Witness Name: Nicola Sturgeon
Statement No.: 4
Exhibits: NS4
Dated: 06 November 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF NICOLA STURGEON

In relation to the issues raised by the Rule 9 request reference M2A/NS/01 dated 28 July 2023 in connection with Module 2A, I, Nicola Sturgeon, will say as follows: -

1. I am Nicola Sturgeon of the Scottish Parliament, Edinburgh EH99 1SP. I am currently the Member of the Scottish Parliament for Glasgow Southside. I was appointed First Minister of Scotland by Her Late Majesty Queen Elizabeth on 20 November 2014, on the nomination of the Scottish Parliament. I held office as First Minister from then until 28 March 2023. I am also a Privy Counsellor.

2. This witness statement relates to the matters addressed by the Inquiry's Module 2A, which is considering the Scottish Government's core political and administrative decision-making in response to the Covid-19 pandemic between 21 January 2020 and 30 April 2022 ("the specified period"), when the remaining Covid-19 restrictions were lifted in Scotland. The headings and structure of the statement are as specified in the Inquiry's Rule 9 Request.

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

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

5. References to exhibits in this statement are in the form [NS4/Number - INQ000000].

PART A – DECISION MAKING STRUCTURES

My roles and responsibilities

6. I held office as First Minister throughout the period from January 2020 to April 2022. As First Minister during that period, I was head of the Scottish Government and so had overall responsibility for our pandemic response, and for engagement with the UK Government and other devolved administrations. However, in keeping with the principle and practice of Cabinet government, I exercised that responsibility on occasion and where appropriate through delegation to ministers.

7. I was previously Deputy First Minister and Cabinet Secretary for Health in the Scottish Government, from 17 May 2007 to 19 May 2011, Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy from 19 May 2011 to 5 September 2012 and then Deputy First Minister and Cabinet Secretary for Infrastructure, Capital Investment and Cities from 5 September 2012 to 19 November 2014.

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

8. A detailed explanation of the decision-making governance in Scotland is set out in the Scottish Government's corporate witness statements, most notably that of the Director General for Strategy & External Affairs statement dated 22 June 2022 [NS4/001 - INQ000215495]. I will not duplicate that material here – instead what follows is an overview. The main Scottish Government decision making body was the Scottish Cabinet. I chaired weekly meetings of the Cabinet. Discussions at meetings

of the Cabinet, which were attended by the Chief Medical Officer for Scotland (CMO), enabled a shared understanding to be developed amongst Cabinet Secretaries about the epidemiology of the pandemic, its multiple impacts and the effects and consequences of potential interventions. Informed by this understanding, Cabinet set our overall approach and took the strategic decisions, including in relation to non-pharmaceutical interventions (both regulations and guidance). In general, a Cabinet paper setting out options for such decisions would be tabled by the Deputy First Minister (though I would usually be personally involved at the drafting stage of such papers to help frame the options that Cabinet would consider). Following discussion of the paper and consideration of the options, Cabinet would reach its conclusions. On occasion it would delegate decisions on points of detail to me. In reaching these decisions, I would take account of the views expressed at Cabinet and consider the advice of officials, as well as clinical and other expert advisers. Cabinet minutes and papers, which have been provided to the Inquiry, will record the decisions taken, the basis of these and the occasions on which there was delegation of any decisions to me. Decisions that involved regulations were then subject to parliamentary approval. I also attended – and usually chaired – Ministerial meetings of the Scottish Government Resilience Room (SGORR (M)). These were attended, as necessary, by other Cabinet Secretaries and Ministers, officials, and clinical and other advisers. As the pandemic progressed, SGORR (M) would also be attended by partner responders, including local government and Police Scotland. Whereas Cabinet took the strategic decisions and set the approach, SGORR (M) was focused on the operational aspects of our response. I also had regular discussions with ministers, officials and advisers in what we referred to as 'Gold' meetings or in Deep Dive' sessions (the latter sometimes arranged by the Scottish Government Covid-19 Advisory Group (C19AG) to be briefed on data and modelling and consider different aspects of our pandemic response – however, any decisions requiring to be made from these discussions would routinely be taken by Cabinet; indeed discussions in 'Gold' meetings were often convened to help shape the options that Cabinet would consider. In addition to participation in Scottish Government bodies, I took part in intergovernmental meetings with the UK Government on Covid-19 throughout the period covered by the Inquiry to understand and, where possible, influence relevant UK Government decision-making and to share relevant information about the pandemic in Scotland and the Scottish Government's assessments, decisions, and actions in response. These included meetings convened by the Cabinet Office through the Cabinet Office Briefing Room (COBR). I did not take part in UK Government Cabinet or other internal meetings. A list of decision-making

committees, groups and forums dealing with the UK Government's response to Covid-19 that I attended between January 2020 and February 2022 – including a detailed timeline – is included in the supporting evidence for this statement [NS4/002 - INQ000130883]. Where the Scottish Government holds papers for these meetings, I understand they have already been provided to the Inquiry. Any briefing provided to me ahead of these meetings would have been provided by Scottish Government officials, it may have included papers issued by UK Government. As these meetings were usually set up by the UK Government, they should be able to provide a record of who was in attendance. I cover in later sections of this statement engagement with the UK Government.

