders and DNCD, Dr John Harden worked together for months to ensure appropriate guidance was in place. There was a gold command and various other structures on the ground at the site throughout and in my opinion it went well. There were some positive cases but no large outbreak, despite tens of thousands of delegates throughout the city. I walked through the whole site the night before the delegates arrived with the key public health advisers including the UN (United Nations) and the WHO to see how the guidance had been implemented.

220. I believe that additional information on these matters is covered in the Module 2A Corporate Statement of the Director General for Health and Social Care.

The emergence of the "Omicron" variant (first detected in South Africa in November 2021)

221. The timetable for the Omicron variant is in the *Technical Report* [JL/001 – INQ000130955]. I learned alongside my UK colleagues. The four nations' senior clinicians were meeting weekly by this stage.

222. The public health advice was based on the science available on the Omicron variant and the therapeutics and vaccines then at hand.

223. I am asked about the First Minister's comment on 10 December 2021 that Scotland faced a "tsunami" of Omicron cases with it likely to become the dominant variant of COVID within days and the changes to the self-isolation rules that followed. My role was communicating these decisions to the public. The description of a "tsunami" was appropriate based on the severity of the variant we faced, the speed it was spreading, and the nature of the upcoming holiday.

224. Physical distancing measures and nightclubs closing for three weeks was, again, a risk-based judgement to try to stop the harm from Omicron while still allowing life as normal as possible. It was about finding a balance.

225. I believe that additional information on these matters is covered in public statements made by the First Minister.

The lifting of restrictions in April 2022

226. The decision to lift restrictions, in line with most others, was announced in Parliament and at media briefings. I then did multiple TV and radio briefings and interviews as well as stakeholder meetings to communicate what had been decided. Further information on these matters is covered in the Module 2A Corporate Statement of the Director General Strategy and External Affairs.

Conclusions and lessons learned

227. I am not aware that the Scottish Government received advice to take measures which it could not because the measures related to reserved matters but, of course, advice and decisions were based on geography, devolved responsibility, and availability of funding. I believe that additional information on these matters is covered in the Corporate Statements of the Director General Strategy and External Affairs and the Director General for Health and Social Care.

Conclusions and lessons learned from the use of NPIs in response to the Pandemic

228. On the use of NPIs, I have nothing to add that is not already covered in other questions and corporate statements.

Care homes and social care

229. In the strategy relating to the role of care homes and those in social care, my role was in communicating with the sector which I did openly and often. The sector was constructive and determined to ensure safe care as far as possible. We discussed infection control, PPE, isolation, and the latest science often. I began this role as previously described in March 2020 with my first media interview on March

13th, 2020. Protection of those in care homes, balanced with maintaining their dignity and human rights considerations, was crucial throughout the pandemic.

230. The increased risk of the spread of Covid in care home settings is covered elsewhere. I was present for discussions between scientific advisors and Ministers on discharging hospital patients and care homes. I did not provide advice as an individual or make any decisions.

231. I believe that additional information on these matters is covered in the Module 2A Corporate Statement of the Director General for Health and Social Care.

Borders

Internal UK borders

232. I believe that additional information on these matters is covered in the Module 2A Corporate Statements of the Director General Strategy and External Affairs, and the Director General for Health and Social Care.

International borders

233. Given my remit, my role regarding international borders was to communicate travel guidance as it was produced and updated, including occasionally meeting with airlines and airports. I was not involved beyond this but I believe that this matter is covered in the Module 2A Corporate Statements of the Director General Strategy and External Affairs, and the Director General for Health and Social Care.

Decision-making between the Scottish Government and (a) the UK Government and (b) the other devolved administrations in Wales and Northern Ireland

234. When required there was a 4-nation response. I have previously described my experience of the collaboration between the 4-nations in response to questions in Part A. The Senior Clinicians group, the four CMOs and the four CNOs all worked well together. I also regularly attended the 4-nation Health Minister meetings and contributed when appropriate.

235. The clinical structures worked well and continue to work well. I believe we have stronger clinical infrastructure in place for future pandemics.

236. At risk groups were constantly considered in the formation of advice.

237. The effectiveness of intergovernmental working is for others to answer. In my roles in communication and clinical advice, I think the coordination worked well.

238. I believe that additional information on these matters is covered in the Corporate Statements submitted by the Chair of COVID-19 Advisory Group, the Statement of the Director General Strategy and External Affairs, the Director General for Health and Social Care, and the Director General Corporate.

