Witness Name: Jeane Freeman
Statement No.: 2
Exhibits: JF2
Dated: 16 November 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF JEANE FREEMAN

In relation to the issues raised by the Rule 9 request dated 5 July 2023 in connection with Module 2A, I, Jeane Freeman, will say as follows: -

01 I am Jeane Freeman of the University of Glasgow, University Avenue, Glasgow, G12 8QQ where I have held a post since February 2022 and am currently Dean of Strategic Community Engagement and Economic Development. 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, solicitors taking my statement via interview 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 have also been 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 in this statement are my own.

02 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.

03 References to exhibits in this statement are in the form [JF2/Number - INQ000000].

A. Decision Making Structures

Roles and Responsibilities

04 In May 2016 I was appointed as the Minister for Social Security within the Scottish Government, and I held this role until June 2018. As part of this role, I led the establishment of Social Security Scotland, including the underpinning legislation under the newly devolved social security powers. In June 2018 I became the Cabinet Secretary for Health and Sport. I held this role until May 2021. I had no involvement with the Scottish Government's response to the pandemic after that point.

05 My responsibilities as Cabinet Secretary for Health and Sport included the NHS and its performance, staff and pay, health and social care integration, patient services and patient safety, national clinical strategy, quality strategy and national service planning, allied Healthcare services, carers, adult care and support, child and maternal health and sport and physical activity. I was supported by the Ministers for Public Health, Sport and Wellbeing and for Mental Health.

Decision-making structures within the Scottish Government in response to the Covid-19 pandemic

06 As Cabinet Secretary for Health and Sport, I was a member of the Scottish Cabinet which met at least weekly as the key decision making forum of the Scottish Government. I attended meetings of the Scottish Government Resilience Room as relevant to my portfolio – which was consistently the case for the Covid Pandemic. I attended early meetings of COBR in January and February 2020 at the invitation of the UK Government on 24 and 29 January [JF2/001 - INQ000056163] and 5 and 26 February [JF2/002 - INQ000056147], [JF2/003 - INQ000056215], [JF2/004 - INQ000056201], [JF2/005 - INQ000056216]. I also attended subsequent meetings on 2, 4, 9, 12, 16, 18 and 23 March, 9 and 16 April and 10 May [JF2/006 - INQ000056157], [JF2/007 - INQ000056217], [JF2/008 - INQ000056218], [JF2/009 - INQ000056206], [JF2/010 - INQ000056219], [JF2/011 - INQ000056221], [JF2/012 - INQ000056210], [JF2/013 - INQ000056211]. I attended three meetings of the Healthcare Ministerial Implementation Group, chaired by the UK Secretary of State for Health, 24 March, 2 April and 9 April 2020. I also took part in Four Nations calls (with UK, Northern Irish and Welsh health Ministers), which took place weekly on a Thursday from the end of April 2020. I occasionally deputised for the First Minister on Four Nations calls with the Chancellor of the Duchy of Lancaster. I also convened the Mobilisation Recovery Group from 28 August 2020, COVID 19 Strategic Issues meetings, which were chaired by FM under SGoRR conditions and attended FM

chaired deep dive meetings (involving members of the C-19 Advisory Group) with Sir Jeremy Farrar (16 December 2020) and on scenario planning (4 February 2021). I also attended when requested, relevant Committee meetings of the Scottish Parliament.

07 During the COVID-19 pandemic between January 2020 and May 2021, I was primarily responsible for health and social care. Other bodies which were important points of contact in my role included Public Health Scotland, Health and Social Care Trade Unions, COSLA, Scottish Care, Health Boards and their chief executives, Astra Zeneca, Pfizer, the First Minister's Advisory Group on Covid, the Lord Advocate and the Care Home Relatives Group. I attended or convened many "deep dive" meetings which covered subjects such as testing, vaccines, Scotland's Proximity app and the redesign of unscheduled care. It is extremely likely that decisions would have been taken and actions instructed after such meetings.

08 The primary individuals involved in reaching key political and administrative decisions within the Scottish Government were the First Minister, the Deputy First Minister and myself. The First Minister was responsible for the overall response to the COVID-19 pandemic. The Deputy First Minister was responsible for the resilience structure. My responsibilities in the COVID-19 pandemic were specifically within the health and social care response. Our overarching objective as a government was as far as possible, to protect the Scottish population from the harms of COVID-19 and minimise the loss of life. The overarching principles guiding core political and administrative decision making within the Scottish Government in this period were as set out in the Framework for Decision-Making published in April 2020. There the Scottish Government set out these principles as follows:

Safe	We will ensure that transmission of the virus remains suppressed and that our NHS and care services are not overwhelmed.
Lawful	We will respect the rule of law which will include ensuring that any restrictions are justified, necessary and proportionate.
Evidence-based	We will use the best available evidence and analysis.

Fair & Ethical	We will uphold the principles of human dignity, autonomy, respect and equality.
Clear	We will provide clarity to the public to enable compliance, engagement and accountability.
Realistic	We will consider the viability and effectiveness of options.
Collective	We will work with our partners and stakeholders, including the UK Government and other Devolved Nations, ensuring that we meet the specific needs of Scotland.

09 Other Cabinet Secretaries had respective roles within their portfolios which involved key decision making at times. For example, the Finance Secretary would liaise with the UK government on issues of funding. The key civil servants involved were the Chief Medical Officer, the Chief Nursing Officer, the Chief Pharmacist, the Director General of Health/Chief Executive NHS Scotland, the National Clinical Director, Special Adviser for the Health portfolio, my private office, and the private office for the First Minister. There was no specific role for the Secretary of State for Scotland in the response of the Scottish Government during the Covid-19 pandemic and there was no liaison between his office and my office.

10 Between January 2020 and May 2021, I worked very closely with the First Minister in reaching key political and administrative decisions in relation to the management of the pandemic in Scotland. I met with the First Minister during this time period every day at least twice a day. These meetings were in person. We would also on occasion make phone calls to each other to follow up on previously agreed actions and discuss any developments or new information which had occurred or been presented. There would be additional in person meetings dependent on what was needed.

11 I communicated with the First Minister primarily in person and via phone calls. My preferred method of communication was in person. The only other form of communication with the First Minister was through text messages and telephone

calls. The content of these text messages was limited to following up on decisions already taken through other means of communication.

12 In my role as Cabinet Secretary for Health and Sport, my main working relationship with the Deputy First Minister was through cabinet meetings. I did not have regular 1;1 meetings with him. We would both attend the Scottish Cabinet and Scottish Government Resilience Room (SGoRR) meetings, and we were both part of the First Minister's Advisory Group on Covid-19. I would speak with the Deputy First Minister over the phone on occasion.

13 Beyond my statement above, I did not discuss the management of the pandemic with the First Minister or the Deputy First Minister on informal or private communication channels or other messaging platforms.

14 In my role as Cabinet Secretary for Health and Sports, I worked closely with the Ministers of Health, Sport and Well-being, Joe FitzPatrick, until 18 December 2020, and subsequently Mhairi Gougeon, in operationalizing key political and administrative decisions about the management of the pandemic in Scotland. In addition, I also worked closed with Clare Haughey in her role as Minister of Health with responsibility for mental health. Between January 2020 and autumn 2020, the frequency of meetings with them depended on the work required in any specific circumstance or area. Towards the autumn of 2020 and leading into 2021 I had regular meetings with them in order to provide an update on the overall health portfolio. I communicated with both ministers through Microsoft Teams or Zoom. I did not discuss the management of the Covid-19 pandemic with either minister using informal or private communication channels or other messaging platforms.

15 I had regular portfolio meetings which involved my Ministers and key officials. Prior to January 2020, these meetings were held fortnightly and in person. From the end of March 2020 (when the first lockdown began), until April 2021 they were held weekly and via zoom/teams. Joe FitzPatrick and I (or Mhairi Gougeon) and Clare Haughey would have all attended these meetings unless apologies were given. Another series of regular meetings with my Ministers were the weekly comms meetings. Until lockdown in March 2020 these were held weekly. From April 2020, these meetings became woven into the portfolio meetings. Again, I and the health ministers would have attended these meetings unless apologies were given. I also had meetings with my ministers on a frequent basis in regard to matters of individual portfolio responsibility. These included discussions around vaccines/testing/drug

policy/dentistry and sport related/cluster outbreak covid incidents. We also attended the Mobilisation Recovery Group, which met from August 2020 and initiated or attended meetings with Opposition health spokespeople. Finally, I attended meetings of the Scottish Parliament as required, both in Chamber and with relevant Committees.

16 In my role as Cabinet Secretary for Health and Sport I also worked closely with Kate Forbes, who was the Cabinet Secretary for Finance at the time. We spoke regularly about funding in relation to the Scottish Government's response to Covid-19 as far as that affected areas in my portfolio. I also worked closely with Ivan McKee who was the Minister for Trade at the time, specifically in relation both to the international procurement of personal protective equipment (PPE) and the creation of a domestic PPE supply chain.

17 The group of key decision makers within the Scottish Government and their advisers had a close, trusting and effective working relationship. I believe this affected the manner in which the Scottish Government managed the pandemic. It ensured as far as possible the Scottish Government responded timeously to new information, made decisions based on available evidence and implemented these decisions as speedily as possible.

18 It is my view that the information and advice provided to me between January 2020 and May 2021 were timely and regular in the circumstances of the Covid-19 pandemic. The information and advice provided to me was regularly updated. In this context, it was readily available, sought and shared well within the key group of decision makers.

Informal Decision Making and Communication

19 Key decisions about the Scottish government's response to the COVID-19 pandemic were not made outside formal government process. All key decisions were made in formal settings and minuted or noted.

20 The only information which I received in an informal manner was factual and medical information about the nature of the virus. I would receive this information through text messages, email or by telephone depending on the urgency with which I should be made aware. These updates could be frequent given the developing nature of the virus and our understanding of it and would come primarily from the National Clinical Director or the Chief Medical Officer. On occasion the information would relate to a specific debate or discussion within the scientific community and may include reference to a journal article or social media post. Some text messages are retained on my mobile

phone, alongside a WhatsApp exchange with the CMO and are being supplied to the Inquiry. Where factual information or advice was contributing to subsequent decisions, these would be recorded in a minute or note.

21 I do not recall and am not aware of meetings between core decision makers including the First Minister and counterparts in the UK government which I would have expected to attend in my role as Cabinet Secretary for Health and Sport but which I was not party to.

22 There was a very clear process by which significant meetings were conducted within the Scottish Government. Cabinet Secretaries would be made aware of the agenda prior to each meeting and their private offices would source the briefing. If a Cabinet Secretary placed an item on the agenda, they would ensure that other attendees had the relevant briefing. There would be a minute of a previous cabinet meeting available in advance of each meeting. All decisions made at Cabinet and other significant meetings would be recorded. For example, in relation to the First Minister's Advisory Group on COVID-19, when either the First Minister, the Deputy First Minister, or myself would have specific questions that we wished to raise, this would be communicated in advance to the Group. The meeting would be subsequently held, and any formal actions noted.

23 The Cabinet is the highest Ministerial decision-making body of the Scottish Government. As set out in the Scottish Ministerial Code, [JF2/015 - INQ000102901] the Scottish Government operates on the basis of collective responsibility. This means that all decisions reached by the Scottish Ministers, individually or collectively, are binding on all members of the Government. The First Minister approves the content and timetabling of the agenda for any Cabinet meeting. Generally, these are matters likely to engage the collective interests of a number of Cabinet members.

24 Most substantive Cabinet papers are circulated to the First Minister, Deputy First Minister and other Cabinet Secretaries in correspondence for a period prior to the scheduled meeting. The draft Cabinet paper is then cleared by the lead Cabinet member and tabled for discussion. SCANCE (Scottish Government Analysis of News and Current Events) is a paper comprising short written items from each Ministerial portfolio. SCANCE aims to be a rapid and flexible way to brief Cabinet about rapidly developing or otherwise important issues which do not require a standalone Cabinet agenda item. SCANCE cannot be used to seek formal decisions from Cabinet.

25 From my perspective as the Cabinet Secretary for Health and Sport, there were no side meetings or informal meetings in and around Cabinet in which significant decisions were discussed.

26 There was a regular meeting on Thursday evenings over Zoom which involved the health secretaries from the Four Nations and on occasion, their respective ministers. I would always have an official present. These meetings were recorded, and notes were taken. The purpose of these weekly meetings was primarily to discuss any operational issues being experienced. For example, we discussed the performance of the Lighthouse Laboratory network, including where there were backlogs in the processing of tests in a particular laboratory and how that impacted on process times elsewhere across the 4 nations.

27 We also discussed aligning the timetable across the 4 nations for the delivery of the vaccines.

28 A WhatsApp group existed for the Cabinet Secretaries for Health of the Four Nations. All four health ministers agreed to the formation of this group. The WhatsApp group was used to facilitate the running of the weekly meetings over Zoom. I am providing the messages I still hold with these individuals to the Inquiry. Formal communication existed between the private offices of the four health secretaries. Formal communication existed primarily with between my office and Matt Hancock's.

29 I was not a member of any other WhatsApp groups, or other forms of group chats on platforms involving key decision makers, politicians or senior officials discussing the response to COVID-19 in Scotland or the UK.

30 I am aware of guidance which governed internal communications, messaging and data retention. This was set out in the Scottish Government Records Management policy and associated guidance and latterly in specific guidance on mobile messaging applications [JF2/014 - INQ000131069]. To the best of my knowledge this guidance was adhered to in relation to discussions or decisions made about the Scottish Government's response to COVID-19. I am not aware of any gaps in the use of the Scottish Government's Electronic Document and Records Management System or of any key communications that have not been retained on this system.

31 To the best of my knowledge, the use of informal communications did not affect the efficacy of decision making or the proper recording of decisions.

Inter-governmental working between the Scottish Government and (i) the UK Government and (ii) the other devolved governments in response to the pandemic

32 Within the Scottish Government there are a set of devolved responsibilities. Each individual and office within the Scottish Government worked within their devolved roles as they related to the management of the pandemic.

33 It is my view that the communication between the Four Nations health secretaries was generally reasonably good, albeit that it could be slow at times. There were occasions when discussions and decisions had been agreed upon by the four health secretaries, but the UK government's response would be different. I found it frustrating and difficult at times to understand the rationale for the basis on which decisions changed after they had been agreed at four nations meetings.

34 Inter-governmental fora that provided clinical and scientific advice during the pandemic worked effectively for the purposes of my role as Cabinet Secretary for Health and Sport. I do not believe that COBR worked as well as it could or arguably was needed during the pandemic, as it was too large, insufficiently discursive and appeared for the most part, to operate on basis of an agenda set by the UK government alone.

35 As there were multiple inter-governmental fora operating in parallel, I would receive all key information and advice from key clinical and scientific advisors. Whilst there may have been a risk of information overload given the volume of information and the necessary frequent updates to it, I remain firmly of the view that it was necessary for me to have all the relevant information to allow me to make necessary decisions. Being able to deal with large volumes of at times complicated information, analyse the information and form the judgements necessary for decision making is part of the job of a Cabinet Secretary in normal times and even more so during a global public health emergency.

36 I do not have a view on whether the four Ministerial Implementation Groups should have remained in place after May 2020 in light of them being replaced by the Covid-S and Covid-O committees.

37 In broad terms, my experience was that the engagement between the Scottish Government and the UK government, such as in relation to the coordination of policy and communication responses, sharing of data analysis, and pooling of resources worked reasonably well. The Scottish Government had taken a very clear view that any pre-existing tensions and disagreements had to be set to one side in the face of the

pandemic with the priority being to work as collaboratively and respectfully as possible to protect the populations we served.

38 The main challenge in relation to intergovernmental working between the Scottish Government and the UK government was that we were dealing with two different systems for health and to an extent, social care between England and Scotland. This was a challenge when considering the operationalisation of decisions. There were challenges for example in respect of understanding the differences in geography across the Four Nations and how that impacted on both aspects of policy and on delivery. As noted, before there were challenges in respect of resources where the UK held reserved powers could impact on the Scottish Government's intent to take specific actions in managing the spread of the virus. It is my understanding that the First Minister at the time raised these issues with the Prime Minister and I believe they were also raised at COBR and with the Chancellor of the Duchy of Lancaster. Although these issues were raised at various fora, it is my view that the Scottish Government and the UK Government were not always able to overcome these challenges.

39 It is the case that the pace of the pandemic response, the unprecedented rhythm of ministerial meetings and the short turnaround time on commissions for papers meant that the Scottish Government may not have always received invites, agendas or papers in time. I do not find the Secretary of State for Scotland's reasoning for the late receipt of agendas entirely credible. I do not believe the Scottish Government was late in supplying information to the UK Government during the pandemic. It was my experience that within the UK government there was a view that the Scottish Government was not an equal partner in the management of the pandemic response. My observation was that this view also applied to the other devolved governments.

40 It is the case and has been so despite the 20 plus years since devolution, that the knowledge, understanding and experience of devolution varies considerably within Whitehall Departments. It is regrettable that successive Secretaries of State appear to have been unwilling or unable to improve that situation. From my experience of working with the UK government both before and during the pandemic and in previous roles, there is a significant need to improve on that situation at both official and political levels of Whitehall. At points during the pandemic, colleagues from Wales and Northern Ireland also raised issues around this understanding.

41 The First Minister made announcements to the public at the timing agreed by the Scottish Government, as a result of a collective decisions made by Scottish ministers.

The timeliness of announcing these decisions was important to the people of Scotland and the announcements were made with the best interests of the Scottish people in mind. There were times during the pandemic when announcements were specifically coordinated between the four nations, for example, in relation to the delivery of the vaccine programme.

42 At the outset, the Scottish Government was clear that wherever possible it would follow a four nations approach, but retained the right to depart from that if, based on the data, evidence or advice provided, it judged it to be in the best interests of people in Scotland to do so. This important caveat applied to the approach of all the four nations of the UK. Consequently, where the approach changed it did so because of the judgements the Scottish Government made based on the factors outlined.

43 There was no advice received that we should not plan on this basis, and no 'plan' to depart from the four nations approach inasmuch as the existence of a plan can be implied as representing a long-standing intent. In this, as in other decisions and judgements, the Scottish Government acted on the basis of the information available to it at the time.

44 Where the risk of confusion on the part of the public could exist, the Scottish Government's view was that retaining the clarity of its message, the clear explanation of the decisions being taken and the rationale for those decisions and the regular communication of these through all communication channels at its disposal was the most effective way to guard against and mitigate any potential confusion. The Scottish Government also ensured that its ministerial colleagues in the other nations understood what it was doing and why.

45 The address by the First Minister on 11 May 2020, in which she clarified that UK government guidance to return to work did not apply in Scotland and the reasons for that is an example of this. In her media briefing she provided the data, as was done at every daily briefing, on confirmed case numbers, hospitalisations and deaths where covid was present. That data and the trends seen over a number of data periods together with the clinical advice the Scottish Government received was the basis for its retention of the 'Stay at Home' advice at that time.

46 I do not consider that the First Minister's comments with respect to the UK Government's shift away from the 'Stay at Home' message should have in any respect adversely affected relationships between the Scottish Government and the UK Government, given all four nations clearly understood and had stated that they

respected the right of each nation to act in a way it judged to be in the bests interests of those it represented in what was a public health emergency. I am not aware that this situation in particular affected the working relationship and was not aware that it altered the pre-existing relationship between the First Minister and the Prime Minister. It was the case in some instances that the UK Government made decisions citing England data with which we did not agree.

47 Between January 2020 and May 2021, I had direct contact with the respective Cabinet Secretaries for Health across the four nations in relation to the management of the pandemic in Scotland. My interactions with the health secretaries were largely operational in nature. We discussed where policy positions differed across the four nations in relation to health and explained the reasons for these differences. I believe these interactions were effective.

48 My personal and working relationships with key decision makers and advisers in the Scottish Government, the UK government and other Devolved Governments during the pandemic were warm and productive. I do not believe there were any personal relationships between the Scottish Government and the UK Government that made it more challenging to work together. I am not aware of any personal relationships that may have had an overall effect on the manner in which the Scottish Government worked together with the UK Government and other Devolved Governments or the efficacy of its response to the pandemic in Scotland.

49 I am not aware of the role that Alister Jack MP, the Secretary of State for Scotland, and his office played in UK Government's core decision making insofar as it related to the management of the pandemic in Scotland. I am not aware and have no experience of the formal and informal role and responsibilities the Secretary of State for Scotland and his office may have had in facilitating intergovernmental workings between the Scottish Government and the UK Government. When Matt Hancock met with me and the CMO on 12 March 2020 to discuss Scotland and the UK's preparedness for the pandemic, Mr Jack was present but that was the only direct contact I had with him.

50 I believe the Secretary of State for Scotland attended COBR meetings which I was also present at and that he was also regularly present at meetings chaired by the Chancellor of the Duchy of Lancaster, at some of which I attended for the First Minister. I had no other direct or indirect contact with the Secretary of State for Scotland.