9. The Scottish Government's objective was to protect as far as possible the Scottish population from the harms of Covid-19 and minimise the loss of life. A key part of that, especially in the initial phases, was ensuring that the NHS didn't become overwhelmed and therefore be unable to care for those with Covid and other urgent and life-threatening conditions. Initially, our objective required what I will describe for shorthand as the 'blunt' instrument of lockdown. As the pandemic progressed, the Scottish Government continued to take very seriously the importance of minimising the direct health harm of the virus and this led us to take a measured, and cautious approach to easing and, at times, re-introducing restrictions. However, we were also acutely aware of the social, economic, and wider health harms of Non Pharmaceutical Interventions (NPIs) and this – together with developing knowledge about the characteristics of the virus and later the availability of treatments and vaccines – led us to pursue the same objective through what became known as our Four Harms approach, which involved a sophisticated balancing of conflicting harms to reach decisions that minimised overall harm. The approach and principles which guided our political and administrative decision making were summarised in 'Covid-19 A Framework for Decision Making' published by the Scottish Government on 23 April 2020 [NS4/003-INQ000131025] as follows:

APPROACH

- SUPPRESS the virus through compliance with physical distancing and hygiene measures, ensuring that the reproduction number remains below 1 and that our NHS remains within capacity.
- CARE for those who need it, whether infected by the virus or not.
- SUPPORT people, businesses and organisations affected by the crisis.

- RECOVER to a new normal, carefully easing restrictions when safe to do so while maintaining necessary measures and ensuring that transmission remains controlled, supported by developments in medicine and technology.
- PROTECT against this and future pandemics, including through effective testing, contact tracing and isolation.
- RENEW our country, building a fairer and more sustainable economy and society.

PRINCIPLES

- SAFE: to ensure that transmission of the virus remains suppressed and that the NHS and care services are not overwhelmed.
- LAWFUL: to respect the rule of law which will include ensuring that any restrictions are justified, necessary and proportionate.
- EVIDENCE-BASED: to use the best available evidence and analysis.
- FAIR & ETHICAL: to uphold the principles of human dignity, autonomy, respect, and equality.
- CLEAR: to provide clarity to the public to enable compliance, engagement, and accountability.
- REALISTIC: to consider the viability and effectiveness of options.
- COLLECTIVE: to work with partners and stakeholders, including the UK government and other devolved nations, ensuring that we meet the specific needs of Scotland.

10. As head of the Scottish Government, I was responsible for the overall development, implementation, and presentation of the administration's policies and for promoting and representing Scotland at home and overseas. In the context of the Covid-19 pandemic, this meant that I bore overall responsibility for the decisions of the Scottish Government in responding to it, albeit that I did not personally take every decision. I also had principal responsibility for communicating to the public the Scottish Government's understanding of the virus, the decisions we were taking in response and what we were asking the public to do and not to do. I was provided with advice, evidence and information by a broad range of individuals and organisations, including civil servants across the policy areas that the Scottish Government is responsible for, but especially health, education, the economy, justice and strategy and external affairs; the Chief Medical Officer (CMO); the National Clinical Director (NCD); the Chief Nursing Officer (CNO); the Chief Social Policy Adviser (CSPA); the Chief

Scientist for Health (CSH); the Chief Economist; the Chief Statistician; National Records of Scotland; Public Health Scotland; and the Scottish Government Covid-19 Advisory Group. I have described the role of the Scottish Cabinet in paragraph 8.

11. While I had overall and ultimate responsibility for all Scottish Government decisions, I exercised that responsibility on occasion and where appropriate through delegation to ministers, which is in keeping with the principle and practice of Cabinet government. The Cabinet Secretaries and ministers appointed by me had responsibility within their own portfolios for operationalizing the decisions of Cabinet; taking decisions that did not require Cabinet approval; engaging with counterparts in the UK government and other devolved administrations; and communicating with stakeholders. As well as his portfolio responsibilities – which in the specified period were Education & Skills (up until May 2021) and Covid Recovery (from May 2021) – the Deputy First Minister (DFM) had responsibility for resilience matters and assisted me in matters that were strategic or cross government. Civil servants and special advisers provided the briefing and advice that enabled me and other Ministers to take the required decisions and communicate these to the public. A full list of Cabinet Secretaries, Ministers, civil servants, and special advisers who were in post during the specified period has been provided to the Inquiry [NS4/004 - INQ000131090]– however, those I engaged most closely with included: DFM (John Swinney), Cabinet Secretary for Health & Sport (Jeane Freeman), CMO (Dr Catherine Calderwood and later Professor Sir Gregor Smith), NCD (Jason Leitch), CNO (Professor Fiona MacQueen until January 2021 and thereafter from February to August 2021, Professor Amanda Croft, and from August 2021 until the end of the specified period, Professor Alex MacMahon); Director General for Strategy & External Affairs (Ken Thomson), Director, Strategy (Dominic Munro), Special Advisers (Liz Lloyd, Davie Hutchison, Colin McAllister). The Office of the Secretary of State for Scotland played no role in the Scottish Government's handling of the pandemic.