Interrelation between the Scottish Government and local government

239. The role of local government is covered in the corporate statements. My role was in communicating the state of the pandemic and up-to-date guidance to stakeholders, which sometimes included local government. I spoke to the Society of Local Authority Chief Executives (SOLACE) and the executive leaders of the Convention of Scottish Local Authorities (COSLA) several times. I was also often involved in conversations with individual local authorities when necessary. Sometimes this was with the Deputy First Minister.

240. There was constant dialogue between key Scottish Government decision-makers and local authorities. All local authorities involved responded well to circumstances at the time.

241. My involvement with local government was in communicating decisions to them, often with the Deputy First Minister or others. This worked well. I also made myself available to senior local politicians and officials for Q&As. This also worked well.

Covid-19 public health communications

Public health communications strategy of the Scottish Government during the Pandemic

242. As outlined in the corporate statement from DG Health I was the principal clinical communicator to the public, stakeholders, and the Scottish Parliament during the pandemic. I was, of course, part of a team. CMO, DCMOs, clinical leaders from PHS, scientists from the C19AG, the DNCD and others also engaged across these groups and did a lot of communications.

243. Public communications: These were the main routes of public communication I contributed in:

244. TV press briefings: I participated in many press briefings with the First Minister and Cabinet Secretary for Health. These happened regularly and often daily. They consisted of an opening statement from the First Minister, an occasional statement from me or a senior clinical advisor, often the CMO and then questions from the media. They were broadcast live on TV and the internet. Transcripts are available. I first did a live TV briefing on Tuesday 7 April 2020 and my final one was 10 December 2021.

245. News media: News media works, in the main, by a broadcaster or newspaper contacting Scottish Government and 'bidding' for an interviewee. I did many hundreds of these, often multiple in a single day, seven days a week. I appeared regularly on BBC radio and television, STV, Channel 4, independent radio stations and online. I did multiple phone-in shows. I appeared on a range of non-news shows. These appearances were a mixture of information sharing, Q&As, journalists asking questions and sometimes panel discussions. My role was to outline the state of the pandemic, describe the science as known at each point and share the most recent advice for the public. I endeavoured to do this openly and accurately throughout. It was the First Minister's explicit plan to emphasise clinical communication and she often asked me to do this. This was evidenced at the TV briefings and in the media appearances. It was a deliberate strategy to lessen the politics and increase the trust in the messaging. Others also appeared in the media including the CMO and the DNCD.

246. Marketing: The marketing team in Scottish Government were responsible for advice to Ministers on marketing plans, resources, and costs. Their contribution and planning are contained within other statements. As I became more well known I was increasingly used in our marketing material. The final adverts were always signed off by Ministers.

247. Stakeholders: I spent a lot of time, along with the wider team, speaking with groups of stakeholders including the business community, faith and belief leaders and elite sport. These engagements were usually led by the relevant policy group from the Scottish Government, and I was invited to update on the latest state of the pandemic and invariably take questions. These sessions were about sharing the latest position and guidance and to hear from the stakeholder groups. The details of these meetings and any notes are held by the relevant policy groups. I was often asked by external groups to update them, such as the Chambers of Commerce, the Institute of Directors, Young Scot. These took a similar format; a general update and a Q&A. I updated Scottish Government Directors weekly at the regular Thursday morning Directors' meeting. Again, this was a short update on the state of the pandemic followed by a Q&A.

248. Parliamentarians: At the start of the pandemic, I spoke to all MSPs about the latest position and took questions. I also spoke to the Scottish Parliament leadership as appropriate about the safety of the Parliament itself. I took part in meetings with party leaders led by the First Minister. I appeared multiple times at Scottish Parliamentary Committees, often weekly for prolonged spells. Initially this was the Covid Committee and later the Covid Recovery Committee. I accompanied Michael Russell and John Swinney MSP, respectively. I answered questions freely and openly. These committee appearances were broadcast live, and transcripts are available. I appeared before one UK parliamentary committee. Transcripts have been provided to the UK Inquiry.

249. My approach was to be as open as possible with the public and stakeholders, to be candid and to concentrate on why we were asking the public to take particular actions. Behavioural science advice was that if we explained the 'why' the public would be much more likely to understand and follow the guidance. The message changed regularly, the principles of candour and explaining as far as possible did not.

250. It was crucial to maintain trust in the message and the messengers. This strategy was led clearly from the top and the First Minister was very prominent in the media and in the Parliament. She also realised that she needed clinicians to help, a role I filled when asked. The messages promulgated about the Scottish Government's justifications for its key strategic decisions were fair and accurate reflections of what I understood were the actual reasons for its decision-making.