The other Devolved Governments

51 Between January 2020 and May 2021 there were regular meetings and calls between the health secretaries of the four nations. Where appropriate, there were also meetings and calls between the officials of the three devolved nations. There were regular meetings and calls between the Chief Medical Officers of the 4 nations. There was a mutual aid agreement between the Four Nations with respect to PPE and that was enacted with Scotland at one point providing PPE to Wales and Northern Ireland. Once approved by me, communication in this regard would be handled between officials.

52 I had a very good understanding of when and why the governments in Wales and Northern Ireland were taking steps in their management of the pandemic and, aside from my comments earlier, understood as best I could the decisions of the UK government as they were communicating and explained by Mr Hancock. I believe the health secretaries of the four nations made an effort to explain to each other how and why management of the pandemic differed in each of the devolved nations.

Funding

53 I was not directly responsible for the funding of the Scottish Government's response to the pandemic and would refer questions in this area, including the detail of what limitations and difficulties were faced and any impact on the decisions made surrounding NPIs to the Cabinet Secretary for Finance. I agree with the statement of the Director General Strategy and External Affairs on behalf of the Scottish Government in that there were occasions when the Scottish government wanted to keep restrictions in place longer but felt unable to do so because of the UK government's decision to withdraw furlough funding and the disproportionate harm that would therefore be incurred. For example, based on the data we had, the Scottish Government wanted to continue with restrictions on the operation of businesses in order to contain the spread of the virus. The Scottish Government was unable to do that because it did not have the means under devolved powers to raise funds. In relation to how the Scottish Government engaged with the UK government in relation to funding, this was outside my portfolio and the former Cabinet Secretary for Finance is better suited to comment on this.

54 I generally agree with the statement of the Director General Strategy and External Affairs on behalf of the Scottish Government that the UK government would be inclined to make funding, such as the furlough scheme, available across the UK when it judged that the epidemiological situation merited it, based largely on its assessment of

conditions in England. The former Cabinet Secretary for Finance is better suited to comment further on this as this was part of her portfolio.

Conclusions and Lessons Learned

55 The core and senior decision making body for the Scottish Government is Cabinet. As I have described above, Cabinet discussion was based on papers supplied and the key points of discussion and outcomes were minutes accordingly. Decisions were implemented by the lead Cabinet Secretary and the relevant officials according to their areas of responsibility.

56 In relation to the response to Covid-19, I did not have any concerns regarding the performance of the First Minister, Deputy First Minister, any Cabinet Secretary, Minister, senior civil servants, or any special advisor or individual in charge of a significant aspect of the Scottish response to the pandemic between January 2020 and May 2021.

57 In relation to the response to Covid-19, I did not have any concerns regarding the performance of any of my counterparts in the UK Government or the Devolved Governments with whom I had dealings between January 2020 and May 2021, except where decisions agreed between the 4 Health Ministers were then altered through a process within the UK Government in which we played no part.

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

Advisory bodies

58 During the course of the Covid-19 pandemic, the Scottish Government had regular access to papers produced by the UK Scientific Advisory Group for Emergencies (SAGE) and the output of SAGE meetings. SAGE was created primarily to provide scientific advice to UK Ministers during emergencies, but Scottish Ministers were also allowed access to that advice and during the pandemic we received feedback from officials who attended on behalf of the Scottish government and from Professor Andrew Morris, Chair of SGCAG. However, the Scottish Government had limited insight and influence over SAGE's development and the reasons behind any changes made. Whilst the evidence and advice produced by SAGE was an important source to us, it was also the case that the commissioning of advice from SAGE was undertaken by UK government departments who were of course, focussed primarily on conditions in England and there was no capacity for Scottish Ministers to engage directly with SAGE. This situation led the First Minister of Scotland, rightly in my view, to commission our CMO to set up the Scottish Covid Advisory Group which, working in complement to

SAGE, could address these deficits. Scotland also had access to information from the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG), the Joint Biosecurity Centre (JBC) and the Joint Committee on Vaccination and Immunisation (JCVI).

59 The Scottish COVID-19 Advisory Group (SGCAG) had the remit to "consider the scientific and technical concepts and processes that are key to understanding the evolving COVID-19 situation and potential impacts in Scotland". The SGCAG evolved over time depending on demand and the requirement for advice on different topics depending on the phase of the pandemic. The SGCAG had a number of sub-groups, on Public Health Threat Assessment; Education and Children's Issues; Universities and Colleges; on Testing; and the COVID-19 Nosocomial Review Group.

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

60 The Scottish COVID Advisory Group was set up from March 2020 to provide advice specifically for Scotland. Scottish Government clinical and science advisers and officials who attended SAGE meetings met with key Scottish ministers and answer specific questions. The Group also engaged advice on epidemiology and virology, benefitted from input from very senior members of PHS and included expertise on behavioural science, which the Scottish Government considered critical to its response in management of the pandemic.

61 The SGCAG was formed in order to provide additional scientific analysis of the impact of Covid-19 in Scotland. The first meeting of the group was held on 26 March 2020, early in the response to Covid-19, to apply the advice coming to the four nations from the Scientific Advisory Group on Emergencies (SAGE) and other appropriate sources of evidence and information and use it to inform decisions in Scotland during the pandemic. Members were chosen and appointed, via a letter from the CMO, based on their scientific or technical expertise and their understanding of the situation in Scotland.

62 The SGCAG was designed to share information with SAGE on a reciprocal basis. The SGCAG had access to papers from SAGE and its subgroups, while the SAGE secretariat was provided with copies of SGCAG papers. Consequently, the SGCAG did not duplicate the work of SAGE but interpreted it in the Scottish context.

63 In so far as I am able to comment, I consider that the SAGE/SGCAG system, under which SAGE and the SGCAG and their sub-groups, advised on scientific matters, was

appropriate for dealing with a pandemic of this nature and for ensuring that where necessary, available scientific and clinical advice was offered which was appropriate to Scotland.

64 The system by which scientific advice was provided to the Scottish Government in the period before the formation of the SGCAG was of value. However while Scottish Government officials were observers at SAGE and would receive advice in that manner, Scottish Ministers had no direct engagement as noted earlier and we identified a clear need to have direct access to an eminent group of scientific and clinical advisers who also understood the situation in Scotland and with whom we could engage directly in order to improve our own understanding as was necessary for the decisions we needed to take. The National Clinical Director and the Chief Scientific Adviser for Scotland would provide and receive advice through contacts in the rest of the UK and Europe.

65 I did not regularly attend SGCAG or SAGE meetings. These would have been attended by SG clinical leads who would then have reported back to and updated me on the current position. My diary reflects that I attended one meeting of the SGCAG on 1 May 2020. I also attended a briefing from the members of the SGCAG to the First Minister on 29 June 2020 as well as regularly attending specific deep dive sessions mentioned above.

66 The role of the Chief Scientific Adviser to the Scottish Government is set out in the corporate statement supplied by DG Economy in June 2023. The CSA was a member of the C19AG and contributed advice in that context. She did not have any direct reporting role to my role as Cabinet Secretary for Health and Sport. However, I did have contact with Professor David Crossman, the Chief Scientist (Health) (CSH) to the Scottish Government. This role is part of the Chief Medical Officer Directorate (CMOD) in the Scottish Government, and works to identify, promote and encourage research which addresses the health and healthcare needs of the people of Scotland. The role of the CSH is set out in the corporate statement supplied by DG Health and Social Care (Health Entities) provided June 2023. The CSH was the Deputy Chair of the SGCAG and contributed advice in that context.

67 The role of the Chief Medical Officer and Deputy Chief Medical Officers is as independent clinical advisers to government. An important part of the role of CMO is to be able to use judgement and professional clinical experience to be able to communicate effectively and fully, so that their commitment to professional and ethical

requirements as defined by the GMC is not breached. During the pandemic, the CMO or a DCMO would be in attendance to provide clinical advice in SGoRR and Cabinet as required. The CMO or DCMO attended media briefings to support public scrutiny of their advice.

68 I believe that the advice I received from the Chief Scientist (Health), Chief Medical Officer for Scotland and Deputy Chief Medical Officers for Scotland, the Chief Nursing Officer for Scotland, Chief Pharmacist and the National Clinical director during the course of pandemic was clear and transparent. I felt able to and did challenge the advice provided me by these officers, the SGCAC and SAGE in order to prove my understanding of the advice as did the First Minister and the Deputy First Minister which I observed from my interactions with them. I do not have knowledge of whether other core decision makers in the Scottish Government properly challenged scientific advice provided it to them.

69 The four harms assessment was the structure through which the Scottish Government was provided with expertise related to the economy, communities, including vulnerable or at risk citizens, and education. The four harms assessment was formally articulated as part of *COVID-19 – A Framework for Decision Making* which was published on 23 April 2020 and was intended to support decision makers to balance the harm to health from Covid directly, with the harm resulting to health indirectly and wider economic, education and social harm. The SGCAG also considered the issues of at-risk and vulnerable groups and ethics.

70 In April 2020, SG published clinical advice and an ethical and support framework [JF2/017 - INQ000274110] that aimed to support front line staff with clinical and ethical decision making throughout the pandemic. The ministerial code pertains to the actions of ministers. As far as I am aware, there were no concerns raised under the code related to the management of the pandemic.

71 It was recognised that whilst the primary harm facing the population was from the COVID virus, other consequential harms needed to be understood and considered. The development and application of the 4 Harms Assessment sought to take account of the consequential harms and risks to the economy, other areas of health and social harms which may or were likely to arise from the range of measures being considered at any one time to mitigate against the risk of Covid harm to health.

72 The CMO and senior clinicians provided advice on direct and indirect health harms as a consequence of viral spread and COVID-19. However, I and other ministers also

considered wider impacts of the pandemic and the measures to control it in taking decisions. This approach was formalised in the Four Harms assessment incorporating consideration of societal and economic harms. Under this process, combined cross-government advice, evidence and modelling was presented to ministers to inform our decisions.

73 To the best of my knowledge, decision makers used the four harms assessment after it was introduced in April 2020 to weigh medical and scientific advice with other considerations when making key decision-making in response to the pandemic.

74 The Scottish government's response to Covid-19 was based on the best available advice at any given time, scientific or otherwise. As the understanding of the nature of the virus and its impact on individuals increased, the sufficiency and adequacy of the scientific and other expert advice improved. There was a process of continuous refinement and improvement of data and analysis. I believe I was able to understand and interrogate any advice provided to me through one-to-one discussions with clinical and scientific advisors and the Covid-19 advisory groups.

75 In cases which involved conflicting medical and scientific information and advice, these were always pointed out to me by my advisors. I was provided with alternative analysis and alternative recommendations by my advisers. There was a significant amount of information available from reputable advisers in Europe and the United States. I would review the alternative advice and ask questions of our advisors in order to ensure the Scottish Government was taking account of as many views as possible. I would have discussions with my advisors and make judgments based on those discussions.

76 I am not aware of any decisions in relation to which medical and scientific information or advice or data modelling was not sought but which ought to have been sought.

77 In relation to the patient experience within the healthcare system during the pandemic, I had access to information and advice from regular discussions with trade unions working in health and social care, Care Home Relatives Group, Scottish Care, BMA, Royal Colleges and COSLA. In addition to this, the Director General for Health and Social Care, the Chief Executive of NHS Scotland and the former Minister for Public Health, Joe FitzPatrick were in regular contact with the NHS Scotland health boards. Information from these conversations was fed back to me where relevant.

Data and modelling

78 I believe I had adequate access to reliable data and modelling information, including from the private sector. I believe I understood the data and modelling information advice, including its limitations, which was made available to me. Data was disseminated to me daily, often twice daily and on occasion, more frequently. Information was provided to me about the number of people in hospitals, the number of deaths and whether these happened in care homes or hospitals. Additionally, I received daily SitReps related to PPE volumes in hand and on order and held and related to infection incidents and levels in adult residential care. All of this allowed me to monitor the situation across a range of areas and instruct action where necessary.

79 Advice was provided by SGCAG, CMO/DCMO, Chief Pharmacist, CNO, Chief Scientist (Health) and others as detailed above. In addition, officials provided a suite of statistics on a regular basis including modelling data, and wastewater data. These would cover issues such as transmission, infection, mutation, re-infection, geographical spread and death rates based on the best available data at the time. At a later stage in the pandemic, daily data on vaccine delivery was provided by officials focused on operational support and programme delivery modelling.

80 The systems for the collection and dissemination of data amongst the Health and Social Care Directorate, other Scottish Government directorates, the NHS NSS and PHS were adequate at the start of the pandemic for a 'normal' situation. These systems also provided the foundation on which the Scottish Government and agencies could make the necessary updates to data collection, validation and delivery at pace in a pandemic situation. The systems were responsive to the understanding of the virus and were subject to constant improvement.

81 For my purposes as the Cabinet Secretary for Health and Sport, the mathematical modelling of epidemiological outcomes available to me was sufficiently reliable.

82 In relation to other factors, such as economic, societal, educational, non-Covid health related and mental health impacts, I believe the modelling was significantly improved with the introduction of the Four Harms assessment.

83 In relation to whether the impacts on vulnerable and at-risk groups were sufficiently modelled, these were considered in clinical modelling, especially in the way new and emerging strains of the Covid-19 virus impacted clinically vulnerable and at-risk groups. Other impacts on vulnerable and at-risk groups were picked up under the four harms framework.

84 I believe it was an accurate representation of the reality of government decision making to refer to using 'following the science.' The Scottish Government relied on clinical and scientific advice to inform decisions made and I used this phrase on occasion.

Other sources of information and advice

85 I was not directly involved but believe that advice from the UK Government International Comparators Joint Unit (ICJU) was shared with the Scottish Government from late June 2020. I understand that ICJU advice was then shared with relevant policy teams/leads on various aspects of Covid response for their consideration in preparing advice to ministers. Relevant information provided by international organisations such as the WHO and the World Health Assembly was accessible to the Health Protection Network and the CMO. Information sourced via these routes would have been reflected in briefings and analysis to ministers to support decision making on the response to Covid-19.

86 The Joint Biosecurity Centre established in May 2020 was a valuable source of information, in particular where thematic or bespoke products were available. Along with Health Ministers from other devolved nations, I sat on its Ministerial Board. I do not recall why it was merged with the UK Health Security Agency: the rationale for this would be a matter for the UK Government.

87 Between January 2020 and March 2020, the Scottish Government considered the response of other countries to Covid-19, such as those of Taiwan, Singapore and New Zealand whether similar measures were applicable in Scotland. Not all of these measures were available to the Scottish Government as a consequence of the devolution settlement. For example, it was considered during this time period, that completely closing the borders, as was the case in New Zealand, was not an option available to the Scottish Government, not least because control of borders into the UK including Scotland, sat with the UK Government.

88 Between January 2020 and May 2021, in my role as Cabinet Secretary for Health, the Scottish Government consulted with NHS boards, both Chairs and Chief Executives, Scottish Care, COSLA, the Royal Colleges, universities delivering medical and nursing education, and health trade unions, including the BMA, RCN and RCM. In other portfolio areas, Ministers would consult with relevant stakeholders and where there was relevant health or social care feedback, provide that to me. Frequently consulting with these groups was very important as it allowed the Scottish Government to ensure that information from stakeholders was properly considered in core decision-making. It was

also important to understand what these groups needed to help them deliver on decisions made by the Scottish Government. I would feed back to the First Minister or in Cabinet meetings following these discussions.

89 Decisions made by the Scottish Government would be communicated back to stakeholders in follow up meetings, as meeting with stakeholders and interest groups was a constant and iterative process. The offices of the Chief Medical Officer, the Chief Nursing Officer and the Chief Pharmacist would also be in contact with the relevant bodies.

90 Given the volume of information generated and the necessary frequent updates, there was of course a risk of information overload for key decision makers, but I believe it was of critical importance to have all the relevant information and be able to question it where appropriate to improve my understanding as a non-clinician.

91 In relation to whether a separate symptom profile for Covid-19 was required than that set by the UK Health Security Agency, this is a question for clinically experienced advisers. However, I am not aware of any advice suggesting a different symptom profile was required.

Operation of advisory mechanisms

92 It is my understanding that the structures available for the provision of medical and other scientific advice to decision makers within the Scottish Government enabled core decisions to be taken effectively and efficiently. I met with and spoke to my key advisers daily, often more than once a day. This is how we ensured that information they were receiving, for example international comparators or UK actions, were communicated with me. This was followed up in writing. I believe these structures functioned effectively.

93 I believe I received more than adequate advice and information on which to base my decision making, or my contribution to decision-making, with regard to the response to Covid-19. In order to ensure that clinical evidence was applicable and relevant to Scotland, the SGCAG was set up, which was beneficial to inform the decision- making processes. Within the time constraints of an emerging and developing pandemic, I believe key decisions were taken by me and other key decision makers following the most appropriate and thorough process of advice and consultation possible in the circumstances.

Conclusions and lessons learned

94 In terms of areas that worked well, very quickly over the course of the early stages of the pandemic, Public Health Scotland, in collaboration with NHS Health Boards and others, increased the level, type and frequency of data collection so that modelling could be improved. The understanding and wider application of genomic sequencing also developed throughout the pandemic. These were all important areas that emerged as a consequence of dealing with the virus. The application of this information to Scotland was an initial gap which was filled very well by Public Health Scotland and by bringing together specific expertise through SGCAG.

C. Initial understanding within the Scottish Government and responses to Covid- 19 in the period from January to March 2020

Initial understanding of the nature and extent of the threat

95 Towards the end of 2019, I became aware through media reports of a situation that appeared to be developing in the Wuhan province. I asked my clinical advisers for any information they could get around that, just so we could be conscious of it. We did not realise at that point the threat we were dealing with, but I wanted to be sufficiently aware of what was happening, as far as that was possible. In the early part of 2020, very quickly clinical advisers were able to provide more detailed information. The CMO for Scotland was connected with her counterparts in the rest of the UK. She and our National Clinical Director at the time were also part of an international network of clinicians and were able to speak with colleagues elsewhere in Europe and understand their knowledge and information.

96 We could also see the situation emerging in Italy and began to receive more information about the Covid-19 virus, how it transmits and who it impacts more severely. I was aware, even at that point, that there were groups of people that are more vulnerable to viruses and exposed to severe illness and death. I had awareness of the implications of Covid-19 for Scotland from the CMO and her network of experts. Knowledge was being updated very quickly and there would be discussions before the SGCAG was set up. These included various experts such as Mark Woolhouse, Stephen Reicher on behavioural science and others, which helped to explain some of SAGE's advice, or offer a counter to SAGE's advice.

97 Between January 2020 and March 2020, the Scottish Government's clinical advisers were liaising with the WHO and other relevant international organisations during this

period. Contact between the CMO for Scotland and the WHO was primarily co-ordinated through the CMO for England. I was also liaising with other health secretaries in the four nations and normal coordination mechanisms were in place between Scottish Government Officials and their UK counterparts.

98 An information briefing to the Minister for Public Health, Sport and Wellbeing, was copied to me on 17 January 2020, noting one potential case in the UK. A further briefing was circulated to the FM, DFM and key officials on 24 January 2020 setting out information on case numbers in China and beyond from the WHO and outlining planned actions in the event of a confirmed case in the UK/Scotland.

99 The core group of decision makers involved in attempting to understand the implication of the Covid-19 virus, receiving advice from clinical advisers at this time were myself and the First Minister. When communicating medical advice to me and the First Minister, the CMO would reference scientific articles and reports published in January 2020. These would be brought to our attention and referenced in her advice.

100 The information and advice at this stage was relatively sparse and was updated on a daily basis. As we progressed through this early stage of the pandemic, our understanding of impact grew as more information became available. Initially, the assumption was that like influenza, the Covid-19 virus would not transmit between those who did not have symptoms. It became apparent very soon that with this virus, asymptomatic transmission was possible.

101 Between January 2020 and March 2020, in terms of health, I put NHS Scotland on emergency footing using the relevant legislation. This meant that the direction the health service took was determined by me. We undertook a number of steps to ensure the health service in Scotland was ready to deal with the modelled high numbers of people requiring hospital treatment, including intensive care. This involved the cancelling of elective and non-urgent healthcare. This also involved redeployment of staff to areas to respond to patients with Covid-19 and arrangements to bring back retired qualified health staff. This also involved bringing into the health service final year medical students and nursing students to supplement the workforce, bearing in mind the virus would impact healthcare staff. There was significant work done, based on clinical advice, on the type of PPE needed, ensuring a flow of supply to increased distribution routes to cover social care and community-based care, to establish a Covid-19 pathway for patients in the community to protect GP services for patients did not have Covid-19. There was a large amount of guidance around supporting healthcare

staff and in particular, specific guidance for people deemed clinically vulnerable and at-risk based on their existing health conditions. Work was also undertaken to significantly increase Scotland's capacity to process Covid-19 tests, while retaining a capacity to process other diagnostic tests needed for emergency care or cancer. I believe the foundation on which Scotland could increase preparedness was very sound and the health service in Scotland responded very quickly to prepare for the pandemic. In that sense, Scotland was reasonably well prepared and had the advantage of good supply lines through a single procurement system.