12. I worked very closely with the then DFM, John Swinney and had regular communication with him. There was a range of formal meetings that we both attended, including Cabinet, SGORR (M), 'Gold' meetings and Deep Dive sessions – which due to remote working were usually on Teams or Zoom - and we also spoke regularly by telephone. Formal meetings were scheduled but informal calls would take place on an unscheduled basis.

13. In addition to the formal meetings we attended, either in person or on Teams/Zoom, the DFM and I communicated by telephone. This was our principal means of informal communication. We also used text messages, but only occasionally. We did not use WhatsApp or any other messaging platform. Our informal discussions were in the main discursive not decision making. We would discuss how the pandemic was progressing and 'chew over' the challenges we were grappling with and the options open to us. However, other than in the very early phase of the pandemic when some decisions required to be taken at extreme speed, our informal discussions would not result in decisions being taken. Decisions were taken in formal meetings. Decisions taken are recorded as part of the Scottish Government corporate record.

14. I worked very closely with the then Cabinet Secretary for Health & Sport, Jeane Freeman, until her departure from government in May 2021. My communications with her, especially during 2020, were daily, often several times a day. We were amongst a relatively small number of people who were not working remotely but from St Andrew's House, the Scottish Government HQ in Edinburgh, so most of our communication was face to face, and we often met face to face multiple times per day. Ms Freeman attended Cabinet, SGORR (M) and many of the 'Gold' meetings and Deep Dive sessions I referred to earlier. In addition to these meetings, our main scheduled discussions were in the mornings – usually sometime between 10 and 11.30am. At these meetings, we would discuss the daily data, the latest epidemiology and progress of the pandemic, and any operational issues that required attention. These meetings would also consider the messages that we thought it important to communicate at the daily media briefing, which would follow around midday and at which Ms Freeman regularly accompanied me. These meetings would also be joined by whichever clinician was attending the media briefing that day – in the initial weeks that was always the CMO and thereafter it would be either the CMO, a Deputy CMO, the CNO or the NCD. A Scottish Government official and a special adviser would also be present at these meetings. We would meet again immediately after the media briefing to discuss any issues that had been raised and ensure appropriate action was being taken.

15. Although Ms Freeman and I met mainly in person, or on Teams/Zoom meetings, we also communicated by telephone and occasionally by text. We used no other messaging platform. Informal calls and discussions would mainly be general discussions about the state of the pandemic, issues of concern, and updates on operational matters.

16. I worked closely with the Cabinet Secretary for Health and Social Care, Humza Yousaf in the period between May 2021 and April 2022 (he took up the post following the Scottish Elections in May 2021. Ms Freeman stood down as an MSP at this point in time). Given the state of the pandemic in that period, the rhythm of meetings related to it was less intense than it had been with his predecessor. We would engage mainly through Cabinet and SGORR (M) meetings, and in Deep Dive type sessions on topics including vaccine delivery and, increasingly, NHS recovery.

17. As well as face to face, or Teams/Zoom type meetings, Mr Yousaf and I would also communicate by telephone and through WhatsApp. We did not use any other messaging platform. Informal calls and discussions would be mainly follow-ups to decisions made in formal settings and updates on operational matters.

18. I engaged regularly with all Cabinet Secretaries through Cabinet and SGORR meetings. Engagement with and day to day allocation of tasks to junior ministers was the responsibility of their Cabinet Secretaries. In addition to the DFM and Cabinet Secretary for Health & Sport, I worked most closely with the Cabinet Secretary for Finance (from May 2021, she was Cabinet Secretary for Finance and Economy), Kate Forbes, and the Cabinet Secretary for Economy, Fair Work and Culture (until May 2021), Fiona Hyslop. This engagement was mainly through formal meetings – from March 2020 until August 2020 I chaired a weekly meeting focused on the economic impacts of the pandemic which was attended by both. It was not my practice to use text or any other messaging platform with them. I also worked closely with the CMO, Dr Catherine Calderwood and later Professor Sir Gregor Smith, the CNO, Fiona Macqueen, and the NCD, Jason Leitch. These meetings were mainly face to face or on Teams/Zoom, although we would also have had occasional communication on the telephone. I did not hold a mobile phone number for Fiona MacQueen at any time and have set out in my statement in response to the Inquiry's additional Rule 9 request received on 30 October 2023, the occasional text and WhatsApp messages I had with Drs Calderwood and Smith and Professor Leitch respectively. I have also submitted some private social media messages between me and Professor Leitch. I worked closely with certain special advisers (though special advisers are not decision-makers) – these were my Chief of Staff (until May 2021) Liz Lloyd, Davie Hutchison, and Colin McAllister. At least one of them would attend Cabinet, SGORR (M), COBR (M) and other 4 Nations meetings. At least one would also attend 'Deep Dive' sessions and my morning meetings with Ms Freeman. They

tended to work in St Andrew's House so interactions would mainly be face to face, though they would also participate in Teams/Zoom meetings. I would also communicate by telephone, mainly with Liz Lloyd, and have submitted copies of WhatsApp messages between her and I. We used no other messaging platforms.