251. We received regular feedback from polling data and from marketing evaluations. These helped with messaging and tone.

252. My role pre-pandemic did involve a lot of communication but mainly to healthcare audiences and peers. I have been a clinician, an academic and an advisor to the Scottish Government over my career. I have spent a lot of time communicating globally on subjects such as patient safety and healthcare quality. Pre-pandemic I had done some media but mainly around specific subjects such as patient safety. Early in the pandemic I was asked by the First Minister to fulfil some of the clinical communication role. I did some media appearances while Catherine Calderwood was CMO but none of the very early TV press briefings. On the day Catherine resigned I was on BBC Breakfast discussing the pandemic and was asked that day to do some TV press briefings in Catherine's absence. The evolution of the role was mainly through availability and demand. There was a huge demand from news organisations for information and we were very keen to get the message out to the public. It fell to me to do much of that. I did not do it alone. The new CMO, Gregor Smith, also did many TV press briefings and our deputies did occasional media appearances. I had a co-director in my directorate; a; a senior civil servant, Linda Pollock. She led the directorate during the pandemic and carried much of the day-to-day burden of a large slice of the civil service. I also had a strong support team of admin staff, writers and other clinicians who supported my media appearances.

253. I appeared on TV and radio daily both through the televised media briefing and other media appearances. I was very clear I was speaking to Scotland and constantly emphasised Scottish guidance. I spent considerable time describing Scottish guidance to the Scottish population. There was opportunity to also concentrate communication around the border area using specific media channels such as STV Borders. This allowed me to describe the Scottish guidance to those closest to the border some of whom were working or visiting relatives in England regularly. I attempted to help with any confusion arising. The scientific advice underpinning any 4-country differences is covered elsewhere in this statement and by others. The way we tried to avoid confusion was to have Scottish briefings, for the Scottish population, on Scottish questions. The scientific advice was the same, but how that was interpreted by decision-makers differed.

254. As described, the First Minister was the principal decision maker. The communications department handled bids. The marketing department handled marketing, TV adverts, and other means of communication.

255. To my knowledge, there were no restrictions placed on the publication of medical data and studies carried out by the individuals/bodies providing advice to key decision-makers within the Scottish Government. There were not any key public health communications that went against expert medical or scientific advice, but science is not static, and, in the pandemic, it changed constantly, often live on TV and radio. We communicated the guidance and science as we knew it, each day.

256. C19AG was involved in informing communication but did not approve messaging. Approving messaging is not an appropriate role for an advisory group. Many of the members of the advisory group did extensive communication independently in the media, particularly Professor Mark Woolhouse, Professor Devi Sridhar, and Professor Linda Bauld. Their contributions were invaluable.

257. The messaging and approach varied over time as the science and guidance changed. Frequency of messaging was adjusted according to the amount of information we had to share. The marketing changed as and when the message needed adjustment.

258. There was extensive communication around vaccinations. The same categories above were crucial; news, marketing, and stakeholders. I was involved in TV adverts, briefings to journalists, meetings with stakeholder groups, and many phone-ins with the public to emphasise the safety and importance of vaccination. I remember many days of multiple media appearances on vaccination. It was a crucial part of our communications. We also spent time with groups that are seldom heard who were potentially more vaccine-sceptic such as the Scottish Polish community, gypsy traveller leaders, faith leaders, and others.

259. The Scottish Government did follow the science and said so. I often used the phrase. I also often explained that the science was not static and not only a question of public health. It was behavioural science, virology, social science, and other aspects. The idea of following the science was to reassure the public and stakeholders that we were using evidence to give advice and make decisions. I often

said it was not an exact science because it was a complex balance and there was no easy path.

260. The communication structure in the Scottish Government is described elsewhere. I have described my involvement above.

261. The reason for the first lockdown order being announced for the whole of the UK by the Prime Minister is for the decision-makers to answer. From a communications perspective it was much more straightforward for all four countries to enter lockdown together.

262. We took steps to ensure that the public health communications, including the daily press conferences, were accessible for vulnerable and minority groups and non-English speakers. For example, all of the daily press conferences were BSL (British Sign Language) translated. My understanding is that the First Minister's daily speech was put onto the government website and was translated. I was keen to ensure I appeared often on media outlets that focussed on other diasporas. I tried to be accessible and available for non-native English speakers using the media they used. More information is provided in the corporate statement from communications and marketing.