102 My understanding of the essential features of the virus was informed by the understanding of my clinical advisers. I believe this was a situation replicated globally. As senior clinicians, epidemiologists and virologists understood this virus was behaving in a way that was different from what had been previously modelled, my understanding of what that meant increased.

103 In January 2020, I believe I reacted as appropriately as I reasonably could in the circumstances, given that our response and understanding increased as we understood the virus was spreading through Europe. I believe the First Minister also understood the imminence and the importance of the threat of the virus as it spread throughout Europe. I and the First Minister properly appreciated the seriousness of the spreading virus.

104 As our understanding grew about the virus, Cabinet and other parts of government became more directly aware of the threat as we began to try and take steps to contain spread of the virus, minimise the numbers of people that would be harmed by COVID and increasingly recognised the consequential risk of harm in other areas, including other health impacts.

105 I do not think there was a view within the Scottish Government that Covid-19 was similar to influenza. Swine flu was the most recent experience that clinical advisers and decision makers had of a likely emerging pandemic. My recollection is that decision makers and advisers became aware very quickly about how different Covid- 19 was from either swine flu or influenza.

106 I understood why a declaration of a Public Health Emergency of International Concern would be made by the World Health Organisation. As the UK is treated as a single body by the WHO, the UK Government would make any formal representations or expression of views to the WHO in relation to a declaration of a Public Health Emergency of International Concern. I would consider that WHO advice is always

relevant to Scotland. I would look to my clinical advisers for their view on the degree of relevance and the degree to which the Scottish Government was able to implement WHO guidance. If the Scottish Government was not able to implement WHO guidance, I would look to my advisers for their views on how the Scottish Government could reach a position to be able to implement the WHO guidance and what mitigation measures could be implemented, if any, in the interim.

107 By the end of January 2020, the First Minister and I were aware that we were undoubtedly dealing with a potentially fatal virus and were already making decisions about preparing for the virus. We had by this point done a significant amount of work to think through what needed to be done to realign Scotland's health service to cope with the virus. My priorities at the end of January 2020 were to ensure that we were maximising our knowledge of the spread of the virus and its likely effect, working through and taking steps to ensure that we could cope with the health threat of Covid-19.

108 The first case of Covid-19 in Scotland was recorded at the beginning of March. I was also aware of cases at this time in the rest of the UK. Briefing on the Reasonable Worst-Case Scenario (RWCS) was provided to a meeting of SGORR(M) on 17 February, the outcome of which was discussed in Cabinet the following day. There was further discussion of the implications of a RWCS following the first cases in Scotland in Cabinet on 3 March.

COBR/SGORR

109 COBR meetings are instigated by the UK Government. The agenda for the first COBR meeting on 24 January 2020 was decided by the UK Government. I attended as the Cabinet Secretary for Health and Sport for Scotland, both of which are devolved matters. I considered my attendance at the meetings important so I could hear first-hand the thinking of the UK Government and my colleagues in other Devolved Governments and where possible, contribute to these discussions. The discussions at COBR were considered and taken account of as the Scottish Government looked to make decisions in relation to Scotland. I attended the first COBR meeting, and the First Minister also attended subsequent meetings. In response the Scottish Government also formally stood up its own Resilience Room ("SGORR").

110 I think the role of Prime Minister is a very senior one. The attendance of the Prime Minister at meetings is an indication of the degree of seriousness and importance that

the UK Government places on the subject matter of a meeting. The Prime Minister not attending early COBR meetings could be taken as an indication that the UK Government at that point did not consider Covid-19 as serious a threat as it clearly was.

111 The First Minister and I both attended the COBR meeting on 2 March 2020. The First Minister decided which meetings she attended. COBR is the UK Government's emergency response mechanism, so I believe it is reasonable that it was chaired by a UK Government minister. Given the level of threat of Covid-19 that was evident by March 2020, it was entirely appropriate that the Prime Minister chaired the COBR meeting which took place on 2 March 2020. I am not aware of who instigated the COBR meeting on 2 March 2020.

112 With regards to Scottish Government's decision-making responsibilities in relation to health, I was clear that health and social care were devolved responsibilities. I was responsible for the response of Scotland's National Health Service and Scotland's care system to the threat of the Covid-19 pandemic. Elements of that response clearly linked with areas that were reserved, for example funding, in the ways I have outlined previously in this statement.

Pre-lockdown response

113 Measures which asked the public to observe respiratory and hand hygiene promoted by the Scottish Government between February and March 2020, were informed by advice being provided by clinical advisers about how the Covid-19 virus spread. This was in line with the approach taken by the rest of the UK. To the extent that they were based on clinical advice, I believe they were adequate.

114 Measures put in place by the UK Government are a matter for them. In the lead up to March 2020, the Scottish Government's appreciation as to the degree to which Covid-19 was spreading through the UK grew. Testing for suspected cases of Covid- 19 in Scotland began on 24 January 2020. On 6 February, the four UK CMOs advised that testing in the UK should be widened from individuals with symptoms who had recently travelled from China to those travelling from other areas with known outbreaks. On 10 March 2020 the CMO emphasised to Cabinet that testing and contact tracing were vital at this stage: unexplained cases, where no link to a known source could be identified were likely to be indicative of the start of sustained community transmission.

115 In February 2020, in response to the spread of the virus in Italy, the modelling for the Four Nations plan was progressed. This plan states that as much as each of the four nations could, they will respond to the Covid-19 pandemic together. Around the time the Four Nations plan was agreed and published, from February 2020 to March 2020, the Scottish Government was preparing for the reasonable worst-case scenario. I made a statement to the Scottish Parliament on 3 March 2020 that outlined the reasonable worst-case scenario and modelling. On 17 March 2020, I placed NHS Scotland under emergency measures.

116 My decision-making in this regard was informed by the Four Nations plan, the modelling on which it was based, and the advice received. This plan and modelling, based on the information available at the time, outlined information about the virus, such as its symptoms, likely impact on the population and hospitalisations. This modelling also indicated the resources, such as hospital beds and medical equipment, required to ensure that the healthcare system was a well-placed as
possible to cope with the demands of Covid-19, in a situation described by the modelling of the reasonable worst-case scenario.

Flattening the curve

117 The strategy of 'flattening the curve' was part of the Four Nations plan, which the Scottish Government had agreed. It was part of a phased approach to responding to the virus. This was based on clinical understanding of the virus and how it transmitted. Once it was not possible to delay the spread of the virus, the next stage was to contain it. This was the stage at which restrictions were required to be imposed, such as those on movement. This means that the virus would spread, but the speed at which it would spread could be 'flattened,' allowing the health service to have some room to respond to the spread of the virus. I believe I had access to adequate data and information from our clinical and scientific advisers to assess what the curve was and if or how it could be flattened.

118 The Scottish Government began to move away from the strategy of 'flattening the curve' when the overall trend in case numbers showed significant improvement and NHS Scotland was coping with the demand placed on it. At this point the balance of risk judgment was that it was possible to begin to lift restrictions and move into the Test and Protect phase. This phase still carried restrictions but did not full lockdown restrictions. Broadly speaking, it seemed to me at this time that the approach was comparable across the Four Nations, with different operationalisation according to each nation's particular data and circumstances.

Herd Immunity

119 My understanding of 'herd immunity' is that it is a strategy which allows a virus to spread, on an assumption that the more people catch a virus, the greater the community's immunity to that virus broadly. To my knowledge, the Scottish Government did not subscribe to a strategy of 'herd immunity' at any point. I did not at any point consider it possible to shield the vulnerable from severe infection as part of such a 'herd immunity' strategy. All the modelling of the virus was very clear about the groups of the populations which would be most severely affected the virus. It was also clear on the manner in which these groups would be affected included death. The Scottish Government took the view that allowing a virus to spread in those circumstances was an extremely risky strategy.

120 I cannot say that 'herd immunity' was part of the UK Government's strategy in responding to the Covid-19 pandemic. I am aware that there were discussions that considered it as a strategy, but I was not party to those discussions so cannot confirm whether it was formally part of the UK Government's response strategy. 'Herd immunity' was not part of the four nations plan. I do not recall 'herd immunity' being recommended by the Scottish Government Covid-19 Advisory Group. I am not sure whether it was ever recommended by SAGE.

121 Given that 'herd immunity' was not considered as a strategy by the Scottish Government, it was not connected to any other factors outside of providing a clinical understanding of the impact of the virus on particular cohorts of individuals. However, with regards to the Scottish population's compliance with Non-Pharmaceutical Interventions (NPIs) more broadly, the Scottish Government sought the views and advice of behavioural scientists on securing the public trust when making decisions relating to NPIs.

122 On 12 March 2020 the Prime Minister announced the publication of guidance advising those with Covid-19 symptoms to self-isolate at home for at least seven days. The Scottish Government agreed that this guidance also applied to Scotland. The application of the guidance in Scotland was based on clinical advice from our Chief Medical Officer, who was engaged in regular discussions between Chief Medical Officers of the four nations.

123 The advice to self-isolate for seven days was based on clinical advice and as a non-clinician, I cannot comment on whether the period should have been longer. We were advised that the only way for such interventions to be effective was if the Scottish public

understood the rationale behind what was being asked of them and trusted the basis on which they were asked to do so. A legal requirement risked creating a separation between what the Scottish Government was asking the Scottish public to do and the public's trust. We were very firmly of the view that we needed the trust of the Scottish public to secure compliance with the decisions we were making, and that trust was achieved by maximising the information provided to the public.

124 The Scottish Government's rationale for the change in strategy from 'contain' to 'delay' on 15 March 2020 was based on a clinical understanding of the virus, its spread and the clinical advice available at the time. There was an increase in the level of spread of the virus and the number of cases. The manner and speed at which the virus was spreading at that point meant it was no longer possible to contain the virus. It could not be contained within geographical areas or within groups of people. The purpose of contact tracing was to 'contain' the virus. Consequently, using resources for contact tracing at a point when data and advice clearly indicates that it is no longer possible to contain spread and the approach must move to the delay phase, is no longer the best use of those resources which must now be reallocated to testing.

125 Testing resources were directed towards hospital patients because patients in hospital were already sick. If patients also acquire Covid-19, it increased the clinical risk to them. Additionally, if patients who were admitted have Covid-19, it was important to know that and therefore necessary to test and isolate them from other patients to prevent spread to other patients and to staff.

126 On 15 March 2020 the Scottish Government announced, as part of its 'delay' phase, that indoor and outdoor mass event of 500 people or more should be cancelled. It also announced that schools, cafes, pubs and restaurants would close. These decisions were implemented to limit the number of people gathering in any one place to slow down the transmission of the virus. The basis for these decisions was the clinical data and advice which advised that containment was no longer possible and informed moving into the 'delay' phase to limit the opportunities for the virus to spread.

127 The Scottish Government had committed to the Four Nations plan and had agreed on a four nations basis that the best way to deal with the virus was to collaborate and cooperate as much as possible. Imposing restrictions on people's movement, opportunity for employment and education, needs to as far possible to apply across the four nations.

128 The Scottish Government considered a range of options available to it before the adoption of the first national lockdown. We made judgements based on the data, advice, commitment to the Four Nations plan and an understanding that many of the options required financial resource over which the Scottish Government did not have complete control. These were all significant considerations in the period leading to the first national lockdown.

Super-spreader events

129 The risk around particular events were discussed, primarily in SGoRR meetings. This included the Cheltenham Festival 10-13 March 2020, and Six Nations Rugby including Scotland v France 8 March 2020. Advice was provided by the Covid-19 Advisory Group (SGCAG) and Health Protection Scotland (HPS). The CMO also provided advice following discussion between the four UK CMOs.

130 The Scottish Government's strategy to control the spread of Covid-19 at and after these events was outlined in the four nations plan published on 3 March 2020 and the phases outlined. The initial phase involved containing the spread of the virus, which while effective to a degree, was not sufficient to prevent wider transmission.

131 I am not aware of the Scottish Government taking account of the cancellation by the Italian government of the women's international rugby match between Italy and Scotland which was due to take place on 23 February 2020, however there was a brief discussion at COBR on 27 February and as a result I asked for consideration to be given to what events were due to take place in Scotland over the coming months with international participation. I am not aware of the Scottish Government taking account of the men's international rugby match which went ahead on 22 February 2020 in Rome, however I am aware that the CMO spoke to the Scottish Rugby Union chief medical officer on 24 February to discuss arrangements for those returning from Italy.

132 There was no knowledge by the Scottish Government of a Covid-19 outbreak at the point the Nike Conference was underway. Health Protection Scotland (HPS) was alerted on 2 March 2020 that an individual overseas who had been at the conference had tested positive and on 3 March 2020. HPS recorded a positive case in Scotland of an individual who had been at the conference. That case and details of the outbreak was confirmed to Ministers on 3 March 2020 and were included in a news release issued on 4 March 2020 and in the normal case reporting schedule. The case reported on 3 March 2020 would trigger the tried and well tested Incident Management repose

by HPS which involves tracing of contacts and in this instance, liaison with relevant agencies elsewhere in the UK and overseas.

133 Investigation confirmed a total of 25 cases both within and outwith the UK were linked to the Conference and of these, 8 were resident in Scotland. All were contact traced and reported in details of the number of cases in Scotland at that time. The IMT approach was effective in controlling the outward spread of these conference linked cases in Scotland, as was confirmed by the subsequent Public Health Scotland investigation using genomic sequencing.

134 Consideration was given by me and the First Minister on the wider publication of the link with the Nike Conference, but the advice received was that given the low numbers of cases in Scotland at that time, patient confidentiality was a critical factor. To have named the event would almost certainly have identified the patients and the duty of clinicians where possible to uphold patient confidentiality should be remembered in this context.

135 With respect to rugby matches, SAGE advice at the time was that outdoor events presented a lower risk of virus transmission compared to indoor events particularly those where attendees knew each other. On 3 March, specific advice recommending that the 6 Nations Rugby Match - Scotland V France should not be cancelled was provided to the FM and myself by the CMO. This was based on Health Protection Scotland (HPS) advice that on Public Health grounds there was no scientific recommendation to postpone the event.

D. Testing

136 My involvement in the testing and tracing strategy was to receive clinical and expert advice on the approach that should be taken in relation to this strategy, to understand how to operationalise the strategy, authorise any resourcing that was required and monitor its operationalisation taking any decisions necessary to resolve resource or other challenges.

137 At the outset of the Covid-19 pandemic, it was widely believed that transmission was not possible between individuals who were not experiencing symptoms. Therefore, at that point this directed our approach to testing.

138 Roughly around the middle of March 2020, the Chief Medical Officer notified the Scottish Government about asymptomatic transmission. I was also aware of WHO advice on testing from my advisors and the extent to which this advice would apply to

the UK. As we increasingly understood the nature of the virus and how it operated, and therefore that asymptomatic transmission was occurring, this carried implications for the importance of testing and of contact tracing in the management of the pandemic.

139 As it became clear that asymptomatic transmission was occurring, we sought to increase our testing capacity as part of the overall UK response in order to meet additional testing demand.

140 Between January and February 2020, testing capacity of NHS Scotland was at a size designed to meet normal everyday diagnostic testing requirements for NHS Scotland. It was not designed to meet the testing requirements of pandemic. This is why significant effort was made in Scotland and as part of the UK to increase the testing capacity of the National Health Service to deliver and process tests.

141 It was not possible to implement a mass testing programme before February 2020 given the level of testing capacity of NHS Scotland and the advice at that point which suggested that asymptomatic transmission was not possible. It was only as we understood the nature of the virus and asymptomatic transmission that we understood the dedicated level of resource required to be able to deliver a mass testing programme as part of the UK's response to the Covid-19 pandemic.

142 Scotland has for a long time had a surveillance programme, which is in part delivered through General Practice and overseen by what is now Public Health Scotland. This surveillance operation was increased during the Covid-19 pandemic and contact tracing formed an early part of our response in the contain phase of the Four Nation plan. On 10 February 2020, two labs opened in Scotland to ensure more rapid turnaround of testing in Edinburgh (100 tests a day) and Glasgow (250 tests a day). This strategy was about identifying where cases were appearing, tracing the contact that these individuals had, and then to test whether these contacts had Covid-19. Surveillance was also undertaken to understand where cases of the Covid-19 virus was appearing across the geography of Scotland. This developed significantly through the use of genomic testing.

143 The purpose of lockdown restrictions was to severely restrict opportunities for the virus to transmit and mutate new streams. As the virus transmitted, it had the opportunity to alter itself in order to be more infectious. The purpose then of lockdown was to limit the opportunity for virus transmission in a severe way in order to limit the opportunity for mutation and be cope with the numbers of people becoming seriously ill and requiring intensive care in hospital treatment as modelling had originally suggested.

144 As we moved to a position in the pandemic when case numbers indicated it was possible to begin to ease some of these restrictions, that is when the Test and Protect scheme was needed in order to identify, pinpoint and contain the virus and its spread as best as we could.

145 The four nations of the UK were at official and ministerial level discussing the implementation of this strategy. In Scotland this scheme was called Test and Protect and in England it was called Test and Trace. Essentially, these schemes were introduced in order to continue to control the virus as restrictions on people's movement were removed. However, the most sensible way to implement this was to develop each scheme to suit the particular geography and requirements of each of the four nations. This accounts for the differences across the four nations. For example, the scheme in Northern Ireland needed to take account of movement to and from the Republic of Ireland.

146 It is my understanding that the Test and Protect system and contact tracing as part of this, was fully operational nationwide by the end of May 2020. Details of the chronology of the development of the system are included in the corporate statement supplied by DG Health and Social Care in June 2023, including the agreed interaction with the UK-wide laboratory testing programme as well as the development of Scotland's Test and Protect infrastructure.

147 I think Scotland's contact tracing operation worked very well during the Covid-19 pandemic, thanks in large part to Public Health Scotland officials. I also think there was good cooperation with local authorities and local authority officials within Scotland. Our capacity to process tests through the Lighthouse Lab in Glasgow, which was part of the UK's Lighthouse network, worked well overall and the Glasgow Lab was the most efficient of the Lighthouse laboratories. It worked exceptionally well to set up and deliver the testing operation at scale within a very short period of time.

148 Initially the Scottish Government's target was to test 3,500 samples a day across NHS labs by the end of April. However, on 30 April 2020, this target had been exceeded and laboratory capacity to process tests in Scotland had increased to 8,350 samples per day. Subsequently, Scotland's Testing Strategy had a target of building laboratory processing capacity to approximately 65,000 tests per day between NHS Scotland laboratories and Lighthouse Lab in Glasgow, ahead of winter 2020. These targets were published on the Scottish Government website. I am not aware of any interference in broader processes as a result of resources being diverted for this purpose.

149 The importance of testing and contact tracing was understood early in the course of the pandemic. The Directorate for Test and Protect was established on 6 April 2020 to lead on testing capacity across Scotland to support a Test, Track, Isolate approach to managing Covid-19. In terms of resourcing, Test and Protect utilised parts of the UK's four nations testing programme, in which devolved nations received a share of services.

150 One of the issues to consider as we look towards future pandemics, is to what degree we retain an increased baseline capacity for testing in Scotland, beyond that which might be required for everyday NHS diagnostic testing in Scotland. Another issue to consider is to what extent Scotland has backup plans to increase its testing capacity with pace.

151 On 14 September 2020 when the First Minister said there were "very serious concerns" about Covid testing backlogs, I believe she was referring to the time during the pandemic when the Glasgow Lighthouse Lab was processing tests primarily from the rest of the UK. As a consequence, tests taken in Scotland were being processed at a much slower rate with results provided back to individuals at a slower rate. This was producing very serious concerns in Scotland in relation to tests submitted for processing from care homes and because individuals were waiting for a long period of time to receive their test results, that had an impact on both of them, their families and their employment. It also posed a risk to the continuing high levels of compliance. At this time, the Scottish Government was asking individuals who tested positive for Covid-19 to isolate at home, not go to work and not have any contact with their families. Therefore, significant waiting times for individuals produced significant difficulties them and risked that they would not be able to follow Scottish Government advice that was being given to them. These were issues of concern. My recollection is that these issues were resolved with the UK government and there was agreement about proportionality of processing tests in terms of the Glasgow Lighthouse Lab being able to process tests that came from citizens in Scotland.