19. I do not have notebooks or diaries containing any information relating to the pandemic. I did not retain messages with other individuals during this time (January 2020 to April 2022) as any issues of substance would have been passed on or recorded in other ways, by my private office issuing an email to the relevant officials or policy area. I have set out more detail in my response to the additional Rule 9 request received on 30 October 2023. I have submitted any messages – or copies thereof – that I do hold. It is possible that others hold messages from me which will be passed to the Inquiry – and if so, I will be happy to answer any questions about these.

20. As is normal within government, several of the ministers who were key decision makers, and their advisers, have known each other for many years and so have personal as well as professional relationships. However, the working environment within the Scottish Government in general and during the pandemic in particular was always professional, serious, and formal – for example, titles such as First Minister, Deputy First Minister, Cabinet Secretary would be used in meetings, not first names. And while the working environment was collegiate, it was also appropriately challenging.

21. The personal relationships that existed within government did not affect the way the Scottish Government managed the pandemic or the efficacy of its response.

22. I have been asked about the efficacy of key decision-making and advisory structures. In my opinion, these generally worked well. However, they developed and improved as the pandemic progressed. I would highlight two aspects that needed to be, and were, improved. Firstly, due to the sheer pace of decision making that was required in the early phase of the pandemic and the limitations of the scientific evidence base at first, these structures were initially more ad hoc than would otherwise have been the case. However, this changed with the development of the Scottish Government's Four Harms approach and the decision-making process which was put in place to support this (the corporate statement of 22 June 2023 from the Director General for Strategy & External Affairs statement describes this in detail [NS4/001-INQ000215495]. Second, as I set out in my Module 2 statement [NS4/005 -

INQ000235213], while the quality of advice provided by SAGE was extremely high, I was concerned that the advice was not sufficiently specific to Scottish circumstances, and that I did not have the opportunity to engage directly with and ask questions of its members. For that reason, in March 2020, I asked the then Chief Medical Officer for Scotland, Dr Catherine Calderwood, to establish the Scottish Government Covid-19 Advisory Group (C19AG).

Informal Decision Making and Communication

23. Subject to my reflections later in this answer about March 2020, it is the case that key decisions about the Scottish Government's response to the pandemic were made in formal meetings – there was a high degree of formality in all our decision making. Strategic decisions would be made by Cabinet and more operational ones by SGORR. These decisions would often be informed by discussions in 'Gold' meetings or Deep Dive sessions. In March and early April 2020, some key decisions were taken on a four nations basis at COBR. A timeline of key political decisions is attached [NS4/006 - INQ000131055]. During March 2020, the sheer pace and nature of decision-making meant that some decisions were taken in less formal meetings, convened at short notice, between me and key ministers/advisers, most notably the DFM, Cabinet Secretary for Health & Sport, and the Chief Medical Officer. While these would in the main be face to face meetings, there would also have been telephone calls. Text messaging, while possible, would have been the exception. Although these decisions were taken out with formal structures, they were communicated quickly afterwards to Parliament. Indeed, over the course of March 2020, I updated Parliament through First Minister's Questions or statements on five occasions and other Cabinet Secretaries/ministers did so on ten occasions. Examples of key decisions which fall into this less formal category include: (i) the decision to cancel mass gatherings of more than 500 people was taken by the Cabinet Secretary for Health & Sport and I, with input from the Chief Medical Officer, on the morning of 12 March 2020 – I told Parliament during First Minister's Questions at noon that day that we were minded to do so, subject to views of the other UK governments at a COBR (M) meeting that afternoon, and the Cabinet Secretary for Health & Sport confirmed the decision to Parliament that afternoon; (ii) the decision to close schools from Friday 20 March 2020 was taken by me and the DFM, with input from the Chief Medical Officer, on 18 March 2020 and the DFM made a statement to Parliament on 19 March 2020.

24. The approach to recording and minuting Scottish Government meetings is set out at paragraph 63 of the corporate statement submitted by the Director General Corporate on 23 June 2023 [NS4/007 - INQ000215474] as follows:

"In accordance with the Scottish Government's Record Management Plan and Information Management Principles, decisions made by both Ministers and officials which form part of the Scottish Government corporate record are recorded. In addition, governance group meetings will normally have a formal minute taken and a note of any actions arising from the meeting. The minute will provide a collective summary of the discussion which took place at the meeting, and record key decisions and actions. Other types of meetings will not necessarily have a formal minute, if there are actions arising from the meeting or decisions taken at the meeting then it is usual for these to be recorded. In responding to the Covid-19 pandemic, the Scottish Government was acting at pace with many meetings convened at short notice and actions being commissioned in real time, a record may therefore not exist. Generally, meetings within Scottish Government are not recorded either verbatim or via digital recordings. "

By their ad hoc and often short notice nature, particularly in the fast-moving situation we faced in the early phases of the pandemic, not all informal meetings that I took part in were recorded, and unless they gave rise to decisions that required to be actioned (which subject to the examples cited in the preceding answer about March 2020 would not usually be the case) they would not routinely be minuted.