263. I endeavoured to be very clear at all times when explaining the advice to Scotland. I did appear regularly on UK-wide media, and I tried hard to distinguish specific geographic advice when it varied. The fundamental science and the basic advice was always the same. The specific rules sometimes varied. My experience was that the differences were overstated, and I rarely found any difficulty communicating the differences. I spent a lot of time speaking to ITV Borders who cover the border region between Scotland and England. This was an attempt to be clear with those residents what applied to them.

264. There was clear behavioural science advice to the Scottish Government from a number of individuals, mainly via the C19AG. Professor Stephen Reicher and Professor Linda Bauld were crucial in this regard. It certainly influenced my messaging, and the First Minister was also a recipient of the advice. It was also used extensively in marketing evaluation and delivery.

265. I am asked about a note with PHS's corporate statement at paragraph 4.2.8. This is not a matter I can comment on.

266. The extent that public health messaging was consistent and clear is a question for others to judge but, within the limitations of a novel infectious agent, massive public concern and asking the public for unprecedented behaviour change, yes, I thought it was consistent and clear.

267. The public communications were based on the decisions of the First Minister and her cabinet. These are well documented and have been supplied to the Inquiry. The advice on which these were based, and the communication was based have also been provided.

268. I was never under any pressure to communicate instead of a Minister. It was clear that the communication burden was enormous and had to be shared between politicians and clinicians. I regularly engaged with Scotland's faith communities, sometimes with a Government Minister, sometimes alone.

269. I have provided views regarding the Scottish Government's strategy behind its focus on models in projecting the course of the pandemic and the medical and scientific advice upon which models were based earlier in my statement (at Section A). I believe that the SG communications team are best placed to answer questions regarding the accessibility of SG's communications as this is outwith my remit. Questions on PHS' corporate statement would be best answered by PHS.

270. I believe that additional information on these matters is covered in the Module 2A Corporate Statement of the Director General Strategy and External Affairs.

Effectiveness of messaging

271. Marketing colleagues in Scottish Government did and still do extensive evaluation and research of all their marketing products to inform future iterations. The same applies to news media colleagues who did and still do regular assessments of the reach of their communications. There was regular polling of the Scottish population on public health communications. These polls have been provided to the Inquiry.

272. The polling data showed that the public trusted the message and the messengers. The public were, in the main, compliant, and understood why restrictions were crucial. Marketing colleagues were continually evaluating the effectiveness and reach of messaging to hone and design future messages. The First Minister, and others too, regularly reviewed the polling data.

273. Daily television briefings were the go-to place for the Scottish people and the media to learn about the newest information. Viewership numbers were high, especially during the most difficult times or when guidance changed. The First Minister, with communication colleagues, decided who would appear at television briefings, with some adjustments for availability. On very difficult days, such as the announcement of the second lockdown, the CMO and I were both present. This was deliberate to reinforce the seriousness of what we were asking the Scottish people to do.

274. Communication with the health boards, including the national boards such as PHS, NHS National Services Scotland and others, was via sponsorship routes, regular meetings, and briefings. Communication within Scottish Government was consistent and daily. This was principally managed by the Directorate for Covid Public Health, Director-General Health & Social Care. Input from colleagues at PHS was crucial to all communication at every level of government and with health boards. For example, there were regular meetings with health board CEOs. I was often involved, giving updates, and answering their questions.

275. The care sector was more complex in that it comprises multiple partners. The principal communication route was via social care policy leads. I spoke to colleagues in this sector regularly and on request. I often spoke to care leaders.

276. As NCD my cross-sector communications role complemented ministerial engagement with the Scottish people. As with the televised press briefings, Scotland's political leaders indicated that trusted clinical communication was essential to helping all groups understand what was happening and why decisions were being taken. I attended many meetings with business leaders and education leaders, sometimes alongside the relevant Minister. I made myself available to any group who wanted to discuss the latest science and guidance. I wrote to all of Scotland's parents via schools. These letters have been provided to the Inquiry.

277. The polling suggests that both the message and the messengers were trusted. Compliance with restrictions was remarkably high and good communication was crucial to achieving this.

Maintenance of public confidence

278. I believe the messages that the Scottish Government was promulgating about its approach to the management of the pandemic did promote public confidence. The combination of political and clinical communication was trusted throughout. Compliance with restrictions was high. Vaccination rates were higher than expected. Polling suggests the message and messengers were trusted.

279. How public confidence and compliance were measured is for marketing and communications colleagues as they regularly monitored and evaluated our messages, providing ongoing advice on appropriate messaging based on this.

280. We regularly published state of the pandemic reports. We regularly discussed actual data and modelling data at press briefings and on TV and radio.