E. <u>Decisions in relation to non-pharmaceutical interventions ("NPIs")</u>

Overview and General questions about NPIs

152 There was considerable understanding within the Scottish Government of the potential wider health, social and economic impact of NPIs, which widened and deepened as the pandemic progressed. From my perspective, in terms of health, I understood the

risks that we were trying to manage between the impact of Covid-19 on citizens, particularly those identified as highly vulnerable to this particular virus, with the necessary reduction in standard NHS care that would be required in order to cope with the demands of the Covid-19 pandemic. For example, we had paused cancer screening programmes and knew as we were doing this, that we were incurring a significant risk of cancer being undetected for some time, all the while knowing that the earlier that cancer can be detected the greater the individuals' chances of full remission and recovery. The situation we were dealing with on a daily basis required making judgements and balancing the risk of harm when no single decision was risk free.

153 I was clearly aware of the social impact of vulnerable individuals being isolated in their own homes as a consequence of lockdown and missing out on social interaction. I was also aware of the potential impact that this would have on their mental health as well as an awareness of the economic cost of asking businesses and employees to pause their businesses.

154 The Scottish Government thought considering how long the public would be willing to comply with the restrictions on their movement and behaviours was important. Our decisions were informed by seeking advice from behavioural science, in particular Professor Stephen Reicher of St Andrews University. We were also informed by the Scottish Government's strong view from the outset that there was an obligation as a government to inform the public and provide it with information about the virus and the number of cases and other necessary information. We wanted to explain the rationale for our decisions and believed on that basis we would have the best opportunity to secure the necessary trust from the wider public to comply with the restrictions that were being imposed.

155 Our clinical advisors identified cohorts of the public that were most clinically at risk from Covid-19 these were identified as the elderly, people with underlying health conditions and people who in terms of their health were compromised or immunosuppressed. We took account of these groups in particular as we were looking to make decisions.

156 Information and knowledge about long Covid-19 emerged later in the pandemic. It became clear through 2020, that for some people, even upon recovering from the immediate Covid-19 infection, they were left with other related health issues, for a short or long period of time. I was not aware of any knowledge or information about long Covid-19 in advance of this.

157 Asymptomatic transmission was also not expected in the early stages of the pandemic by our clinical advisors. However, once it became clear that asymptomatic transmission was a feature of this particular virus, we considered this when making decisions about NPIs.

158 In terms of Covid-19 being an airborne virus, the clinical understanding about this in large part was behind in the very early stages of the pandemic. However, once the airborne nature of the virus became apparent our advice in relation to respiratory and hand hygiene to counter this was consistent all the way through the pandemic.

159 Between March 2020 and May 2020, my understanding of the seriousness of the threat of Covid-19 did not diminish. I understood very clearly that the virus was a serious threat to public health and that it was a public health emergency. I did not think this threat was going away in the foreseeable future. The real question for me was around the degree of the threat this posed to the Scottish public and our growing capacity to contain and manage the virus.

160 The purpose of lockdown restrictions between March 2020 and May 2020 was to significantly reduce the spread of the virus from one individual to another by restricting individual human interaction in all its forms. The Scottish Government understood that this did not mean the case numbers would not be high. However, we understood that this meant not seeing significant increases in what were already large case numbers. The 'hammer and the dance' concept, which is essentially to impose a wide range of severe restrictions followed when judged appropriate by restrictions which vary in type and duration according to the prevalence of the virus within population cohorts or geography was an approach taken based on case data, clinical advice on the nature of the virus, its variants and transmission rates. It should be understood that the data and advice were updated over time. To the best of my knowledge no advisers suggested an alternative approach, although consideration was always given to the merits of localised versus Scottish wide restrictions and account taken of the likely and known impact of cohorts of the population. I am unaware of any direct contact made between Scottish Government and Mr Pueyo.

161 The Scottish Government's Covid-19 advisory group and our clinical advisors had an extensive network of contacts domestically and internationally. They were updating themselves and each other on how other countries were managing the pandemic. I, along with the First Minister was watching and reading to see what other countries

were doing. We noted that while our approach was comparable to other countries in many ways, there were also significant differences. For example, New Zealand was able to impose a complete lockdown of its borders, which was not an action that was available for Scotland to follow.

162 With regard to NPIs, decisions needed to be taken regularly about when to ease or tighten measures, about how much measures should be eased or tightened, and about which measures should be eased or introduced or changed or removed. These decisions required assessments to be made of the current and near-term state of the pandemic (and hence how much of a change in measures was warranted given the need to suppress the virus) and of the effects of changing different measures, alongside consideration of the potential interaction of measures.

163 In addition to considering the impacts of NPIs on the four harms, other factors also needed to be taken into account such as the need to ensure that the decisions on NPIs were lawful. To ensure that the approach remained lawful, regular formal assessments were made – for example, at least every three weeks – on the necessity and proportionality of all the legal measures. This included both existing legal measures and potential changes in measures. The test applied was whether a measure was "necessary to prevent, protect against, control or provide a public health response to the incidence or spread of infection in Scotland with coronavirus".

164 The process for the First Minister making a decision under a specific delegation from Scottish Cabinet first involved a discussion within Cabinet relating to a specific matter. At this point members of Scottish Cabinet could express a view and would have been consulted. If there was more information required for a decision to be made on that matter, but there was a time constraint on making this decision, there would be a specific delegation to the First Minister to make that decision. Therefore, she would make the decision on the basis of the information Scottish Cabinet already had on top of the additional information being provided. From my experience, it was not common for the First Minister to make decisions under specific delegation from cabinet in a non-pandemic or a pandemic situation.

165 The existence, risk, and consequences of long Covid were brought to my attention by both and my clinical advisors and the charity Chest, Heart & Stroke Scotland, who were undertaking some work on this with individuals with long Covid who had been in touch with them. This particular charity was undertaking the work because it dealt

with both respiratory and heart conditions, and these were the areas in which the long-term impacts of people who had suffered from Covid-19 were appearing.

166 During my time as Cabinet Secretary for Health and Social Care, there were early discussions and a growing awareness of Long Covid, but it was not clear from our clinical advisors at that time, the extent to which Long Covid was a risk for particular individuals and whether it required any alterations to the NPIs at our disposal. It was clear to me that we required to quantify Long Covid and how particular healthcare and psychological support could be offered to the individuals affected. I had asked for that work to be underway before I left office in May 2021.

167 The rationale for NPIs imposed on religious worship, as with marriages and other social gatherings was that the virus transmitted easily between people, and we wanted to the restrict the number of people in any gathering while respecting the individual's right to practice their religious beliefs. Also, as we knew that the virus was airborne, singing was also considered a risk, this was an additional restriction. We received advice from clinical advisors, but we were also in direct contact with representatives from specific interest groups, including faith groups.

NHS capacity

168 Early modelling, which underpinned the four nations plan, indicated the potential of Covid-19 to affect large numbers of the population, of which a significant percentage would require acute hospital care. It also indicated that a significant percentage of that number would require intensive care. From the modelling of the reasonable worst-case scenario, we knew that we had to plan on the basis of the worst case. The NHS in Scotland could not continue to operate all the other healthcare services it did and deal with the numbers that would potentially place demands on it as a consequence of Covid-19. Ensuring the NHS in Scotland was not overwhelmed underpinned our decision making.

169 I believe key decisions made by the Scottish Government were effective in protecting the NHS from being overwhelmed during the pandemic. The first decision was to put the NHS in Scotland on an emergency footing under the relevant legislation, which meant that all of our NHS boards would follow the same set of actions. The second decision was to work through and identify which areas of healthcare could be paused, and we retained only cancer and emergency care. This allowed us to redeploy staff in the health service inside our acute settings to the area of acute care

that Covid-19 would demand. Next, we established a Covid community pathway for primary care, which would allow GP Practices to be Covid-free and continue to provide primary care to their patients. We also asked retired healthcare practitioners to return to work to supplement the workforce alongside the agreement of the relevant royal colleges and higher institutions to bring final year medical and nursing students into the NHS workforce in a way that did not compromise them being able to complete their degrees. We also made decisions around ordering volume of PPE and the increase in its distribution routes to not only cover acute settings, but also community, primary and social care. Decisions were made, as noted, to resource growing capacity to process tests and to implement the Test and Protect programme and provide direct health support to residential care settings. Finally, we also made decisions relating to the operationalisation of the vaccine programme.

170 The rationale for constructing NHS Louisa Jordan was to provide additional NHS capacity. NHS Louisa Jordan was not ultimately needed to treat patients with Covid-19, as the other measures were both adequate and effective. As a result, we were able to make use of this additional facility to undertake some of the 'paused' healthcare, providing day procedures and operations to reduce the numbers of people necessarily waiting for that care.

171 We committed to quadruple the number of ICU beds in Scotland and we did that by securing additional ventilators and by retraining NHS theatre staff to be able to staff ICU beds so that we had both the kit and the workforce to provide the level of intensive care needed. I believe that was effective. We did quadruple the number of staffed ICU beds in Scotland and were therefore able to meet the demand.

172 In terms of PPE, we had the advantage of a single procurement arm called National Services Scotland that has a long-standing relationship with the providers and manufacturers of PPE. So, at the very outset and despite very high global demand and associated pricing, we were able to increase the volume of PPE on order. In addition, the stocks of PPE had to increase because we were now supplying it to areas of health and social care not previously supplied form the public purse. The level of global demand and the increased pricing posed severe challenges to health and social care provision outwith the hospital setting. We took the decision to supply these settings of primary, community and social care directly. We set up new order and distribution routes to enable us to do so and increased our volume demand from suppliers. We also secured the necessary equipment to allow two companies in Scotland to produce items of PPE and therefore have a domestic supply chain.

173 The new order and distribution routes of PPE inevitably experienced challenges. I wanted to ensure that we were quickly alerted to any problems and acted to resolve these. So, we set up and widely advertised a direct help line for any NHS or social care staff to call in relation to any issues with PPE. This helpline was staffed seven days a week and had a dedicated minister to pick up issues. We set up this helpline to hear about these problems and resolve them as quickly as we could, ensuring that there was sufficient stock of PPE, and where there were issues, we took steps to try and address these. I personally received a daily sit rep on levels of PPE held in stock and on order and could directly question any areas of concern and take steps to address these.

174 "Protect the NHS" was a central part of the Scottish Government's public messaging from the outset of the pandemic, particularly around lockdown restrictions. The rationale was straightforward. Given the expected number of Covid cases which would require hospital care and that NHS staff were themselves not immune from contracting the virus, we needed everyone to work with us to ensure our NHS could cope with the demand it would face.

Schools

175 Responsibility for the decision to close schools lay outside my portfolio as Cabinet Secretary for Health and Sport. I would refer you to the Deputy First Minister for further detail on this. My understanding is that he was guided by the views of clinical advisers and the Covid-19 Education Recovery Group. I am not aware of any specific data that identifies any particular measure as being more effective than another.

Vulnerable and at risk groups

176 For the purposes of assessing and weighing whether NPIs should be implemented, relaxed, altered or lifted, the Scottish Government identified that it required to consider older people, people with health vulnerabilities, people with underlying health conditions, clinical vulnerabilities, people with disabilities, individuals from ethnic minority communities, people who were homeless and people of different faith groups. All of these groups were considered in implementation of NPIs, how support would be offered and in the decision around which NPIs to impose, within the overall context of the level of Covid risk to public health and what was practically possible at any given point.

177 Our understanding of vulnerable and at risk groups deepened during the course of the pandemic and new criteria based on emerging evidence, data and clinical consensus resulted in additions to the Shielding List. For example, on 30 October 2020, people

with Down's Syndrome were added to Group 4 of the Shielding List, and Chronic Kidney Disease Stage 5 (CKD5) was added to Group 5. We particularly became aware of the growing identification of the clinical impact of Covid-19 on people of different ethnic backgrounds. Through the work of other Ministers and their engagement with key stakeholders we also took additional measures that might be needed to support individuals who were particularly vulnerable in the community, including those who were rough sleeping, those who were seeking asylum, or for whom English was not their first language.

178 The advice we received in relation to the impact of NPIs on vulnerable and at risk groups was a combination of clinical advice and advice from elsewhere within the Scottish Government with responsibilities relating to particular response, for example, homelessness, asylum seekers or community cohesion. The Scottish Government worked with organisations and groups representing people with particular vulnerabilities or experiencing inequalities. My understanding was that there was a good understanding of the challenges of those groups and individuals. This understanding was available and fed into decisions taken by Scottish Cabinet relating to NPIs.

179 For my responsibilities as Cabinet Secretary for Health, I received specific advice from my clinical advisers on the impact of NPIs on clinically vulnerable groups and my contact with stakeholder groups representing the disabled provided another source of information and advice to me. I understand that other portfolios of Scottish Government may have commissioned some further assessments, which would have informed what the relevant Cabinet Secretary contributed during Scottish Cabinet discussions.

180 I believe the First Minister and other core decision makers in the Scottish Government gave serious consideration in decision making throughout the pandemic to the impact of NPIs on at risk and other vulnerable groups in light of existing inequalities and tried to mitigate their impacts as far as it was able to.

181 In relation to the comment from Age Scotland that social care was a secondary concern for the Scottish Government when compared to the NHS, I do not agree with the overall gist of the comment. In my view it fails to recognise that, for example, leadership in terms of social care does not rest exclusively with the Scottish Government, but also with individual local authorities under the provision of social care. Additionally, residential social care is primarily delivered by private entities. There was a very strong liaison between me, COSLA, Scottish Care and the relevant trade unions for social

care, including in home social care and adult social care that sought to resolve issues relating to PPE and support of adult social care staff.

182 We recognised the impact of temporary closure of adult social care facilities and the impact that might have on the individuals concerned in terms of isolation and mental health and tried where we could find additional ways to support them. We also recognised that there were serious impacts for elderly people who received adult social care, both in a residential and a home setting and provided additional financial support to both local authorities and the residential care setting to help with this, in addition to the specific PPE support noted However, I do not accept that I was unaware of these problems or did not take action where I could to resolve them.

183 In relation to the comment from Save the Children Fund UK in relation to whether more could have been done to ensure the rights and needs of children and young people were prioritised during the pandemic, I believe this fell outside my responsibilities as Cabinet Secretary for Health and Social Care. However, children and young people who were clinically vulnerable were clearly identified at the outset of the pandemic and specific measures were put in place to support them and provide direct advice to them and their families. My understanding is that other measures and steps were taken within Scottish Government with respect to nursery education and care, particularly for those young people and children with vulnerabilities.

184 In relation to the comment from Scottish Women's Aid that the Scottish Government failed to understand, recognise and take account of the disproportionate effect of the pandemic and lockdown on women and children, particularly those experiencing domestic abuse, I believe this fell outside my specific responsibilities as Cabinet Secretary for Health and Social Care and I am not the appropriate person to comment on this.

185 I am disappointed by the comment from Inclusion Scotland that the Scottish Government did not adequately consider disabled people when decisions about the response to Covid-19 were made by the Scottish Government. I am not aware of any specific issues Inclusion Scotland raised with me in this respect during the course of the pandemic where they thought the Scottish Government could improve the actions being taken, or mitigating the impacts as they arose. Having held positions previously to support disabled people, I was very conscious of that group as Cabinet Secretary for Health and Social Care. Within the specific remit of my responsibilities, I believe we acted where we could take account of the health and social care needs of this group.

186 I am sorry to hear the comment from Clinically Vulnerable Families that the Scottish Government did not engage with clinically vulnerable people at various times and failed to consider strategies to protect clinically vulnerable people and that they were let down in the way that they described. From a very early stage in our response, individuals who were clinically vulnerable to the virus were identified and through the work of the four Chief Medical Officers a comprehensive list of conditions and diseases was regularly updated and improved upon. These formed the basis of very specific advice and support that was put in place for clinically vulnerable people. I do understand that as restrictions were eased, individuals in this category may have felt particularly vulnerable.

Vulnerabilities relating to pre-existing health conditions

187 The definition of clinically extremely vulnerable (CEV) was decided in unison by the four nations CMOs at the beginning of the pandemic. An Identifying Clinically Extremely Vulnerable Group was established early in the pandemic to liaise with the CMO's office on the definition of groups at highest risk of severe illness or death from Covid-19 on an ongoing basis as new evidence emerged. This included the identification of people to be added to the Shielding List through coding and data searching and liaising with PHS, issuing of letters to people shielding via liaison with NSS, communications with Health boards, GP Practices and secondary care clinicians. Our development of NPIs relating to the medically vulnerable and its shielding strategy during the course of the pandemic was to provide those individuals with particular advice, guidance and social support. In May 2020, Clinical Leads Advisory Group (CLAGS) was set up by the Scottish Government. This Group was created on the request of Dr John Harden, Deputy National Clinical Director (DCND), who took on the role as the Clinical Lead for Shielding in May 2020, in order to support his advice to the CMO and policy officials. This was a group of specialist clinicians with expertise in the conditions covered by the shielding categories. CLAGs provided advice, information, data, proposals and outline approaches to the DNCD for Scotland but was not itself a decision-making body. Dr Harden chaired the Group.

Additionally, our discussions with supermarkets about home deliveries and our engagement with local community groups to particularly support those individuals who were shielding. The Scottish Government's strategy was focused on maximising the protections put in place for these individuals.

Decisions relating to the first lockdown

188 A national lockdown was adopted by the Scottish Government as a strategy for responding to the pandemic in March 2020. The Scottish Government was aware of the data in terms of rising case numbers, and it became apparent that the spread of the virus could no longer be contained, and it needed to move towards adopting a strategy to delay the spread of the virus. This was the primary reason for the Scottish Government adopting a national lockdown as a strategy for responding to the rising case numbers as a result of the pandemic. I supported the decision to impose a national lockdown as I believed it was the necessary next step in responding to the pandemic. Economic factors were considered before adopting a national lockdown, but my primary responsibility was in relation to public health, and I believe a national lockdown was necessary for the protection of public health.

189 While I understand the argument for adopting a national lockdown prior to March 2020, this measure was not available to the Scottish Government. There were important financial considerations, for example, financial support for business and employees to allow them to cope as a consequence of lockdown restrictions. The financial support which would enable the Scottish Government to support these businesses and employees was largely at the hands of the UK Government. At this stage a four nations approach was required to enable the UK government to prepare to release the financial support to enable the Scottish Government to implement a national lockdown. Once agreed, I believe the implementation took place as quickly as possible.

190 I don't believe a national lockdown could have been avoided if earlier interventions had been adopted. Interventions which had been adopted in other countries to contain the spread of the virus, were not available to the Scottish Government. For example, the Scottish Government could not close its borders as New Zealand had done in early 2020.

191 Before the Scottish Government adopted the strategy to impose a national lockdown, there was wide ranging discussion as to the options available with regards to dealing with the rising case numbers as a result of the pandemic. The Scottish Government understood the seriousness of adopting a national lockdown and the impact this would have on individuals in Scotland. The nature of our scientific understanding of the virus, its transmission and mutation had deepened by this point.

192 The Scottish Government considered protection of the most medically vulnerable but did not believe it was possible, practicable or reasonable to single out a specific population while the rest of the public experienced no restrictions. We were aware of

the psychological impact of identifying and isolating a group of people in this manner, which was a factor in our decision not to adopt strategies which only targeted the protection of the most medically vulnerable.

193 The Scottish Government's exit strategy at the time of the imposition of the first lockdown was informed and measured by the available data, scientific and clinical advice and the Scottish Government's judgement on the public appetite for compliance. This would allow the Scottish Government to ease some restrictions in order to test how this would impact case numbers. If cases did not rise exponentially, this would allow the removal of a further set of restrictions. The approach was incremental and measured with reference to existing lockdown restrictions.

194 The resignation of Catherine Calderwood as Chief Medical Officer for Scotland was a loss in terms of the level of understanding and knowledge available to the Scottish Government. The former First Minister and I had been working closely with Catherine Calderwood prior to the pandemic and up until April 2020. However, the Scottish Government was in a fortunate position in that the office of the Chief Medical Officer had a Depute who had been involved in discussions and SAGE meetings up until April 2020. There were also other advisers from Public Health Scotland, our National Clinical Director, Chief Nursing Officer and Chief Pharmacist and academic advisers whom the Scottish Government closely consulted with during this period.

195 Between January 2020 and September 2020, there were emerging bodies of scientific work which pointed to effective treatments for Covid-19 including existing anti-viral treatments developed for other infections. From the Scottish Government's perspective, this work seemed promising.

196 In terms of the development of a vaccine, the Scottish Government was aware of the significant work ongoing to develop a vaccine. I understand that officials had discussions in 2020 with both Pfizer and AstraZeneca, who were both in the process of developing a vaccine. The Scottish Government discussed with both companies their position in the development process, and whether quantities they were looking to produce would be sufficient. I recall that there were also discussions within the Four Nations Health Ministers on this topic. However, the Chief Pharmacist and her deputy were not involved in any UK vaccine groups, except to the Medicines and Healthcare products Regulatory Agency deployment meetings (from November 2020). It was clear at that time however, that no vaccine was expected in the near future, and physical containment remained the priority. In line with best advice from the Chief Medical

Officer and experts in epidemiology, a phased response had been put in place, ranging from 'Contain' and 'Research', through 'Delay', and finally to 'Mitigate'. Research was ongoing, but the current phase of the response lay mostly in Containment, but with elements of Delay. The evolution in the number of cases and the results of community surveillance would, over time, give a better picture of the prevalence of the virus in the community and of how it might be expected to spread.