25. The only messaging platforms I used were text messages and WhatsApp. However, I did not use either to a significant extent in relation to the pandemic response, and certainly not to make decisions. I was working in St Andrew's House on a daily basis as were some of the colleagues that I worked most closely with i.e. the Cabinet Secretary for Health & Sport and the Chief Medical Officer – so even when in March 2020 (as I set out in paragraph 23) some decisions were taken out with formal structures, this tended to be in face to face discussions. I would, of course, send messages on occasion to my private office seeking information or feeding in views, or to special advisers (mostly Liz Lloyd) asking them to do so on my behalf, and I then relied on my private office to action these requests which I understand they would do by email. I have set out in my response to the additional Rule 9 statement received on 30 October 2023, detail of those I would have exchanged occasional text or WhatsApp messages with – anything of significance that required action would be

raised at formal meetings and recorded appropriately. The Scottish Government's policy on the use of messaging platforms was set out at paragraph 66 of the DG Corporate statement [NS4/007 - INQ000215474] as follows, and I believe I complied with this:

"To support the delivery of business the use of messaging applications such as 'text' or 'WhatsApp' is permitted. These applications are used for the quick exchange of information. There is Scottish Government guidance on the use of such applications, which requires key points and any decision to be recorded in an email or text document and saved in eRDM. "

26. I did not retain WhatsApp or text messages. However, I believe that the Scottish Government policy set out in the preceding paragraph was complied with.

27. There were no meetings between core decisions makers, including my counterparts in the UK government and other devolved administrations, that I would have had an expectation of being invited to which I was not party.

28. I have been asked to explain the mechanics by which significant meetings were conducted and will do so by reference to the two most significant Scottish Government bodies in relation to the pandemic – the Cabinet and SGORR. As First Minister, I agreed the agenda for Cabinet and chaired meetings. Papers were prepared and circulated in advance – the papers inviting key or strategic decisions in relation to the pandemic were usually submitted in the name of the DFM. Other Cabinet Secretaries would submit papers as necessary on specific aspects of the pandemic response within their portfolio responsibilities. I and Cabinet Secretaries would be provided with – or request – supporting briefing as required. During the pandemic, I would invite the CMO to update Cabinet at the start of the meeting on the latest data and epidemiology and this would inform the decisions Cabinet was being asked to take. Discussions would be free, and frank and all Cabinet Secretaries would be invited to contribute their views and ask questions as they wished. Decisions at Cabinet are arrived at collectively – there were never any votes taken in relation to the pandemic – and at the conclusion of the discussion, I would summarise the decisions we had arrived at. Minutes of cabinet meetings were prepared and circulated in the normal manner. I would also – on most occasions – chair meetings of SGORR (M) and agree the agenda in advance. However, I would ask a senior SGORR official to facilitate the meeting by ensuring that the right people

from within the Scottish Government or from partners such as COSLA or Police Scotland were called upon to give updates on the key matters under discussion. Action points would be circulated following the meetings. In the context of the pandemic, key decisions taken at Cabinet or SGORR would be quickly communicated to the public through parliamentary statements/process or media briefings.

29. Meetings would be recorded by officials in attendance and a minute or note giving a sense of the issues discussed and conclusions reached would be circulated and retained on corporate systems. Meetings were not routinely recorded verbatim or digitally.

30. Subject to my comments in paragraph 23, I am not aware of significant decisions being taken at side or informal meetings. It is, of course, the case that some meetings would have more informal or ad hoc structures and membership than, say, Cabinet or SGORR meetings. However, where such meetings discussed issues of significance or took decisions, they would have been considered formal meetings and recorded appropriately.

31. Again, subject to my comments in paragraph 24, any meetings that were significant in that they took decisions or resulted in action would have been considered formal and recorded appropriately. Any meetings that were genuinely informal would by their nature not be recorded and so there is not a list of them.

32. I was not party to any WhatsApp (or any other messaging platform) groups in relation to the Scottish Government's pandemic response. I am aware that there was a 4 Nations' Health Ministers group and a 4 Nations' CMO group, and there may have been others involving ministers and officials, but I was not part of these.

33. I am not aware of key communications that were not recorded in line with Scottish Government policies on Records Management and Mobile Messaging Apps.

34. The Scottish Government has policies on records management and the use of mobile messaging apps that governed and guided internal communication, messaging, and data retention, and which have been provided to the Inquiry [NS4/008 - INQ000131068 and NS4/009 - INQ000131069]. I am not aware of these policies not being adhered to in general or in the case of my communications.

35. I am not aware of any identifiable gaps in the use of the Scottish Government's Electronic Document & Records Management System.