281. Disinformation is a big subject. We sought advice from communication experts. Our main tactic was to continue to tell the truth and tell it often. I tried not to directly counter conspiracy theories unless directly asked by media. We used social media as a transmission route. I did not engage in dialogue with those spreading disinformation.

282. Public confidence is crucial when the response to an emergency needs behaviour change. We had access to behavioural science expertise and the crucial message from them was always explain the 'why' before the 'what.' Confidence in those giving the message was therefore crucial. I was asked by media about rule breaks and my answer was always that the rules apply to everyone. I do not consider that any high-profile rule breaks were influential during the pandemic because the public knew what to do to protect themselves and their families. Polling suggested compliance remained high throughout. The public knew what to do and why they were doing it.

283. High profile breaches came up at the time in TV briefings and media appearances. I answered regularly that rules apply to everyone and were there for good reason.

284. I had no extra restrictions placed on me than the general population. I was not given any specific guidance about how I was to behave.

285. Compliance with the rules remained remarkably high, evidenced by the infection rate reductions when restrictions were imposed. I do not accept we had to 'rebuild' confidence. Of course, as the pandemic went on over a period of two years people grew weary and guidance changed. The communications throughout the pandemic were based on the science at the time (including behavioural science), the decisions made and the best advice available to the public. That is what I communicated.

Conclusions and lessons learned

286. Public health communications in Scotland during the pandemic was one of the biggest strengths of the Scottish Government's response. The broad team of news communication, marketing and those engaging with wider stakeholders was exceptional. Our communicators, including politicians and clinicians, were trusted. For example, someone like Professor Linda Bauld, from the University of Edinburgh, became a household name for her contribution and remains hugely respected by Scotland's population.

287. The public service broadcasters were also crucial, and I think their role has been underestimated. The BBC and STV were responsive, accurate and trusted.

288. The marketing team in Scottish Government was exceptional, often working very long hours to very tight deadlines to produce new adverts and other materials in response to the changing pandemic. I remain enormously grateful to them all.

289. This is not to say that there were not things that could not have been improved. For example, we learned more about inclusive communication as time passed. We learned more about ensuring that the population understood why they were being asked to do something, before being told what they were being asked to do. We learned more about the ways in which Scotland is not homogenous and we

needed different communication and to adapt delivery of the message depending on who we were communicating to.

Public health and coronavirus legislation and regulations

290. There are a large number of questions in this section that are not within my remit to answer. I have responded fully to all the questions that relate to matters that did fall within my remit.

291. "FACTS" was at a point when it was felt we needed a compact way of reminding everyone about how they should behave as individuals. It was arrived at by marketing colleagues. I communicated it extensively and was on TV, radio and social media adverts outlining it. Polling suggests it was well understood, details are in corporate statements.

292. Polling data suggests the Scottish public was remarkably compliant with "FACTS" and other guidance. This has been provided to the Inquiry.

293. I believe that additional information on these matters is covered in the Module 2A Corporate Statements submitted by the Chair of COVID-19 Advisory Group, Director General Strategy and External Affairs, and the Director General for Health and Social Care.

Lessons learned regarding Regulations and Enforcement

294. My role was to explain the guidance to the public and stakeholders. The difference between legislation and guidance rarely featured. From a public health perspective, I tried to explain the why and then the what. Questions regarding regulations and enforcement are for others.

Key challenges and lessons learned

295. I have nothing to add regarding key issues and junctures in the decision-making process relating to the management of the pandemic in Scotland.

296. The key challenge throughout was a novel coronavirus that caused harm and death. Every country, Scotland included, was reacting to constantly changing science

and medicine. We had limited, and rapidly evolving, understanding of who would be most at risk, whether antivirals would work or if a vaccine was even possible. The combination of PHS, the senior clinical advisers, principally the CMO and the Four Harms structure served us well. Our public and stakeholder communications worked well. As described above we spent a lot of time with media and affected stakeholders explaining the state of the pandemic and the latest guidance. This worked well.

297. I have learned that communication with the public is crucial. It has to be honest, open, and timely. A combination of political and clinical leadership is essential in publicly communicating during a public health crisis. Data and analytics are essential and translation of these data for the public is an important tool in achieving compliance. Behavioural science is a very important discipline to include in forming advice and communication strategies.

298. We have already taken steps to learn from the experience of the last three years and form new structures. The Standing Committee on Pandemic Preparedness is already meeting and will report soon. I have no specific recommendations of my own and would not want to pre-empt that report.

Statement of Truth

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

Signed: **Personal Data**

Dated: 02 November 2023