Continuation of the first lockdown

197 The Scottish Government considered "Zero COVID," the required restrictions and surveillance measures to be a serious and proportionate option. However, it was determined that a "Zero COVID" strategy in Scotland would have been unlikely to be sustainable because of essential travel to and from Scotland, particularly across the land border with England.

198 After reviewing the lockdown with all nations in the UK, the decision was made by Scottish Cabinet on 14 April 2020 to extend lockdown for another three weeks until 7 May 2020 and this was announced in line with the regular schedule of lockdown reviews on 16 April 2020. The decision was based on the advice from our clinical and scientific advisers.

199 On 5 May 2020, Scottish Cabinet made the decision to extend lockdown restrictions in Scotland for a further three weeks, with the indication that they could be changed if there was evidence it was safe to do so, and this was announced in line with the regular schedule of lockdown reviews on 7 May 2020.

200 On 10 May 2020, the decision was made by Scottish Cabinet at the beginning of the seventh week of lockdown to continue with lockdown restrictions. These decisions were made based on the scientific and clinical advice provided to the Scottish Government and this was announced on 11 May 2020.

201 On 23 April 2020, the Scottish Government published details of its strategy for ending lockdown called "Covid-19: A Framework for Decision Making"[JF2/018 - INQ000131025]. The Scottish Government's intent from the outset of the pandemic was to provide the Scottish public with as much information as possible relating to the rationale for its decision making, especially considering the significant impact these decisions would have on their lives. We wanted the process to be as transparent and as open as possible. The Framework itself sets out the rationale for the phased approach, drawing on the WHO's six criteria for easing lockdown restrictions and

explaining the significance of key indicators such as the R number (the average number of people that each infected person passes the virus on to).

202 The Scottish Government's strategic aim was to minimise the overall harm of the pandemic. The harms caused by the pandemic did not just reflect the direct harm caused by Covid infections, but also the other health harms caused, for example, by reduction in NHS capacity or in people seeking medical help, or the mental health impacts of NPI restrictions or the pandemic itself as well as the wider negative impacts on the economy and society. The Framework for Decision Making marshalled the many and various harms of the pandemic into four categories:

Harm 1: direct Covid-19 harm

Harm 2: other health harm caused by the pandemic

Harm 3: societal harm

Harm 4: economic harm

203 Categorising the harms in this way supported structured analysis and decision making. It was based on advice from officials and experts around what the key elements of harm from the pandemic and resulting measures in place could be, based on their expertise and experience of conditions in Scotland. Inequality was not considered as a separate harm, since elements of inequality were relevant to and contributed to each of the four harms in different ways for different groups. These elements were considered as part of the process of four harms analysis which was supplied by the lead officials and advisers engaged in work in each of these areas and routinely presented to Cabinet and to ministers in the course of their decision- making. Over the course of the pandemic, decision-making was also supported by various types of formal impact assessment including Equality & Fairer Scotland (EqFSIA); Children's Rights and Wellbeing (CRWIA), Business Regulatory (BRIA);
and Island impact assessments. The Scottish Government published impact assessments at various stages of the pandemic which provide insights into the relevant considerations for decision-making.

204 On 28 April 2020, the Scottish Government recommended that people cover their faces in some public places such as shops and public transport. This recommendation was based on clinical and medical advice from the Chief Medical Officer for Scotland, the National Clinical Director and Public Health Scotland. This recommendation was based on a rationale that as people moved around more, they should practise hand and

respiratory hygiene and be protective to prevent spread as the virus was air borne in nature. Face coverings were put in place to help with this. The Scottish public was advised to follow these recommendations and encouraged to do so in a number of ways, including but not limited to the First Minister's daily briefing.

Effectiveness of the First Lockdown

205 The effectiveness of the first lockdown was assessed at the time based on the data indicating a reduction in the R number to significantly below one, which implied that the growth in the prevalence of the virus would slow and ultimately decline: the lockdown therefore appeared to have been effective in controlling the spread of Covid-19. This also implied a significant reduction in the direct harm from Covid infections – including serious illness and death - which would otherwise have resulted.

206 In my role as Cabinet Secretary for Health and Sport I am not aware of any formal analysis on what the consequences would have been had decisions been made earlier or at different times. I am not aware of specific assessments relating to the consequences of the first lockdown beyond the consequences for health matters, on at risk groups, although I am aware that the Scottish Government commissioned and received insight from a number of expert and stakeholder groups, for example the Scottish Youth Parliament and the Expert Reference Group (ERG) on Ethnicity and Covid-19.

Conclusions and lessons learned

207 Experience of the first lockdown confirmed to the Scottish Government that its communication with the Scottish public was effective, and the public's response reflected this. The Scottish Government's communication team would poll members of the public to capture their understanding of Covid-19 rules and guidance, compliance, and understanding of the rationale for decisions made by the Scottish Government. Communications by the Scottish Government to the Scottish public were made through a variety of channels, including the First Minister's daily briefing, print, broadcast, and social media among others.

208 The first lockdown also indicated that as the Scottish Government had come to understand, as the virus transmitted from one individual to another, it was provided with opportunities to develop new strains. We required to quickly understand the development of these new strains in terms of their infectiousness and their impact, particularly on specific or vulnerable groups of the public.

209 The understanding of the Scottish Government's advisors grew and deepened as we went through the first period of the pandemic and the first lockdown. We understood that a number of practical difficulties had arisen particularly for vulnerable and at-risk groups. For example, we became aware that access to food shopping became a practical difficulty. The Scottish Government subsequently agreed with food companies to provide online shopping facilities for essential workers and those individuals that were self-isolating.

210 The Scottish Government was grateful for the level of compliance to the rules, regulations, advice and recommendations to the public. From my recollection, there were very few instances in this period when members of the Scottish public wilfully disregarded Covid-19 rules and regulations.

211 An assessment of how the first lockdown progressed in all of these areas, was undertaken by officials all across Scottish Government. Clinical advisors were part of Scottish Cabinet discussions when it came to decisions relating to easing lockdown restrictions. These discussions would inform future actions and decisions made by the Scottish Government. We had hoped by the end of the first lockdown that it would no longer be necessary to impose severe restrictions on the Scottish public as a whole.

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

212 The decision to ease the first lockdown was guided by the Covid-19 Framework for Decision-making and the Route Map which was first published on 21 May 2020. The timing of the decision and the rate and order in which the various restrictions in place were eased reflected the latest data on the prevalence of the virus in Scotland, clinical advice on the significance of various NPIs based on the current knowledge of the virus and its transmission and also an assessment of the impact of the various NPIs under the Four Harms framework described above. The strategic intent remained to minimise harms under the Four Harms framework, including by suppressing the virus. The state of the pandemic and the appropriateness therefore of relaxing various restrictions was regularly reviewed by Cabinet and decisions made on what would be the best balance of restrictions on the basis of advice supplied in Cabinet papers. The various strategies and NPIs implemented by SG drew on advice given by SAGE, four nations Chief Medical Officers and the SG COVID-19 Advisory Group.

213 Given our responsibility to protect public health as far as possible, I believe that the restrictions which were imposed over this period were the fairest way to manage the virus.

214 The Scottish Government had agreed at the outset of the pandemic that it would make every effort to advise and make decisions on a Four Nations basis. However, each government was also clear that it had a responsibility to ensure it best met the needs of its own population, and this could lead to degrees of divergence.

The steps taken to ease the first lockdown

215 As it became very clear to the Scottish Government that the Covid-19 virus produced new and differing strains, it understood that the pandemic was not going to end in the foreseeable future.

216 On 21 May 2020, the Scottish Government published a route map, laying out the order in which restrictions would be relaxed. These plans were informed by clinical advice provided to the Scottish Government through its advisors. The details of these plans were revised at various points as further evidence emerged of the effectiveness of restrictions on reducing transmission. The Scottish Government wanted to make these plans widely available to the Scottish public, local authorities, and others. This was part of the Scottish Government's approach in ensuring that maximum information was available to the public and decision making was clearly set out. We judged that this clarity was a critical element for maintaining public trust, compliance and our obligations to the Scottish public.

217 When Scotland entered the second phase of its road map to ease lockdown restrictions on 19 June 2020, the Scottish Government replaced its "stay at home" message with "stay safe" messaging. This is because restrictions requiring people to stay at home had been lifted. Greater movement was now possible, and people could come together in greater numbers. However, we wanted them to remain vigilant on physical distancing, use of face coverings and hand and respiratory hygiene. This messaging was designed to minimise transmission of the virus. I believe this was effective, the Scottish public understood the message well, and practised hand and respiratory hygiene as per the messaging. I also believe people were increasingly able to visually identify two metre distancing and were able to adhere to these measures.

218 As Scotland entered phase three of the route map on 10 July 2020, the wearing of face coverings became mandatory in shops in Scotland. This requirement was based on the scientific and clinical advice received by the Scottish Government in terms of the

effectiveness of face coverings in preventing transmission of the virus. The Scottish Government also received WHO evidence to suggest that airborne transmission could not be ruled out in crowded, enclosed or poorly ventilated spaces. If that was confirmed further measures would be required to protect against infection and could signal new risks: compared with droplet transmission, airborne (or aerosol) transmission was characterised by the much longer presence of the virus in the air when an infected person had been in a confined space. That contributed to the decision to make face coverings mandatory.

219 The decision made by the Scottish Government to allow schools to reopen on 11 August 2020, with all pupils expected to be in class full time from 18 August 2020, was based on a judgement which balanced the risk of a high level of children and adults socialising together against the recognised harm and difficulty caused to education and social development of children and young people from not attending school. The balance was in favour of pupils returning to school with mitigation in place as to the social interactions involved with attending school. The SGCAG provided scientific advice and evidence that also underpinned the decision to reopen schools.

220 With respect to the decision taken not to impose stricter travel restrictions on border controls during the summer of 2020, this falls outside of my role as Cabinet Secretary for Health and Social Care. I believe Michael Matheson, who held the position of Cabinet Secretary for Transport at the time, would be in a better position to comment on this.

221 Further social restrictions were not put in place in late summer 2020 as scientific advice provided to the Scottish Government at the time suggested that the virus was less transmissible in the summer as people were more likely to be out in the open air and less likely to be in confined or closed spaces.

222 The response to local outbreaks was directed by Public Health Scotland. This included the call centre outbreak identified at the Sitel site in Motherwell in July 2020, the Aberdeen outbreak in August 2020 and the management of a rise in cases in Glasgow in September 2020.

223 Public Health Scotland was the lead agency responsible for incident management during the Covid-19 pandemic. It was directly involved with Scottish Government Health Directorate, which was responsible for providing clinical advice to the Scottish Government. During the Covid-19 pandemic, Public Health Scotland used a modified extension of existing incident management structures, including contact tracing which

had been used for a number of different infectious outbreaks prior to the Covid-19 outbreak.

Eat Out to Help Out

224 I was not involved with the Eat Out to Help Out scheme in any way. I was not involved in any discussions with the then Prime Minister or the then Chancellor, about the Eat Out to Help Out scheme prior to its implementation in August 2020. I am not aware of any support within the Scottish Government for the Eat Out to Help Out scheme. I am not aware of how funding for the scheme was provided for Scotland. I did not represent any views on the proposed scheme in advance of its introduction and I am not aware of any representations made by the Scottish Government to that effect. I do not have any knowledge of whether the Scottish Government had an option not to introduce the scheme in Scotland. I am not aware of whether the Treasury had sought or received scientific advice in respect of its Eat Out to Help Out scheme prior to its implementation.

225 I recall receiving advice from clinical and scientific advisors to the Scottish Government that they were not convinced this scheme could be implemented without considerable risk of increasing transmissions of the virus. I do not recall any advice or suggestion at the time that Scotland was Covid-free or virtually Covid-free. I also believe there may have been representations from business interests to the Scottish Government which advised the scheme was a good idea.

Conclusions and Lessons learned

226 DG HSC undertook an initial lesson learned exercise about pandemic response from March to September 2020, which was published on 6 August 2021, after I left office. I understand this identified ten key themes from consultation across the health and social care landscape in the following areas: diagnosis and contact tracking, modelling of need, demand and consequences relating to Covid-19, establishing of extra physical capacity, supply chain issues, the value in a 'digital front door' for healthcare, programme and project management, workforce augmentation, governance, compliance and risk management, public engagement and education and new models of care in the post pandemic context. It also sets out the systems in place to address these topics. I am not aware of any analysis of how different or earlier decisions might have affected the course of the pandemic.

227 Public Health Scotland (PHS) published a report in January 2021 on the experience of those shielding, showing results from a survey conducted between December 2020 and January 2021, which explored areas such as: the impact of services and support

provided by the Scottish Government's Shielding/Highest Risk Division, thoughts on vaccination, and how pausing shielding in Scotland has impacted different aspects of life. The assessment of economic and social impacts of the lockdown would not have fallen within my portfolio as Cabinet Secretary for Health and Sport. I have no further reflections to add on lessons learned from the experience of this period.

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

228 The rationale behind the various strategies and NPIs which were implemented by the Scottish Government between 7 September 2020 and the end of 2020 was informed by the clinical advice it received. With the assistance of data and scientific advice the rationale was aimed at minimising the level of restrictions on the Scottish population as a whole while containing outbreaks as they arose, in particular within geographic areas. We considered that this approach provided the best possible balance between trying to suppress case numbers, while allowing people across Scotland the maximum degree of freedom of movement that we judged to be safe. This degree varied at different geographical locations and at different times.

229 Decisions taken during this period were based on advice given by SAGE, four nations Chief Medical Officers and the SG COVID-19 Advisory Group. Additionally, the assessment of the impact of implementing NPIs on the four harms was carried out regularly and especially to ensure decisions relating to NPIs were lawful.

230 On 7 September 2020 the First Minister announced that it might be necessary to slow further easing of lockdown measures in Scotland. We saw a widespread increase in numbers of transmissions and believed it to be right that we should warn the Scottish public that the pace of easing restrictions might need to be slowed.

231 The rationale for the decisions on the various NPIs, used between 10 September 2020 and 7 October 2020 including a reduction in people allowed at social gatherings, a ban on visiting households, advice to students not to visit pubs, restaurants and parties and also closure of bars and restaurants at 6pm, was to use these varying restrictions to attempt to control the incidence and transmission of Covid-19 based on the regularly updated data and related scientific and clinical advice received and taking account where possible, of the representations made on impact.

232 In mid-December, the CMO provided a briefing about the discovery of a new variant of the virus. It was first recognised in the South of England through the comparison of genetic information with previously known strains. At that time there were 5 cases of the new variant in Scotland but there was no evidence that it caused more severe illness. The epidemiological analysis conducted at the time suggested that the variant was more transmissible, with a 60% faster growth rate than existing variants. At that time, there was no evidence to suggest that these changes would reduce the effect of the vaccine. The advice included re-examining in more detail the optimal testing frequency for high risk institutions. As further scientific analysis was carried out it became apparent the new variant was more transmissible. In early 2021 we learnt that Kent variant was likely to increase hospitalisation levels.

233 I have described above the various NPIs put in place to control the spread of the virus during September and the rationale on which these were based. While the use of a 'circuit breaker' was an option pursued by other nations, the Scottish Government felt that a combination of enhanced NPIs offered the best opportunity of controlling the spread of the virus. Based on experience from earlier in the year, the Scottish Government was conscious of the impact of a full lockdown on the economy and on individuals in terms of social isolation and mental health. In addition, a full lockdown required financial support to business and employees. Bearing these in mind, on considering the data on case numbers and prevalence together with the clinical and scientific advice, our judgement was that on balance, the Scottish Government felt it was not proportionate to use a full lockdown to curb the spread of the virus in October.

The 5-tier Covid management system

234 The protection levels allocated to Local Authorities, running from Tier 0-4, were announced on 23 October and details of the system and its basis were published on 29 October in a revised Strategic Framework [JF2/019 – **INQ000249320**]. The Framework set out that the tier system was intended *to provide a more transparent and easily understood framework for managing outbreaks and allow rapid but proportionate responses to be taken – locally or nationally – using a range of measures and options.*

235 The tiers were reviewed by Cabinet weekly and the results published [JF2/025 - INQ000280690]. Levels allocations were guided by 5 key indicators: current cases per one hundred thousand people; test positivity; forecast for new cases in the weeks ahead; and the capacity of hospitals and intensive care facilities. Each local authority was provided with weekly modelling graphs and trends made up of the current levels

of the virus and hospitalisations etc. and forecasts which informed the levels decisions. I am not aware of any specific analysis of how this compared to the system in operation in England.

236 Advice was sought regularly from clinicians and data was interrogated to demonstrate the effectiveness of restrictions. In particular, the number of cases, number of hospital admissions and the R number continued to be key indicators of effectiveness in terms of the application of NPIs. Steps were taken in order to communicate the system and its operation effectively, including a 'postcode checker' website to allow members of the public to check what restrictions applied in their area. Changes to the levels were communicated by the First Minister, including through statements to Parliament. I believe the system was transparent, as consultative as possible within the timeframes required and effective and that in producing the level of information and sharing that widely and clearly, the communication was overall, effective.

Conclusions and lessons learned

237 As noted above the effectiveness of the restrictions was assessed on the basis of the clinical evidence regarding the prevalence, transmission and spread of the virus within Scotland. I am not aware of any assessment of how earlier or different decisions might have affected this.

238 I understand that the corporate statement provided by DG Strategy and External Affairs in June 2023 details the Four Harms Assessments carried out at each stage of decision making, including economic, social and non-covid health related consequences. The Four Harms Group was formally constituted during October and held its first meeting on 24 October. It continued to give regular advice to the Scottish Government on the balance of the Four Harms. These assessments continued to be applied to decision making by the Scottish Government throughout this period. The "Framework for Decision Making - Assessing the Four Harms" was published in December 2020 and shows how the analysis and evidence in these areas had evolved since the previous similar publication in May 2020 [JF2/022 - INQ000131028].

239 The impact on vulnerable and at risk groups was assessed through regular Equalities and Fairer Scotland Impact Assessments, and I understand that further information on this system is provided in the corporate statement of DG Communities and that details of these impact assessments have been provided to the Inquiry. The fieldwork

informing the PHS assessment of the experience of the shielding population, referred to above, was carried out at the end of this period.

240 The Scottish Government continued to develop and evolve its approach based on the experience of applying restrictions over this period. That evolution was documented in the regular reviews of the tier system referred to above. Systems were put in place to ensure that the latest understanding of the impact of the virus were reflected in subsequent review of restrictions.

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

Background to second lockdown

241 There was a shared ambition across the United Kingdom to facilitate social contact over the Christmas period. A Four Harms assessment provided the scientific rationale for the decision and the decision (to relax restrictions on Christmas Day only) was communicated to the public on 19 December 2020 through a daily briefing at St Andrew's House, Edinburgh.

242 Scottish Ministers decided to place the whole of mainland Scotland into Tier 4 on 26 December 2020 because given the indications in the data of the rapid spread of the virus at that point, any major differentiation of levels across the country could potentially weaken the effectiveness of the measures being put in place. The introduction of Tier 4 measures emphasised the very serious threat posed by the rapid spread of the new variant at that point.

The Second Lockdown

243 The decision by Scottish Ministers to place mainland Scotland in Tier 4 until the end of January 2021 was based on the case numbers at the time. From that, the clinical and scientific advice given to the Government was to further restrict movement in order to contain the spread of the virus and importantly, the virus' opportunity to produce new strains.

244 As Cabinet Secretary for Health and Sport, I was directly involved in receiving that clinical and scientific advice and in making those decisions, which were collective decisions made by Scottish Ministers. My advice was to follow the clinical advice. In relation to the timeliness of the decision to impose a second national lockdown, I believe we made the right decision based on the evidence we had at that time.

245 In common with all decisions, we were making throughout that period, a number of strategies, other than lockdown were considered. We were mindful of the ask that we were making of the Scottish public in terms of restricting their movement and behaviours. However, the advice we were receiving was such that it was clear in our judgement that we needed to have the full lockdown to try and contain the spread of the virus, reduce its capacity to produce new strains and allow the NHS to cope with the pressures that it faced.

246 I am not aware of any explicit consideration given to the Great Barrington Declaration by the Scottish Government. The Scottish Government recognised that the circumstances and progress of the pandemic varied between countries so there was a recognition that different approaches will be taken, with countries adapting their response to suit their particular requirements. Decisions within Scotland focussed on the latest evidence of the spread of the virus and the measures available to address this, on the basis of an assessment of the Four Harms.

247 Our experience of the decisions made throughout the first national lockdown, the growing understanding of the nature of the virus and how it is transmitted and spread, its impact and the impact assessments that were made following the first lockdown all contributed to the decisions that were made around the second national lockdown.