36. I do not believe that the use of informal communication affected the efficacy of the Scottish Government's decision making or on the proper recording of decisions (subject to my comments in paragraph 24).

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

37. I address these matters in my Module 2 statement [NS4/005 - INQ000235213] and they are also covered fully in the corporate statement of the Director General Strategy & External Affairs provided on 22 June 2023 [NS4/001-INQ000215495]

38. Following the establishment of the Scottish Parliament (and Welsh and Northern Irish legislatures) in 1999, a Memorandum of Understanding and supplementary concordats established arrangements for liaison and dispute resolution between the UK government and the Devolved Administrations (DAs). The institutional structure put in place at this time to support these arrangements was the Joint Ministerial Committee (JMC) which existed in different formats. The plenary format was chaired by the Prime Minister and attended by the heads of government of the DAs. The JMC was intended to be a liaison, rather than decision making body. In my experience, it was not effective. Indeed, in my years as First Minister it rarely met, and did not meet at all between January 2020 and April 2022. In practice, meetings happened only at the will of the Prime Minister of the time and respective Prime Ministers have been reluctant to convene it. A review of Intergovernmental Relations was commissioned by the heads of the four governments in 2018. The outcome of this review was published in January 2022. It remains to be seen whether the new three tier structure that has been put in place will be any more effective than the JMC arrangements it replaces. In addition to the JMC structure, and now its replacement, there is extensive day to day engagement between the four governments, both bilaterally and multilaterally, on a range of devolved and reserved matters.

39. In general terms, the allocation of roles and responsibilities between the UK government and the Scottish Government was already established under the

devolution settlement. There was no process at the outset of the pandemic to allocate roles differently. However, certain mechanisms were utilized or created at the start of the pandemic to support joint working, co-ordination and communication between the UK government and the DAs. The corporate statement of the DG SEA [NS4/001-INQ000215495] describes three broad phases of interaction, which I think encapsulates the general situation well. These were:

Phase 1: Pre-2020 liaison on contingency planning and preparations largely through Heath and Resilience channels

Phase 2: January to May 2020. Engagement on the initial response, primarily through Resilience and Health liaison mechanisms including the Cabinet Office Briefing Rooms (COBR), and then from March to May intense engagement including through Ministerial Implementation Groups – UK Government committees that were set up and to which in some cases devolved governments sent Ministerial participants.

Phase 3: June 2020 to April 2022. Formal and informal official and ministerial engagement mainstreamed into the four governments' handling of the response to the pandemic and planning for recovery.

40. The inter-governmental structures I participated in were, in phase 2 and occasionally in phase 3, COBR and, in phase 3, the Chancellor of the Duchy of Lancaster (CDL)/Heads of DA calls. In addition, Scottish Government Cabinet Secretaries and Ministers participated in Ministerial Implementation Group (MIGs) meetings. At the end of May 2020, the UK government replaced MIGs with a Covid-19 Strategy Committee (Covid-S) chaired by the Prime Minister and a Covid-19 Operations Committee (Covid-O) chaired by the CDL. Covid-O and Covid-S were internal UK government bodies and, with the exception of Covid-O on international travel, the Scottish Government was not invited to participate in these. In addition to the formal, over-arching structures, Scottish Government Cabinet Secretaries, Ministers, and officials also engaged directly with counterparts in the UK government and DAs on specific strands of the pandemic response, such as testing, PPE and vaccine development, procurement, and deployment. There was regular 4 Nation Health Minister calls and also regular calls between the 4 UK CMOs. There was also extensive interaction at civil service level including, from April 2020, regular calls chaired by the secretary to the UK Cabinet, in which the Permanent Secretary to the Scottish Government participated.

41. The Scottish Government also benefited from the expertise of a range of UK advisory bodies, including the Scientific Advisory Group for Emergencies (SAGE), the Scientific Pandemic Influenza Group on Modelling (SPI-M), the Scientific Pandemic Insights Group on Behaviours (SPI-B), the Joint Committee on Vaccination & Immunisation (JCVI), the Joint Biosecurity Centre (JBC) and the UK Health Security Agency (UKHSA).

42. The various arrangements summarised above and set out more fully in the corporate statement provided by DG SEA in June 2023 [NS4/001-INQ000215495] worked with varying degrees of effectiveness over the course of the pandemic. In my view, this was not due to the strength or otherwise of the structural arrangements, but to the culture and mindset that the different governments brought to bear and the levels of trust and mutual respect that existed between us. The extent to which the Scottish Government understood when and why the UK government was taking steps in its management of the pandemic varied. I will expand on this over the course of my statement but, in summary, there was a reasonably good understanding in the very early phase – March/April 2020 – but this reduced as the pandemic progressed. It is also the case that on some matters – for example, international travel, the easing/re-introduction of NPIs, the timespan of furlough, Eat Out to Help Out – the issue wasn't that we didn't understand UK government actions, but that on some occasions we didn't agree with them. In the interests of balance, I appreciate that the UK government may say the same about certain decisions the Scottish Government took.