248 The Scottish Government had brought together a number of educational experts chaired by the Deputy First Minister as Cabinet Secretary for Education and Skills and COSLA and including the Education Trade Unions to consider how we would manage the situation in schools and the education of children and young people throughout this period. It was based on their advice that the decision was made to have the reintroduction of attendance restrictions at schools at the same time as the second lockdown. The continued closure of schools arose from the advice from that education group and its aim was to minimise the risk of spread of the virus amongst children and young people but also to their teachers and other school staff and to family members.

249 The rationale and scientific basis for the extension of the Scotland's lockdown until mid-February 2021 was based on the advice received from our clinical and scientific advisors. This would have been communicated to the Scottish public through the range of means that was being used up to that point, including the daily briefing.

The easing of the second lockdown

250 All decisions made toward the easing of the second lockdown including those relating to the phased return of schoolchildren were made based on the clinical and scientific advice that the Scottish Government received from advisors and advisory groups. Decisions were then communicated to the Scottish public by all means of communication that had been used up until that point, including the daily briefings.

251 Based on the clinical and scientific advice that the Scottish Government and the education group were receiving, a balance had to be struck of that scientific evidence against the desire to allow children and young people to pick up in person education provision as soon as possible. The Covid-19 Education Recovery Group had been providing its view since 24 April 2020 and was co-chaired by the Cabinet Secretary for Education and Skills and COSLA. The Scottish Government was guided in these matters by the advice of the Covid-19 Education Recovery Group.

252 The rationale for providing an updated decision making framework on 23 February 2021, setting out the broad order of priorities for easing lockdown restrictions was aligned with our intent from the outset. That is to provide maximum information to the Scottish public about the spread of the virus and case numbers and the basis on which we were making decisions. Producing this framework as clearly as was reasonable setting out the basis on which we would make decisions to ease lockdown at various stages and communicating that widely was how we had sought to work from the outset.

253 The decision was made on 2 April 2021 to lift the "stay at home" order and replace this with a "stay local" order. The rationale for this was drawn from the case numbers and the degree of transmission. This was communicated to the Scottish public by all means of communication that had been used up until that point, including the daily briefings.

254 Based on the clinical and scientific advice that the Scottish Government received, a balance had to be struck of that scientific evidence and the desire to allow maximum in person education for children and young people. We were very alert to the risk of harm to children and young people from the absence of in person education provision. The decision was made to allow all secondary school pupils to return full time to the classroom after the Easter Holidays, that they would no longer require to follow social distancing rules but would be required to wear a facemask throughout the school. This decision was communicated directly from schools to pupils and parents and local authorities but also through all means of communication that had been used by the Scottish Government up until that point, including the daily briefings.

Conclusions and lessons learned

255 The purpose of the second lockdown, as with the first, was to contain the spread of the virus by minimising the number of people who became infected and from that, those who became seriously ill. By minimising the spread of the virus, we minimise the opportunities the virus has to form new and potentially more dangerous strains. In that respect, the second lockdown achieved its purpose, as was demonstrated by the reduction in the prevalence of the virus evident in the data over this period.

256 There is limited specific analysis I have seen on the impact of the second lockdown, including on the economic and social impacts and the impacts on at risk and vulnerable people. However, the mechanisms that I have described above in previous lessons learned sections continued to apply. In terms of the effectiveness of communication, at the start of 2021, weekly polling showed that 67% of adults aged over 18 in Scotland said they trusted the Scottish Government to deliver information on Covid-19. 4.35 million people in Scotland were exposed to the first vaccination media marketing campaign. 78% of those who recognised the campaign agreed that the communications made them more aware of the importance of being vaccinated.

I: Decisions relating to the period between April 2021 and 20 May 2021 (and, if applicable, to April 2022)

257 All decisions made by Scottish Ministers were based on clinical and scientific advice and were judgements designed first and foremost to protect the public, based on the evidence we had at the time that we made those decisions. I did consider it right to ease the second national lockdown because the advice and evidence suggested it was possible to do so, in a controlled manner.

258 On 16 April 2021, the stay local rule was lifted in Scotland and six people from six different households were allowed to meet up outside again. This decision was again based on clinical and scientific advice received, which included information from behavioural science and the manner in which Scottish pubic were responding to the restrictions. It was designed to continue to minimise the spread of the virus. This was communicated to the Scottish public by all means of communication that had been used up until that point, including the daily briefings.

259 On 20 April 2021, the First Minister confirmed the reopening of outdoor hospitality, gyms and non-essential retail as well as other easings of restrictions, including non-essential travel between the four UK nations from 26 April 2021. By this point, evidence

on which our clinical and scientific advisors based their advice was sufficient to allow us to recognise the impact of restrictions on a number of businesses across the country and allow us to respond to the difficulties they were facing by easing those restrictions. This was communicated to the Scottish public by all means of communication that had been used up until that point, including the daily briefings.

260 The rationale and scientific basis for Glasgow and Moray remaining in Level 3 restrictions for a further week from 14 May 2021 was due to the high rates of COVID in those areas. Again, the decision was communicated to the Scottish public by all means of communication that had been used up until that point, including the daily briefings.

261 I am not aware of any audit of any confusion resulting from the levels system in this period. As noted previously, levels of understanding by people in Scotland were regularly audited. My understanding is that compliance and trust in government over this period in general remained high. I have discussed in the previous section some of the measures in place to support communication of the tiers system.

262 I had no further involvement in the Scottish Government's management of the pandemic after I stepped down as Cabinet Secretary for Health and Sport on 20 May 2021.

263 I was responsible for the vaccination programme, however, the COVID passport scheme itself would have been a collective decision by the Scottish Cabinet. I had no involvement in connection to the preparations for the COP 26 summit which took place in Glasgow between 31 October and 12 November 2021.

Conclusions and lessons learned

264 In the course of preparing this statement, I have been made aware of an assessment of effectiveness of restrictions in this period in the external research paper 'Effectiveness of public health measures in reducing the incidence of Covid-19, SARS-CoV-2 transmission, and Covid-19 mortality: systematic review and meta- analysis' as published, November 2021, in the British Medical Journal (exhibit). The main conclusions include personal protective and social measures (hand washing, mask wearing, social distancing etc.) are linked to the reduction of Covid-19 and measures such as lockdowns should be carefully assessed through weighing the possible negative effects on the population. The same paper also discusses the effect of universal lockdown and closures of businesses/schools and it indicates that such severe lockdowns were effective if they were implemented early on when Covid-19

rates were still low. It also makes comment that other measures were often taken at the same time or soon after so that should be considered when looking at results. It was acknowledged that the measures such as lockdown had an impact on psychosocial and mental health, global economies, and societies.

265 I do not consider that the Scottish Government could have acted any sooner or later or differently than it did in relation to NPIs. In my opinion, the Scottish Government made the best decisions that it could, based on the evidence before it at any point. Given the determination to protect the public from the risk of COVID as best we could and our stated intention to work cooperatively across the four nations of the UK.

266 In the early stages of the pandemic, I was of the view that the UK should impose more restrictions on its UK borders from incoming flights and other means of travel and I did raise that during COBRA meetings and with Matt Hancock, but the UK Government did not agree. It is the case that there were instances when we wished restrictions on businesses for example to be extended beyond the timeframe determined by the UK Government but we were unable to do that because the furlough scheme, which was critical to any success of such restrictions, was implemented by the UK Government and the Scottish Government did not have the financial levers to support a separate furlough scheme.

267 International passengers would have been able to circumvent tougher restrictions in Scotland by travelling via England and this was a self-evident risk that we were alert to. That in itself was not an argument against the tougher restrictions on travel in Scotland that we agreed the scientific and clinical advice warranted. In future, we may hope for a more cooperative relationship between the Scottish and UK Government.

268 I have discussed above the systems put in place to response to learning – I had no further involvement in this process within the Scottish Government after I demitted office.

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

269 I believe the decision making on the part of the Scottish Government and the key Ministers and advisors involved was effective and there was a clear understanding and exchange of information and clarity of decision making. Inevitably, within the context of the UK there were differences in approach between the four nations which were not always resolved but I believe we made every effort to try and secure four nations working where we judged that to be in the best interest of those we represented.

J: Care homes and social care

270 From 17 March 2020 the NHS was under emergency measures, meaning decisions relating to the operation of the NHS in Scotland were my responsibility. Taking this step was based on the modelling of worst-case scenario received and the requirement that presented to ensure that all of the NHS in Scotland was focussed on responding to the threat of Covid-19. The decision to discharge anyone from hospital is first and foremost a clinical decision based on a clinician's view that hospital treatment is no longer required. At the point where people were discharged from hospital to care homes, it would be based on that clinical decision that hospital treatment was no longer required and they would be discharged to a care home or their own home depending on where they lived permanently. The decision to discharge people in terms of freeing up the NHS capacity to deal with Covid-19 and attempting to ensure that all patients no longer requiring hospital treatment were not exposed to the virus in hospital, was of course made in the early days in the context of the modelling of anticipated numbers of the population affected by Covid-19 and the percentage of that number which would require acute hospital care, which along with other decisions was designed to ensure the NHS could cope with the demands of the pandemic.

271 Testing of both health and social care workers started on 16 March and was ramped up significantly from then. On 1 April 2020, the FM publicly confirmed the work underway to significantly increase our capacity to process tests with a capacity on that date of around 1900 tests per day with an increase planned to 3,500 per day and all within the NHS Scotland laboratory network. Commercial partnerships were being developed at the UK level to increase capacity beyond that and as part of one of those partnerships, a new laboratory had been established in Glasgow, which we expected to be operational by the end of April 2020. As testing capacity expanded, we progressively increased the number of health and care service workers who are tested. We had already published guidance to support that.

272 My understanding and expectation of all care homes was that basic infection prevention and infection control measures were understood, staff were trained to operate those and that they would be regularly practiced. Therefore, early into the pandemic, where there was not the capacity to test people being discharged from hospital to a care setting, my expectation was that the basic infection prevention and control standards which I expected the care home sector to be practicing, together with the specific additional guidance provided, would provide mitigation against risk of transmission.

273 My understanding of the domestic care sector was comparable to that of the residential care home sector. I knew that our local authorities took seriously the importance of ensuring staff and those who received care were protected. Of course, there were additional demands on residential and domestic care sectors for PPE because of the nature of the virus and the upsurge in global demand for PPE and, as covered elsewhere we took steps to seek to ensure supply and distribution of PPE for all staff involved.

274 We understood there was a risk of Covid-19 spread in any setting where numbers of people were together, and that was part of the rationale for the NPIs we introduced including lockdown, to limit social mixing and thereby the spread of the virus. Residential care homes were issued specific guidance surrounding the isolation of individuals on their admittance for a period determined by clinical advisors. In order to ensure that, if a newly admitted individual did have the virus, then the risk of spread was reduced. We also took steps to ensure that staff had the right guidance about the PPE that was required. Guidance on this and other areas was regularly updated as new information appeared. We had taken steps to supply that additional PPE to care homes. In normal times, they were responsible for that equipment themselves. In addition, public health directors in each NHS board and their colleagues undertook contact with residential care settings, where that was required, to provide them with advice and guidance. Additional nursing and other support were also made available.

275 The rationale behind the announcement I made in Parliament on 21 April 2020 was as set out in that announcement [JF2/023 - INQ000280688]. We sought to provide assurance to care home residents, staff and the families of those with loved ones in care homes as well as those being discharged about the measures in place to reduce the risk of infection in care homes. In that announcement, as well as the expansion of testing, I also made clear the efforts being made to enhance the workforce in the care sector, increased engagement by Directors of Public Health and the establishment of the Rapid Action Group to address any emerging concerns, as well as outlining further measures to increase the availability of PPE.

276 Clinical advice at the time was a 14 day period of isolation for those entering care homes from the community or hospital to mitigate the risk of transmission, including from those who were asymptomatic at the point of entry. However, as set out above, the addition of testing was intended to strengthen assurance for all stakeholders.

277 The Scottish Government knew that the World Health Organisation was advising the use of widespread testing albeit that it was not specific to care homes or older people.

We knew that to be the case but could not at the outset implement that because we did not have the capacity to do so. Once we did have the capacity to do so then we could implement testing, not only for admission to care homes but also widespread testing for the public.

278 Our overall aim was, as far as possible, to limit the transmission of the virus. Particular social and domestic settings required additional steps and that included care homes and those receiving social care in the community. In some instances, and with regret, we required the closure of adult day centres for example. We knew these offered vital social support to many receiving adult social care but it was part of our intention to limit the number of people coming together in order to limit the transmission of the virus.

279 The Scottish Government's key advisors were making use of their contacts and networks within the UK and elsewhere. Any advice from those relations that they believed to be appropriate would be given to the Scottish Ministers.

280 On 21 April 2020, I had made a statement surrounding the testing of staff in care homes and our progress in working on a four nations basis to increase the testing capacity in Scotland as part of the UK offer. We had the capacity by then to introduce the testing which we had not had the capacity for beforehand. Therefore, at the very outset of the pandemic there was a significant discharge of people from hospital back to their care homes or returning to receiving care at home, whose treatment in hospital had finished and whom we wished to protect from hospital- acquired Covid infection. At this time, we did not have the physical capacity to test, I believe capacity was around 350 per day. We simply had no capacity to do that, so other steps were taken to mitigate against transmission aside from expecting care homes to understand and practice basic infection prevention and control was the guidance around isolating someone who was admitted for 14 days, the wearing of PPE, the supply of PPE and then as our testing capacity improved we then introduced the requirement that someone should have two covid tests before being admitted to a care home whether they were coming from hospital or not.

281 I was in regular contact with Scottish Care and throughout this period met both with Scottish Care but also with individual care home providers, COSLA and with the Trade Unions representing staff in the care home and home care sectors. That contact and those meetings were all around discussions about how we would manage the threat of Covid in residential and domestic care sectors.

282 My ministerial diary records that I met with Scottish Care on the following dates during the pandemic period:

- 18 March 2020
- 3 April 2020
- 7 April 2020
- 16 April 2020
- 22 May 2020
- 5 June 2020
- 19 June 2020
- 1 July 2020
- 16 July 2020
- 7 August 2020
- 24 August 2020
- 7 September 2020
- 23 September 2020
- 7 October 2020
- 20 November 2020
- 9 December 2020
- 14 January 2021
- 17 February 2021
- 25 March 2021

283 These frequent meetings were important to discuss the ongoing management of the virus in the care sector specifically around both infection prevention and control but also the provision of PPE. One of the initiatives that I took in response to issues raised at those meetings was to introduce a direct distribution route of PPE to residential care

homes and in consultation with COSLA and the Trade Unions to agree that adult social care staff working in domestic settings should have a supply of PPE available to them for each of their clients and that they would take the professional decision on what PPE to use dependent on their own individual assessment of the risk presented. Another issue that was raised was the difficulty of care home staff in staying off work if they believed they might have covid or had covid because they were not in receipt of sick pay and the financial restriction was considerable given that they are low paid individuals. Therefore, we took a decision to make sure that financial support would be available to all staff in adult social care knowing that in the future we would need to raise terms and conditions with the care sector but in the immediacy of the pandemic, we took the decision to spend the Government money supporting staff so they could follow the guidance we were giving them to stay at home if they were unwell.

284 I was aware of Scottish Care's position of advocating for robust clinical assessment and testing of residents entering care homes from both the community and an NHS setting. Had we had the capacity to have testing of residents entering care homes from the outset then we would have done so but we did not have the capacity and we did introduce it as soon as that capacity was available. However, we did offer guidance that in effect asked that all admissions to care homes be treated as if on the presumption that they may be COVID positive and the isolation of the individual for 14 days. Therefore, meaning that residents were barrier nursed and supported on a one-to-one basis and of course additionally as I have said, we ensured that PPE was available where a care home told us that they required that additional support.

285 The requirement of the importance of testing was raised in the Scottish Parliament and we were of course aware of the WHO advice on that issue and as previously stated, we were unable to introduce testing in the early part of the pandemic because we did not have the capacity to process the tests. As soon as we did as part of the four-nation initiative to increase testing capacity then we introduced it for individuals being admitted to care homes.

286 I was not influenced by political considerations in the decisions I took regarding the discharge of patients from hospitals to care homes. Nor do I believe that the decisions of other Cabinet Secretaries or Cabinet collectively were influenced by any such consideration. A glance at the record of the Scottish Parliament's proceedings will show cross party support for the steps that the Scottish Government was taking including the discharge of patients from hospital including to care homes, when they no longer

required hospital treatment. As previously stated, the first decision and the decision maker of whether a patient is discharged from hospital is the relevant clinician. Only s/he can determine that someone no longer requires hospital treatment. No politician could or should do such a thing. That includes discharge to any setting whether it is to a person's own home or to a residential care home. The decision to support the discharge of patients no longer requiring hospital treatment to care homes once that clinical decision was made was the responsibility of the Scottish Government in supporting that to happen.

287 As I have previously noted, we were aware that any situation where individuals were together, particularly in any kind of closed setting, was one where the risk of transmission was increased. We were also aware of the WHO guidance on testing but at the outset, lacked the laboratory capacity to deliver that. Our understanding of the importance of testing informed the rapid upscaling of capacity within NHS laboratories noted earlier and our active engagement in the UK wide development of laboratory capacity. Alongside this, as previously noted was our understanding that asymptomatic transmission was a significant feature of the COVID-19 virus and so the decision to test both symptomatic and asymptomatic individuals entering into a care home was made as soon as we were able to deliver on it. This was in addition to the guidance and support described previously.

288 In regard to the concerns noted from Scottish Care, from January 2020 throughout the early part of the pandemic we were engaged in a process of significant upscaling of our testing capacity both in Scotland and across the UK. As our testing capacity increased, we had to make judgements about how we would introduce the opportunity for testing across various sections of the population. NHS and social care staff were a priority because they were treating individuals who were seriously ill from COVID, and we required our staff to be as sure as they could be that they did not have the virus. As we could phase further introduction of testing, we did so.

289 Care homes were responsible for securing their own supplies of PPE, however, in recognition of the issues being raised by the sector, by 21 April 2020, NHS Scotland were providing a top up service in recognition of current, exceptional, demand in all settings. A triage centre was established through NHS NSS for supplying urgent PPE to registered social care providers. Once the system was in operation, improvements were also introduced such local cluster points for distribution of PPE and increasing staff numbers to prepare and deliver PPE.

290 My letter of 13 March 2020 addressed to IJB Chief Officers, Local Authority Chief Executives, IJB Chief Social Work Officers, Scottish Care, Coalition of Care and Support Providers in Scotland, Care Inspectorate and the Scottish Social Services Council included advice from the CMO that appropriate PPE should be used for positive cases and also that long term facilities should ensure that they had access to adequate stock and knew where to access additional supplies if needed. The advice on what PPE to use, how to obtain equipment and dispose of it had been made available through HPS. The CMO underlined that all staff must be made aware of the guidance [JF2/024 - INQ000280689]. How PPE was distributed in a care home setting was a matter for those operating the facility.

291 From very early March, discussions were underway with NHS Boards and with COSLA as to how to reduce the number of so-called delayed discharges, where those judged clinically fit to be discharged from hospital were unable to access appropriate facilities or support outside a hospital setting, leaving a reduced number of hospital beds available for new admissions. On 6 March 2020, the DG for Health and Social Care wrote to Chief Officers, Territorial Health Boards and Local Authorities to note the importance of reducing the number of delayed discharges. The advice underlying this would have been connected to concerns about NHS capacity to manage a significant number of covid infections. As ever, individual discharges remained a matter of clinical judgement within the hospital setting.

292 My statement to Parliament on 21 April 2020 set out a number of measures put in place to support the care homes sector, including requiring NHS Directors of Public Health to take enhanced clinical leadership for care homes. Directors were asked to report on their initial assessment of how each home was faring in terms of infection control, staffing, training, social distancing and testing and the actions they were taking to rectify any deficits they identified.

293 The national Care Home Rapid Action Group (CHRAG) was also established in April 2020 comprising the key partners with operational oversight and delivery responsibility for care homes. The group received daily updates and was tasked with initiating any local action needed, as well as informing and coordinating a wider package of support to the sector. The CHRAG initially focused on care homes but in September 2020 its coverage widened to adult social care under a new group Pandemic Response Adult Social Care Group (PRASCG).

294 From March 2020, the Care Inspectorate had significantly increasing levels of contact with care homes across Scotland. In a statement to the Scottish Parliament on 21

April, I advised that we were equipping the Care Inspectorate for an enhanced assurance role including greater powers to require reporting. Following this the Coronavirus (Scotland) (No.2) Act 2020, which contained provisions around duties of the Care Inspectorate in relation to care homes including on inspections, was introduced on 10 May 2020. This Act came into effect on 26 May 2020 and the following provisions were included:

- That the Care Inspectorate must lay a report before Parliament every two weeks during the emergency period setting out which care home services it has inspected in the two-week period as well as the findings of those inspections.
- New duties for the Care Inspectorate around reporting of deaths in care homes services from or attributable to coronavirus.
- That care home service providers must provide certain information to the Care Inspectorate each day in relation to the numbers of deaths which have occurred in a care home service, whether caused by or attributable to coronavirus or not.
- That the Care Inspectorate must prepare a report of the information provided by care home service providers and share with Scottish Ministers.
- That Scottish Ministers to subsequently lay reports prepared by the Care Inspectorate before Parliament
- The Care Inspectorate reported on infection prevention and control, PPE and staffing and amended its quality framework for care homes to support this process.

295 Coronavirus (COVID 19): enhanced professional clinical and care oversight of care homes guidance was issued by SG on 17 May 2020. I met regularly with the Care Inspectorate to consider the situation and receive their updates on actions taken and their advice on the situation in residential care facilities and used the daily SitReps I received on residential outbreaks to communicate between meetings and inform discussions with my officials and the Inspectorate.

296 An early warning system of enhanced notifications was established, requiring services to tell the Care Inspectorate about both suspected and confirmed cases of COVID-19, and staffing levels affected by COVID-19. The Care Inspectorate operated these oversight arrangements seven days a week to carry out scrutiny checks and enhanced their communication with daily Updates, a dedicated area on their

website, and information on social media. Where risk was indicated as high, the Care Inspectorate commenced onsite inspections.

297 I have already discussed the decision making process around testing for both patients and staff and the advice, timing and constraints on the approach taken above.

298 I was very aware that the restrictions that we were imposing were difficult for the population as a whole and were additionally so for residents in care homes and their close families. However, the judgements we were making were aimed at protecting individuals as best we could from the harm of Covid-19 and as the pandemic progressed, I had a number of discussions with the Care Home Relatives Group, and we were able to ease those restrictions and encourage care homes to follow our guidance on the easing of restrictions. Care homes of course are private enterprises and cannot be directed by me or any government minister in the way for example I could direct the NHS. While some care home employers offered employment contracts closer to the Scottish Government's fair work principles, it was clear that others did not. In recognition of the exceptional circumstances and in order to ensure that social care workers were given the urgent support they deserved, we developed a Scottish Government funded scheme for care workers in respect of sick pay and death in service benefits. The Social Care Staff Support Fund became operational on 24 June 2020 to provide financial assistance to staff facing financial hardship when off work self-isolating and whose employment terms only provided for Statutory Sick Pay (SSP).

299 The rationale for increasing regulatory requirements and the inspections was to ensure that all care homes were following the guidance, receiving support where possible and applying the clinical and infection control practice that had been made available to them. However, we were aware that not all were managing to do so, therefore, the intention behind the additional regulatory requirements and the significant support offered to these private enterprises was to ensure that they were given the best opportunity to provide the level of care and protection to residents. Undoubtedly, in circumstances where individuals are working at pace and under pressure, mistakes and misunderstandings will arise, for example in terms of the guidance issued or the role of the Directors of Public Health, but where we were
aware of those, we took steps to try to redress those and I am confident that our directors of public health behaved in the same way.

300 As described above, from early on in the pandemic the Scottish Government required local professional leads – Directors of Public Health, Executive Nurse Directors, Chief

Social Work Officers, Chief Officers, Medical Directors from NHS boards and Local Authorities to provide oversight and support to adult care homes. The Scottish Government had no direct role in local outbreaks in addition to these requirements. However, with regard to the specific outbreaks raised in Redmill, I did meet the Care Inspectorate on 29 October 2020 to discuss the outbreak and their findings and intended follow up action. In general, outbreak monitoring and intervention was the responsibility of the local incident management teams, with follow up action coordinated by the local Health and Social Care Partnership. The daily SitReps I received as noted earlier, allowed me to monitor the situation and pursue any further action or require additional pace in response that I considered necessary.

301 I think I was clear from the outset that there were a number of risks in all of the decisions that I and collectively as a government we were making, and we were making those decisions based on the evidence we had available to us at the time we made the decisions, our capacity to deliver as noted in relation to testing, and trying to mitigate the risks as best we could. Throughout the pandemic we were making decisions between difficult options, none were risk free and none were optimal. As mentioned, if we could have tested patients discharged from hospital into care homes or a domestic care setting at the outset then we would have done that, but we did not have the capacity to do so. As soon as we did have the capacity then we introduced that testing regime. What was not as clear to me at the outset, but quickly became clear was the degree of variation in the level of understanding of infection prevention and control across the entirety of the care home sector and the requirement for some care homes to be additionally supported to achieve that standard. This was absolutely not because the staff in those homes did not want to provide the best possible care, but because they had not necessarily had the level of training or the support of proper equipment that they should have had. That disparity particularly in the residential care sector is what lead to my commissioning of the Feeley Inquiry into adult social care which reported to the Scottish Government in the spring of 2021.

302 I do not accept that the Scottish Government did not respond quickly to what was needed in care homes and social care in the community. In the context of everything that we were dealing with, as soon as we were made aware of the need for additional support or of problems, we acted very quickly to respond to that. The residential social care sector is essentially composed of private enterprises, some of which are UK wide in their operations and are part of a larger enterprise with other interest and shareholder expectations. In that circumstance, government has limited locus on what they can direct and require. Some of the steps that I took including with the Care

Inspectorate an additional regulation was, in the context of the pandemic, to try and increase the locus of government in the residential care sector. The domestic care sector is a purview of local authorities so whilst the Scottish Government provides financial support much of the delivery is at the hands of the local authority but even, so we have a more direct relationship with local authorities. That is why it is so important that the Scottish Government worked well with the Convention of Scottish Local Authorities, but it is also why in both instances commissioning the Feeley Inquiry and supporting its recommendations were so important as we look ahead to how we can improve the standard of care across the adult social care sector and the dignity and respect with which those requiring social care are treated.

303 It was not the case that the absence of testing in homes with no known Covid-19 positive individual at the beginning of the pandemic resulted in a failure to adopt a preventative approach in a setting with a high risk of community transmission. From the earliest stages of the pandemic, specific advice on enhanced infection control was produced and promoted to the care home sector. In addition, the guidance from an early stage that individuals entering a care home setting, whether from hospital or the community, self-isolate for 14 days, and access to testing for health and social care staff, was intended to ensure a preventative approach was adopted.

304 I do not agree that there was reluctance from decision makers at the onset of the pandemic to take into account the expertise or experience of those operating in the social sector. As previously noted, pre pandemic I had regular contact with Scottish Care and that increased considerably with me and my officials as the pandemic progressed. My officials were also engaged with stakeholders with respect the relevant considerations to be taken into account when supporting a population with significant behavioural needs and challenges and it is the specific discussions with Care Home Relatives Group that focussed attention on the specific issues with respect to family/loved one contact that we then tried to address.

305 I regret if at any point Scottish Care felt that their engagement with anybody of the Scottish Government was tokenistic. I certainly valued their input and advice and the frequent contact that I had with them both before and during the pandemic. Of course, they will understand as I do, that in situations where people are rapidly coming to terms with a circumstance that they have had no previous experience of and are required to respond at pace and in detail, it can be the case that the best practice you would like to follow is not always possible.

306 Public Health Scotland played a vital and valuable role throughout the pandemic, and I am confident that if there were areas where it had limited experience, it sought to address those as best it could.

307 In the circumstances of the pandemic, I believe that the Health and Social Care Directorate, other Scottish Government directorates, the NHS, NSS, PHS and the care sector worked reasonably effectively. Where there were problems drawn to my attention, I aimed to take steps to address those as soon as possible and where practical.

K: Borders

Internal UK borders

308 Wales did impose a public closure on their border with England for a period in order as one of the measures to prevent the inward transmission of the virus from areas of England which bordered on Wales. So, in that sense the closure of borders internal to the UK partially or for particular purposes is technically feasible. However, the border between Scotland and England was not considered feasible for closure not least because of cross-border NHS employee traffic, both between the hospitals in Carlisle and Dumfries and the ambulance service. Recognising that, we sought to be as clear as possible about travel restrictions where those restrictions differed between Scotland and England. I am not aware that formal consideration was given by the Scottish Government to closing borders between Scotland and the other nations of the UK.

309 Guidance set out by the Scottish Government during 2020 related to travel beyond the local authority of residence. By implication this also affected travel between Scotland and the other nations of the UK. The rationale for these measures including the risk of importation of the virus into areas of lower prevalence and in particular the need to address the potential for greater travel between areas of different prevalence under the tiering system when different parts of Scotland were experiencing different levels of restrictions.

310 In late 2020, as the responsible administrations varied restrictions addressing the different circumstances in the four nations of the UK, the four governments co-operated to publish a web page with signposts to the guidance applicable in different areas. Guidance was published to explain the restrictions, and made it clear, for example, that Covid-19 rules and guidance did not prevent anyone from leaving their home to escape domestic abuse or taking other measures to keep themselves safe from domestic abuse. Polling helped monitor if people were clear on what was required of them as a result of both non-legal guidance and legal restrictions.

311 The differences between England and Scotland placing different controls for quarantine for returning travellers was understood and taken account of by the Scottish Government. With regard to the concerns raised by PHS in terms of a differential quarantine arrangements between Scotland and other nations, from September 2020 additional communication measures were put in place to ensure travellers were aware of the quarantine requirements.

International borders

312 I am unaware of any role the Office of Secretary of State for Scotland played in decision-making around the closure of the UK border. As I have advised, I raised a concern about widening the control of inbound traffic to the UK with UK Government, particularly in the context of why we were just stopping flights from Wuhan and not recognising people travel through Europe to get into the UK. I understand that the First Minister may also have raised issues around the closure of the UK border, but I am not aware of those details.

313 Any discussion or decisions in relation to borders were discussed at Cabinet. Michael Matheson was primarily involved in this and would be better placed to address the approach taken in relation to Border control.

314 Regarding my involvement in the decision-making with regard to quarantine and/or self-isolation on arrival into the UK, my representations were made between January and February 2020 surrounding my concerns of ongoing transmission as there were no direct flights from China to Scotland. Thereafter, it was the First Minister and Prime Minister who began attending COBR meetings.

315 Our testing capacity, as already stated, was very low at the start of the pandemic and significant work was undertaken in Scotland and across the UK to increase capacity. Until that capacity was increased it was not possible to test passengers.

316 I am asked to comment on why, on 12 March 2020, the advice to travellers arriving in the UK from category 1 countries to self-isolate even if they were asymptomatic and the advice to travellers arriving in the UK from category 2 countries to self-isolate only if symptomatic was withdrawn. The decision to withdraw, or even introduce such guidance, was a decision made by the UK Government and it was entirely their decision to make. Therefore, it was also their decision as to whether or not there was a legal requirement for travellers to self-isolate, as this is within their reserved powers. The Scottish Government role is very limited and there would be little consultation on such matters. There is self-evidently an interplay between border control decisions which

are reserved to the UK government but which impact on Scotland, and the Scottish Government's judgement as to the necessary measures to control transmission of the virus. This is exacerbated when there is limited if any consultation by the UK government. However, that is the reality of the situation faced and it was the Scottish government's job in those circumstances to take what mitigating steps it could and continue to communicate as clear as possible to all those it represented. Scotland as a devolved nation cannot issue advice against all but essential travel with the same authority as the UK Government Foreign and Commonwealth Office. Those powers are not devolved.

317 In the early part of 2020, studies were not available to inform the Scottish Government where precisely outbreaks of coronavirus were coming from. However, it was clear that there was a significant outbreak in Italy, which we were informed of through the international contacts that our clinical advisors had, as well as what we were seeing generally in the media. As more international engagement took place, which was often informal between our clinical advisors and their senior contacts in Europe, further information became available as to the spread of the virus appearing as noted in Spain and France at that time.

318 On 5 July 2020 I outlined that quarantine checks had not been carried out on passengers arriving in Scotland from overseas (following the measures being imposed regarding two-week isolation requirement from 8 June 2020) because Public Health Scotland officials had not be granted security clearance to access the passenger details required to carry out these checks. The Scottish Government and its officials were ready to implement the isolation checks from the point that the rule was instigated. However, there was delay in this due to the Home Office process of providing clearance to access the information we self-evidently needed on the passengers who would be involved in the quarantine requirement. The Scottish
Government was aware that security or access to home office systems would be required by suitably cleared Public Health Scotland officials. Some Public Health Scotland officials in certain roles have a level of security clearance given the nature of their role, so we understood that requirement and had every expectation that the UK Government, would ease that access, given their stated commitment to collaborative working. Unfortunately, this proved not to be as easy or straightforward as anticipated and significant exchange was undertaken with the Home Office (HO) to resolve the obstacles they considered to be in place and to do so at pace. My direct involvement in relation to this was discussions with Matt Hancock to attempt to expedite that clearance and my immediate contact with my own officials to remain up-to-date with

the situation. It took around four weeks to obtain the necessary clearance from Home Office. It was not possible for the Scottish Government to resolve the issue any quicker than that, given authorisation rested solely with the Home Office.

319 Informal discussion took place during Summer 2020 in relation to whether stricter travel restrictions may be imposed, however, as I mentioned earlier in my statement, such restrictions would involve border control from outside of the UK into Scotland, which was a matter in the hands of the UK Government, and therefore we were limited in terms of any steps that could be taken.

320 I advised at paragraph 313 that Michael Matheson as the Cabinet Secretary responsible for leading on this area, would be best placed to address matters relating to UK Border Control. I will outline below matters which I can speak to.

321 All restrictions to travel imposed by the Scottish Government were considered with care and were as effective as it was possible for them to be. The decisions taken by the Scottish Government in this regard were made in the manner that all decisions were made throughout the pandemic, which was on the basis of scientific and clinical advice. This advice outlined that these measures were required. Where these decisions differed from other governments within the four nations, they were taken because it was judged to be in the best interest of controlling the virus in Scotland.

322 My view is that decision-making with respect to Borders, in particular Borders in the sense of individuals coming into the UK from outside of the UK, did not work as well as it could have. I outlined at paragraph 314 the views I raised about this. These decisions were entirely in the hands of the UK Government and were undertaken with limited genuine consultation with Scotland.

L Decision-making between the Scottish Government and (a) the UK Government and (b) the other Devolved Administrations in Wales and Northern Ireland

323 From the outset, the Scottish Government committed to a four-nation approach to handling the COVID-19 pandemic, with the shared and understood proviso with all parties to the four nation approach, that where we judged a different approach to be in the best interests of the Scottish population, and we had scientific and clinical advice to back that judgement then we would deviate. That was the case for all four countries of the UK.

324 In the early days there was a clear shared approach through the four-nation plan to the handling of the public health threat from COVID-19, based on effective collaborative

work between chief medical officers of the 4 nations and other scientific advisors. That continued, but with the clear caveat as already noted of the mutual respect for each Devolved Government taking decisions that may differ one from the other with respect to NPIs, as well as the nature, duration and timing of those, based on each Government's judgement about what would be most effective in the circumstances and geography that they were dealing with.

325 The four health secretaries met weekly via ZOOM, primarily to discuss operationalising actions agreed but also to try where possible to coordinate the timing of interventions. For example, with regards the delivery of the first vaccine, the timing of that delivery was coordinated between the four health secretaries to ensure public confidence and trust that there would be equity of access to it. This necessitated a slight delay in the delivery in England given the geographical challenges in Scotland, where we had to get the vaccine to our islands, and Northern Island too, where there was an additional journey for the vaccine supply to take. Additional collaboration and communication also occurred on the Mutual Aid agreement around PPE. Given the international demand for PPE, there was a need to ensure that where one country had a sufficiency of a type of PPE that they were willing to lend some of that supply to another nation where they might not have enough. Anything lent in that way was returned when the recipient received their supply. We supplied PPE on that mutual aid basis to both England and Northern Ireland.

326 In respect of COBR meetings, the First Minister and Health Secretary were normally invited to all COBR meetings on Covid-19. The Scottish CMO would also be in attendance. The invitation and the agenda for COBR would come from the UK Government. As meetings moved from COBR to Ministerial Implementation Groups (and later to COVID-O and COVID-S), it was entirely a decision by UK Government as to who was to be invited to each of those meetings. To my knowledge, no explanation was offered as to why Devolved Governments were not routinely included in these meetings, and it was a source of frustration and disappointment to Ministers in the Scottish Government. Similarly, my understanding is that the chairing of the meetings between Michael Gove and the First Ministers of Scotland and Wales and the First and Deputy First Ministers of Northern Ireland, was entirely a decision taken by the UK Government and I am not aware that the views of the Scottish Government were sought.

327 It is inevitable that if one of the four-nations takes decisions in a manner that fails to consult, consider or treat the Governments of the other three nations as equal, then

the effectiveness of a four-nations approach is harmed. It has long been the Scottish Government's position, which was argued pre-Covid, that the most effective intergovernmental structures would be those which are jointly owned. Therefore, operating to handle a Public Health emergency in a situation where those structures are not jointly owned is less effective than it could otherwise have been. My view remains that intergovernmental structures should be jointly owned by all the Governments who are participating. What I mean by that is that there should be equality of access in determining timing, agenda and follow through action. This structure, along with a significantly improved understanding of devolution on the part of Whitehall Departments and Ministers would in my view greatly assist in facilitating effective intergovernmental relations and a four nations response in any future pandemic or UK wide emergency.

328 Where the Scottish Government communicated that it may make different decisions from that of the UK Government, there was no significant disagreement. I recollect conversations between Matt Hancock and I on occasion whereby he would express views if he disagreed on differences in approach and in those discussions and where they involved all 4 health secretaries there was of course a degree of challenge, but there was clarity and acceptance from the outset that each Government would act in a way that they considered to be in the best interests of those they represented. That agreement was in my view correct and helpful but there were situations which I have noted, where the disparity of powers between the 4 governments meant that the decision of one could impact on another in terms that were not helpful.

329 Where the UK Government or Devolved Governments made decisions that were different to our approach, in terms of the relations I had with the other Health Ministers, I would seek to understand why they might take a different decision from the Scottish Government. I would then look to see how we could mitigate against any confusion or misunderstanding that might result in the minds of the public about what they were being asked to do.

330 In relation to discussions on public health between the UK Government and Devolved Governments, the First Minister and Deputy First Minister were primarily involved in these communications and would be best placed to address policies in that regard, as well as in relation to how those discussions took place and who was involved.

331 In respect of informal communications facilitating four-nations decision-making, I have previously outlined that the only WhatsApp group that I was party to was with the other

three health secretaries of the UK Government and Devolved Governments as set out in paragraph 28 above.

332 Scottish Government officials from the office of the Chief Medical Officer were only ever observers at SAGE, as were the other Devolved Governments. With regards to attendance at early SAGE meetings, Scottish Government officials could only attend as invited. Gregor Smith as DCMO first attended SAGE on 3 March 2020. Then on 29 March both Gregor Smith (DCMO) and Andrew Morris (Scottish COVID-19 Advisory Group) attended. I cannot comment on what impact this may have had on the Scottish Government's understanding of and initial response to the pandemic but our concern to understand how the information and data applied to Scotland and our access to question directly scientific and clinical views was instrumental in the setting up of the SGCAG, chaired by Andrew Morris.

333 Relevant Scottish Government officials will have knowledge of the work of the UK Tsars. I recall that my officials had interactions with their offices and those interactions where relevant would inform briefings I received.

334 In making four-nations decisions, detailed and significant consideration was given to individuals who were determined by our Chief Medical Officers to be clinically vulnerable and at risk in terms of the specific measures they were advised to follow and the support that was put in place for them. Other vulnerable groups were considered, and our understanding and consideration of those groups was additionally aided by the introduction of the four harms assessments.

335 The Scottish Government was very alert to the existence of people who lived and worked across the border between Scotland and England, particularly in relation to those working for our national health service as I have mentioned previously.

336 The clinical and scientific advice available to the Governments across the four nations came from the collaborative work of our respective Chief Medical Officers with additional advice from SAGE and, in Scotland, from the Scottish Government Covid Advisory Group (SGCAG). To that extent each Government was working on the basis of the same evidence, and it was the case that each Government advised the other about its intent with respect to restrictions over the festive period. There was collaboration at official level, including Four Nations discussion during the course of November 2020 and I understand that the deterioration in case numbers ahead of the Christmas period was also discussed in a Four Nations call chaired by the Chancellor of the Duchy of Lancaster on 19 December.

337 My understanding is that the work of SAGE and certainly the work of the SGCAG considered the situation in other countries, including I would assume multinational states and the steps that were being taken there and used that to formulate the advice that they then gave to the Scottish Government. That was an iterative process and so lessons were being learned as the pandemic progressed through 2020.

338 Unfortunately, as I have already noted, I do not believe that any of the Devolved Governments were fully involved in the sense of on an equal footing with any decisions that the UK Government made throughout the pandemic. In my view therefore, the situation was suboptimal.