43. I agree with comments made by John Swinney that around the time of the onset of the pandemic, the relationships between the UK and Scottish Governments were 'pretty poor'. In addition to what I would describe as the normal tensions between two governments with different political outlooks, the Brexit vote and the UK government's subsequent approach to negotiations with EU had resulted in a significant deterioration in the relationship. However – as Michael Gove notes in the extract from his oral evidence from Module 1 – this did not get in the way of co-operation in day-to-day governance, either in general or in relation to the pandemic. Indeed, at the outset of the pandemic, given the scale and severity of the situation we faced, my firm view was that any pre-existing disagreements and tensions should be 'left at the door' and the priority should be working collaboratively to mitigate as far as possible the harm we feared the virus would do. Initially, I assumed that the UK

government would have a similar attitude. However, tensions arose when it became obvious that a 4 Nations approach did not simply mean that UK government decisions, even in areas of devolved responsibility, would be applied automatically and by default in Scotland, Wales, and Northern Ireland. Instead of understanding and respecting the distinct responsibilities and lines of accountability of the DAs – and the duties these placed on us – there seemed to be an assumption on the part of the UK government that when we had different opinions or reached decisions different to those they were taking, we were 'being political'. I think this assumption was particularly strong in relation to the Scottish Government. Whatever the political disagreements that coloured the UK government's opinion of the Scottish Government, I strongly feel that in the context of the pandemic this assumption was deeply unfair, unjustified, and unsubstantiated. It also highlights a more general issue – that while UK government ministers may understand the theory of devolution, they struggle with its practical application.

44. There was no part of the Scottish Government's response to the pandemic that was driven in any way by a desire to accentuate the negative in the relationship with the UK government. I am asked to explain why I disagree with Michael Gove's assertion that there was – with respect, this is asking me to prove a negative. If there are specific examples being cited to substantiate such a suggestion, I will address these in detail. However, in the abstract I can simply state categorically that it was not the case. I have been asked if I knew at the time that this was Michael Gove's view of the working relationship between the Scottish and UK governments and while, as stated in the preceding paragraph, I think that the UK government generally assumed that any differences in our approach were being driven by political factors, to be fair to him, he did not personally give that impression. Our interactions were always professional, courteous, and constructive. In my experience, he was the UK government minister who tried hardest to understand the positions of the DAs and help address issues we had. I think the problem was that he wasn't always able, with his UK government colleagues, to turn agreements/mutual understandings that we reached in the CDL/Heads of government calls into practical reality.

45. The only aspect of the pandemic response that I think the former Prime Minister, or the UK government generally, tried to use for political gain explicitly was vaccine procurement and deployment. The UK government on occasion – as demonstrated by Boris Johnson's comments on 23 July 2020 – claimed that the vaccine programme highlighted the benefits of the Union. A more regular political claim made

by the UK government, however, was that it demonstrated the benefits of Brexit. I also think there was sometimes an element of UK government defensiveness in the communications of the former Prime Minister and other ministers, which arose from some commentary (whether such commentary was fair or otherwise is, of course, a matter of opinion) to the effect that the DAs' pandemic responses were better than that of the UK government.

46. I have been asked to comment on the effectiveness of several fora for inter-governmental working. I did not participate personally in all of these. However, I will take them in turn and offer summary views here, which will undoubtedly be expanded on in response to later questions:

a) **Scientific Advisory Group for Emergencies (SAGE)**: I did not attend SAGE meetings but had access to its advice in the form of papers summarizing its discussions and conclusions. I also had feedback from the officials who did attend on behalf of the Scottish Government and from Professor Andrew Morris, the chair of the Scottish Government Covid-19 Advisory Group (C19AG). I found the quality of the evidence and advice produced by SAGE to be high and it was undoubtedly one of the most important sources of advice to the Scottish Government over the course of our pandemic response. However, as covered in my module 2 statement [NS4/005 - INQ000235213], the commissioning of its advice was done by UK government departments concerned primarily with conditions in England and so it didn't always take sufficient account of the situation in Scotland. I was also frustrated, particularly in the early phase of the pandemic, by my inability to engage directly with SAGE to probe its advice and ask questions. These two factors led me to ask the then CMO for Scotland to establish the SGCAG. My only other observation about SAGE is that, in my view, there should be greater transparency around the make-up, selection, and diversity of its membership on any given emergency.

b) **COBR**: I participated in several COBR (M) meetings over the course of the pandemic, but mainly in the early phases. While it served a purpose in the first few weeks of the pandemic, my view is that it could and should have been a more central and effective forum – indeed the principal one – for inter-governmental working for the duration of the pandemic. However, the meetings were too infrequent (and after the initial phase, extremely rare), and the basis for them being held too ad hoc. There was a lack of understanding or agreement about the issues it should be convened to discuss, what form discussions should take, and

how decisions should be arrived at, or what status they would have. There was insufficient time for proper discussion and extremely limited opportunity for DA input. There appeared to be a lack of understanding of the responsibilities and lines of accountability of the DAs. And it too often felt as if the UK government had already reached decisions that it simply wanted COBR to formalize, rather than there being any real sense that discussions would be meaningful and shape the outcome.