M Interrelation between the Scottish Government and local Government

339 The lead minister in relation to our national resilience structures and systems, and in that respect including our relations with local government (including COSLA) was the Deputy First Minister. Consequently, he is better placed to address the communications and decision-making that took place between the Scottish Government and local Government across the broader range of areas related to the pandemic. However, in my role, I did have regular and frequent contact with Councillor Stuart Currie, who was the COSLA representative for health and social care, and in my regular discussions with the trade unions which operated in local authorities. Therefore, I will address matters that are within my remit insofar as they relate to that involvement below.

340 Regarding local authorities' involvement in decisions to impose or ease NPIs, there was a system led by the Deputy First Minister of discussions with particular local authorities who might be affected in advance of a decision being made and then there was a regular meeting with them. This system was known as the Covid Safety and Compliance Programme and was supported by a Compliance Advisory Group. This brought together representatives from across the public sector (NHS Scotland, Police Scotland, Convention of Scottish Local Authorities (COSLA) and Society of Local Authority Chief Executives and Senior Managers (SOLACE)) and provided to them and all LAs, as noted previously, all the relevant data which Ministers were using to make decisions in this regard. For example, when we were moving the majority of local authorities into a different tier, there were two local authorities that were not being moved. Those two local authorities in particular would have had a one-to-one discussion with the Deputy First Minister or another Minister about why they were going to be different and in a more restrictive tier than their neighbours for example, and any views they had were then fed back before the final decision was taken. The Deputy

First Minister would present a paper to Cabinet, setting out the issues and relevant analysis, and (usually, but not always) making specific recommendations.

341 Medical and scientific data on the number of cases in any given local authority area, the number of people in hospital including those in intensive care and the number of people who had died where Covid was given as a cause in the death certificate was all public information and had been from the earliest days of the pandemic. In addition, local government representatives were able to access the expertise that Scottish Government relied on when it was looking at making specific decisions affecting any particular local authority. Local government also of course had access to the local Directors of Public Health who are experts in this area and were particularly involved in the local response to Covid-19.

342 From my perspective as the Cabinet Secretary for Health I believe that the relations with COSLA worked well and effectively, that we were able to identify problems where they arose and addressed those wherever possible through shared decisions. We were also able to respond where issues around regional testing availability, the speed of tests being processed and local test and protect operations needed to be addressed.

343 In respect of health and social care specifically, COSLA had a significant role in the Scottish Government's core political and administrative decision-making during the pandemic and in determining the specific responses we took.

344 In terms of health and adult social care, structures were in place as of January 2020 for formal liaison between the Scottish Government, local authorities and COSLA; in addition, I had regular meetings and discussions with Councillor Stuart Currie. The quality of our joint work in health and social care and the relationship between myself and Councillor Currie and our respective officials was a strong foundation from which to deal with the Covid pandemic. The specific changes that were made were simply to increase the frequency of that contact and those discussions.

N Covid-19 public health communications

Public health communications strategy of the Scottish Government during the pandemic

345 The core of the Scottish Government's public communications strategy was to provide as much validated information as possible to the Scottish public. This was to explain the situation we were collectively dealing with, the rationale and the basis for our decisions and to be very clear about what we were asking the public to do. That strategy

evolved in that way partly because that was, broadly speaking, the approach of the Scottish Government on other issues but also from the experience of handling the swine flu pandemic. Therefore, the combination of a belief that the population of Scotland needed to be allowed to understand the information and the rationale for decisions, and the experience of handling a previous public health emergency, lead to the particular strategy the Scottish Government had. I believe that the strategy was continued throughout the pandemic; as the pandemic progressed, more and more information was being given out as we had more and more information that was validated. Our main consideration each morning prior to briefings was ensuring that the numbers provided with were validated, or if they were not, that they would be prior to that day's media briefing.

346 The overall Scottish Government's public communications strategy was devised by the First Minister. I had no disagreement with it whatsoever and was involved in implementing that strategy in part through my attendance at the daily media briefings but also in other areas to ensure that our consistency of message was carried through in other communication channels that we used.

347 The other key individuals involved in devising and implementing the public health communication strategy included the Chief Medical Officer, National Clinical Director and the Deputy First Minster. However, other public officials such as the Chief Constable of Police Scotland would attend media briefings, as did the Chief Nursing Officer.

348 I believe that the message promulgated about the Scottish Government's justification for its key strategic decisions was a fair and accurate reflection of the actual reasons for its decision making.

349 With regards to the SGCAG there were no restrictions placed on the publication of medical data and studies carried out by the individuals/bodies providing advice. Those providing evidence/data were asked for their permission before publishing. In some cases, data would also be redacted from publications where this was deemed to be at risk of being identifiable data, for example a low number of cases in a small geographic area.

350 To best of my knowledge there was no Scottish Government public health communication that went against expert medical or scientific advice. There were no major changes to the Scottish Government's public health messaging, although we

took opportunities to refine and further clarify our messages where that was appropriate.

351 The promotion of the importance of the vaccination and its potential to minimise the impact of the virus on those vaccinated was based on the clinical advice we received on the efficacy and safety of the vaccinations. Where there were concerns, for example with adult social care staff, we took specific steps with our partners to address those. Our approach was to provide opportunities for people to ask questions about the safety and efficacy of the vaccines and provide clinically correct responses.

352 In the Scottish Parliament and in the media briefings, I am aware that I used the phrases that the Scottish Government were "following" or being "guided by the science". I did so because they were accurate and because I agreed that the public needed to know the basis on which we were making our judgements and decisions.

353 From late January 2020, the Scottish Government worked closely with news organisations as well as partners (including Public Health Scotland, NHS Boards and Police Scotland) to promote online guidance on reducing transmission and to provide advice and support. From the start of March 2020 until the end of 2021, regular news conferences (also known as 'daily briefings') were arranged, usually led by the First Minister. The frequency of these varied, depending on infection rates. They were scheduled to complement Covid-19 ministerial updates to Parliament. These were televised live and streamed on Scottish Government social media channels with recordings posted subsequently. Written transcripts of the opening remarks were also prepared and published.

354 On 23 March 2020, the first lockdown was announced for the whole of the UK by the Prime Minister. However, the Scottish Government is elected by the people of Scotland and consequently in the circumstance of a national public emergency it was entirely appropriate for the First Minister to also address the people of Scotland.

355 Throughout Scottish Government public health communications, we included measures to make the messaging as accessible as possible to the public. This included provision of a British Sign Language interpreter at each of the daily press briefings. We also had the briefings published on the Scottish Government website. The Scottish Government also worked closely with NHS 24, Public Health Scotland and third sector partners to ensure key public health information on Covid-19 was available in multiple languages and accessible formats via the NHS Inform website. Materials were also co-created specific to various communities. For example, the Scottish Government

worked with the Scottish Public Health Network to create a bespoke version of Test and Protect information for the Gypsy/Traveller community. This was distributed by the Convention of Scottish Local Authorities (COSLA) to Gypsy/Traveller sites.

356 I do believe that we communicated well the territorial extent of our decisions and took pains to be clear about where the restrictions we were imposing applied, including where they differed within Scotland.

357 We were fortunate to benefit from the expertise and advice of Professor Steven Reicher from St Andrews University on behavioural science. At each discussion with the SGCAG, his views were sought on our communication strategy, our messaging and how the public may respond to any of the actions that we were taking. This included the different groups within the wider community. We further sought his advice on how best to present that advice. Having that behavioural science expertise was valuable and effective.

358 It can never be the case that every Government does everything perfectly all the time but overall, I do believe that the public health messaging from the Scottish Government was consistent and clear.

Effectiveness of messaging

359 A Covid-19 campaign tracker was set up in April 2020 to evaluate performance of marketing campaigns. Where appropriate this was supplemented with other data such as relevant website or social media analytics, calls to helplines, vaccine uptake and / or app downloads. Regular opinion polling was also conducted. Public access of key public health information on Covid-19 was continuously tracked using an online dashboard tracker for the NHS Inform Coronavirus Hub pages in English and in all translated languages and accessible formats.

360 At the start of 2021, weekly polling showed that 67% of adults aged over 18 in Scotland said they trusted the Scottish Government to deliver information on Covid-19. Although levels fluctuated during the pandemic, high levels of trust were consistently evident. As an example of the effectiveness of communications activity, among the 4.2 million people who had the opportunity to see or hear the original 'We Are Scotland' compliance campaign (June 2020), campaign evaluation research showed that 81% agreed that they found the advertising supportive and 79% claimed to take a relevant action as a result. The polling data and other analytics were used on an ongoing basis to fine tune campaign activity, including for particular audiences.

361 The daily television briefings were an effective method to communicate public health messaging to the public. I believe that the Scottish Government's key public health communications were very effective in securing public confidence and support in the steps that we were asking them to take.

Maintenance of public confidence

362 The publication of modelling data was sufficiently transparent and timely to explain the Scottish Government's strategic decisions in response to the pandemic to the public. The primary area of disinformation that concerned me was around safety and efficacy of the vaccination programme and the vaccines being deployed. This was particularly the case in the social care sector where social care staff were being targeted with disinformation. We took steps with the COSLA and Social Care to hold as many open forums via Zoom as were required that allowed social care staff to ask questions of our clinical advisors including from the Chief Medical Officers office and our National Clinical Director. In response to this, we saw a significant increase in uptake of the vaccine by adult social care workers.

363 Any breach of the restrictions or rules imposed by the Scottish Government by anyone in a position of responsibility was and remains, unacceptable. Whilst the public undoubtedly would be angry and disapproving of such a breach, any linked harm to public confidence would be minimised if action was swiftly taken to deal with any such breach.

364 The way in which you assess the impact of incidents such as those including the resignation of Catherine Calderwood from her role as CMO on 5 April 2020; the actions of Margaret Ferrier after travelling to Westminster whilst experiencing symptoms and attending the Westminster Parliament and then travelling home by train after a positive test and her subsequent prosecution; and the First Minister removing her face covering at a Wake in December 2020, is in terms of whether or not it noticeably affects public compliance with the restrictions you are asking of them. The Chief Medical Officer resigned her role very quickly after the incident was raised and I believe we saw no significant decrease in public compliance from that incident or from the incident involving the First Minister where she very quickly also explained what had happened, whilst offering no excuses and apologised. In the case of Ms Ferrier, both the First Minister and I were very clear that her behaviour was unacceptable. My personal view was that she should have resigned, and I find it regrettable that she chose not to do so.

365 Understandably public compliance was at its highest during the first lockdown period because the rules were very clear and in effect people were being asked to stay at home. Inevitably, where you start to differentiate the restrictions because you are trying to ease them in response to the data available, that can become less clear for individuals. For example, in practical terms it is not common knowledge amongst the vast majority of the population as to where their Local Government boundary is. It would therefore not be surprising that compliance reduced to an extent, but I do not believe that the reduction was significant. I am confident that the vast majority of the population in Scotland had the best of intentions to comply with the rules, and where there was failure to do it was largely not out of wilful intent. Undoubtedly that may have made the situation more difficult to police, but I have every confidence in Police Scotland's ability to deal with a range of situations. Of course, high profile breaches which occurred elsewhere in the UK did have an impact on the public's feeling about whether they should follow rules which others were ignoring.

Conclusions and lessons learned

366 I think the overall Scottish Government public health communications strategy was and remains the right one. It is entirely correct in my opinion for the decision makers to treat those affected by their decisions as competent, able adults and provide them with the information they need and to explain the rationale for each decision being taken. Overall, notwithstanding fluctuations, the levels of compliance throughout a long period of time with significant restrictions are testimony to the effectiveness of the overall strategy.

O. Public Health and Coronavirus Legislation and Regulations

Legislation

367 All proposed legislation would be brought to Cabinet for agreement by the Minister for Parliamentary Business, and legislation debates and discussions in the Chamber were led by Mr Michael Russell, who was the Cabinet Secretary for Constitution, External Affairs and Culture. I played a limited role as Cabinet Secretary for Health and Sport, for example in discussing the legislative consent motion for the Coronavirus Bill 2020 with the Health and Sport Committee on 24 March 2020 and discussing relevant provisions in the second Coronavirus (Scotland) Bill with key officials on 15 May 2020. I also met with the Deputy First Minister on 2 April 2020 to discuss the provisions in the UK bill and the easement of social care assessments.

368 I cannot comment on the detail of the development of the Coronavirus Bill 2020 and associated regulations insofar as they related to Scotland. However, I understand that

there was close liaison between the UK and Scottish Government drafting teams to ensure that there was an effective relationship between this UK legislation and the measures required to be passed by the Scottish Parliament. I cannot comment on the role of the Office of the Secretary of State for Scotland in this regard as I was not directly involved in this process.

369 I am aware that emergency procedures were used for making and amending legislation during the pandemic, including for the passage of the Coronavirus (Scotland) Act 2020. Emergency procedures were used due to the urgent nature of the measures required and their use was agreed by the Scottish Parliament. Inevitably the pace with which decisions were required did not permit the level of debate and scrutiny that is normal in the Scottish Parliament. I believe colleague MSPs across the Parliament understood and appreciated this and I know that Mr
Russell and lead Minister in this area was in frequent contact and dialogue with opposition members to answer their questions and concerns. I had regular direct contact with Opposition Health and Social Care spokespeople and direct written contact on a frequent basis with MSPs in addition to statements and questions in the chamber.

370 I understand that the made affirmative procedure was used to make health protection regulations throughout the pandemic. I understand that in total 74 Covid-19 health protection regulations (SSIs) followed the 'made affirmative' procedure. Of these 'made affirmative' SSIs, 4 were revoked before they went to a Parliamentary vote and of the 70 SSIs which went to a Parliamentary vote, all were approved by the Parliament. Further information has been supplied in the corporate statement relating to legislation provided by the DG Strategy and External Affairs in June 2023.
All of these matters were the primary responsibility of Mr Russell.

371 Advice on the use of the made affirmative and emergency bill procedures would have been provided by SG officials and Parliamentary officials. The made affirmative and emergency bill procedures are both set out in the Scottish Parliament's Standing Orders [JF2/026 - INQ000280691]. Both procedures have the effect of shortening the time available for debate and scrutiny, however, those opportunities still exist – in particular, Stage 2 of an Emergency Bill must be taken by a Committee of the Whole Parliament. Concerns were expressed by members of the Scottish Parliament during the process of debate surrounding the use of emergency procedures, noting that the time available for debate and scrutiny was limited. The Scottish Government response was to maximise the time available within the Parliamentary Standing Orders for these

procedures, noting the urgent requirement for measures to be in place to support the management of the pandemic. For further information on these matters, and on how the devolution settlement affected the enactment of the legislation, I would refer you to the Cabinet Secretary for Constitution and External Affairs, who led these discussions at the time.

372 The process adopted for the review and scrutiny of the Coronavirus (Scotland) Act 2020 and associated regulations are set out in the Act. These set out that Scottish Ministers were legally obliged to review the need for restrictions and requirements contained in regulations at least every 21 days. There was also a legal duty for Ministers to terminate a restriction/requirement as soon as it was considered no longer necessary to the public health response to the virus. For my specific interests in respect of health and social care, there would be a regular request from Mr Russell for my view on whether any relevant restriction/requirement could be terminated. Such requests and my responses will be recorded. The Act itself automatically expired on 30 September 2020, with extension for two periods of six months only to be done with the approval of the Scottish Parliament. In addition, ministers offered a two-monthly review of the operation of the legislation. At the time I left office, the Sixth of these Reports had recently been delivered, although it was not possible to lay this in Parliament due to the pre-election recess. However, the Fifth Report in February 2021 was accompanied by a ministerial statement by the Cabinet Secretary for Constitution and External Affairs Mike Russell. I am not aware why the procedure for these reports' changes subsequently, or of any concerns raised in this regard.

373 My understanding is that the decision that public health legislation should be used as the legal framework governing the UK Government's response to Covid-19 rather than the legislative framework of the Civil Contingencies Act 2004 would have been for the UK Government.

374 My understanding is that the relevant equality impact assessments were completed and have been provided to the Inquiry. As Cabinet Secretary for Health and Sport I was only directly aware of those relating to my portfolio. For example, the Equality and Fairer Scotland Duty Impact Assessment, covers the three pillars that comprise Test and Protect: testing; contact tracing; and support for isolation was undertaken and published which set out the Scottish Government's assessment of the potential differential impact of aspects of Test and Protect across groups with protected characteristics [JF2/020 - INQ000147449]. Due to the emergency introduction of Shielding, an Equality Impact Assessment (EQIA) could not be carried out in advance.

However, an interim EQIA of the support required by people who were at clinically highest risk of severe illness was carried out at the beginning of April 2020. A retrospective EQIA was carried out as a follow up to the interim report from April 2020 [JF2/021 - INQ000147447].

375 However, I understand that the Scottish Government's Equality, Inclusion and Human Rights Directorate scrutinised draft legislative provisions for Covid-19 for potential Equality and Human Rights impacts from March 2020 and submitted advice to ensure that that particular groups were not disproportionately impacted. In December 2020, the Scottish Government published the evidence gathered for the Equality and Fairer Scotland Impact Assessment for the latest edition of Scotland's Route Map [JF2/016 - INQ000182799]. This states that "*Where any negative impacts have been identified, we have sought to mitigate / eliminate these. We are*
also mindful that the equality duty is not just about negating or mitigating negative impacts, as we also have a positive duty to promote equality. We have sought to do this through provisions contained in the Regulations, or by the range of support and guidance available".

376 Regulations were accompanied by online guidance which was updated in response from stakeholders and the public around the impact of the regulations for vulnerable groups. Where necessary, the underlying legislation was also adapted in response. For example, the Coronavirus (Scotland) (No 2) Act 2020 added a requirement for Ministers to take account of information on domestic abuse and to report on the nature and number of instances of domestic abuse occurring during the reporting period. This was to ensure that the specific impact of the pandemic on those experiencing domestic abuse was considered. In addition, there were exemptions to specific provisions in the Covid-19 Health Protection Regulations. For example, the requirement to wear a face covering indoors was subject to exemptions, including relating to funerals. Similarly, the restrictions on indoor public gatherings in a Level 4 area did not apply where the gathering was for certain purposes, including for the purpose of childcare and for gatherings relating to a funeral. In terms of a 'reasonable excuse' for travel from November 2020, the regulations included examples of reasonable excuses including accessing, providing or receiving childcare, visiting a person receiving treatment in a hospital or who is residing in a hospice or care home, participating in shared parenting arrangements, and attending a gathering relating to a funeral or to travel for compassionate reasons which relate to the end of a person's life.

Enforcement

377 I do not recall any concerns raised by or with the Scottish Government about how to explain clearly and effectively to the public the difference between restrictions that weren't legally enforceable and rules that were. I recall the Chief Constable explaining clearly the approach of Police Scotland, which was "Inform, Educate, Enforce". The Chief Constable attended the daily media briefings on occasion to explain/reinforce that approach and answer any questions pertaining to it.

378 Cabinet discussions would consider concerns raised surrounding enforcement of NPIs and proposed penalties but through the Cabinet Secretary for Justice. Cabinet was clear in the approach that Police Scotland intended to take in any cases of breaches of restrictions or rules as discussed in the preceding paragraph. The Chief Constable used his attendance at the daily media briefings to reinforce that, so the wider public understood the approach taken.

379 In terms of health, I do not believe that the timeliness of legislation and regulations had any impact on us issuing guidance on health and adult social care.

380 The enforcement of regulations and the adoption and operation of criminal sanctions were not within my portfolio as Cabinet Secretary for Health and Sport. For this reason, I cannot give any information on the choice of criminal sanctions, consultation with the police, COPFS or the Scottish Courts and Tribunals Service, any concerns raised with the Scottish Government, or what consideration was given to the impact on at-risk, vulnerable or people with protected characteristics. I am not aware of the degree to which the powers given to the police in Scotland differed from those elsewhere in the United Kingdom. Neither can I give details of the use of data or behavioural modelling and its source or the overall approach to the assessment of proportionality and the impact of the sanctions. For more details on these issues, I would refer to you to the Cabinet Secretary for Justice and the corporate statement provided in June 2023 by DG Education and Justice relating to Justice matters.

Lessons learned regarding Regulations and Enforcement

381 I do not have any comment to make in relation to the public health and coronavirus legislation and regulations in regards to key areas which worked well, and any key issues, obstacles or missed opportunities. For comment on these matters, I would refer you to the Cabinet Secretary for Justice.

P. Key Challenges and lessons learned

382 Transcripts and evidence that I provided to the Scottish Parliament have been provided to the Inquiry with this statement. I gave evidence to the Scottish Affairs Committee of the UK Parliament on 11 June 2020 and this has been provided to the Inquiry with this statement.

383 I do not have any further comments or recommendations to add in relation to improving the Scottish Government's response to a future pandemic, over and above what I have outlined in my preceding statement.

Statement of Truth

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

Personal Data

Signed: ________________________

Dated 16 November 2023