c) **4 Nations' Chief Medical Officers**: Obviously I did not participate in these, but I understand from the CMOs for Scotland (Dr Calderwood and later Dr Smith) that these were a highly valued and extremely useful forum for discussion, sharing of information and – on matters within their responsibilities e.g., setting the alert level – decision-making. In the early phase of the pandemic in particular, the insight and intelligence that Dr Calderwood was able to share from these discussions was helpful to the Scottish Government's understanding and decision-making.

d) **The four Ministerial Implementation Groups (MIGs)**: I did not participate in these personally but my ministers who did found the discussions helpful and constructive, and in general they were a useful forum for seeking alignment when possible and understanding of respective positions when not.

e) **CDL/Heads of Government calls**: I routinely participated in these and found them to be helpful and constructive. For the reason alluded to in paragraph 38, they did not always deliver in practice the outcomes we discussed. However, I usually felt that the Scottish Government's views and perspectives were listened to and that efforts were made to address issues raised. They were also a useful forum for deepening my understanding of UK government positions.

f) **Cabinet Secretary Officials Meetings (Cab Sec O)**: I did not participate in these and do not have a perspective to offer on how useful they were.

g) **Covid-19 Permanent Secretary Officials Meetings (Perm Sec O):** as above.

h) **UK-wide Covid-19 coordination forum**: I did not participate in this as it was official led. It was a forum for sharing information between the four governments and identifying and resolving issues where necessary. It was not a decision-making forum. As far as I am aware, it was reasonably effective.

i) **4 Nation Ministerial Covid O calls**: The corporate statement of the Director General Strategy & External Affairs [NS4/001-INQ000215495] provides a summary of this group. I did not attend, nor do I have any comments to add on the effectiveness of it.

j) **SPI-M**: the output and advice from SPI-M was high quality and helpful. However, given the nature of its work - modelling the possible path and impacts of an infectious virus – it came with a significant and inevitable degree of uncertainty.

k) **SPI-B**: the output from SPI-B was helpful. However, the Scottish Government came to rely more on the behavioural science advice that we got from the C19AG

l) **JCVI**: the JCVI is a long-established mechanism for deciding the scope of vaccine programmes, and I developed a significant level of confidence in it when I was the Scottish Health Secretary. Overall, it worked well in the context of the pandemic. My only criticism which I believe I may have voiced at the time – and which may or may not be justified – is that it took too long to decide on the vaccination of children. For a time, this seemed to make the UK an outlier and this was a source of a frustration at a time when school outbreaks and the consequent disruption to education was a significant concern.

In relation to both **m) the Joint Biosecurity Centre (JBC): and n) the UK Health Security Agency (UKHSA):** a summary of each is provided within the corporate statement of Director General Health and Social Care [NS4/057 - **INQ000215488**] I did not attend any meetings. However, I consider that they were both reasonably effective from the Scottish Government's perspective.

47. There was a very significant quantity of information, evidence, and analysis to read and understand during the pandemic and, particularly in the early phase, this sometimes felt overwhelming. However, while there was a risk of information overload, I don't think this was a problem in practice. From my own perspective, and while this was an extreme situation, I was already experienced in processing large quantities of information and making judgments about what sources were of most utility and importance. The normal processes of sharing and disseminating information within government – and between government and other stakeholders – seemed to work reasonably well and any issues that did arise were addressed. I can confirm that I have provided a list of the intergovernmental meetings which I attended, to the Inquiry [NS4/002 - INQ000130883], along with the associated papers indicating the agenda of the meetings and attendance lists which are held. Briefings were prepared for me by officials within the Scottish Government and shared with relevant policy leads and ministers. They were for Scottish Government internal use. I am not aware if briefings or notes were circulated to all attendees, but I do not think this would be the case.

48. As stated in my module 2 statement [NS4/005 - INQ000235213], I consider that more meetings with the Prime Minister (in addition to, not necessarily in place of CDL meetings) would have been helpful, in theory at least. It would have allowed us to share experiences and perspectives directly and on those occasions when our positions diverged, allowed us to build a better shared understanding of why this was the case. Given the former Prime Minister's leadership style, however, I accept there is an argument that this might not have been the outcome in practice. For what it is worth, based on my experience of working with them, I believe that David Cameron and Theresa May would have had more regular and direct contact with the Devolved Administrations.

49. I am asked about aspects of my Module 2 statement in relation to Scottish Government attempts to influence the UK government's position. I do not feel there is much I can usefully add here. The examples I offer in my earlier statement cover the broad subject areas on which these attempts were most regularly made – the nature and timing of NPIs, media messaging, funding and budget flexibilities and furlough. I would add to that international travel where on occasion we argued for a more cautious approach to be taken by the UK government; Statutory Sick Pay arrangements where we favoured a more generous approach to support self-isolation; the flexible matching of testing capacity with demand across the UK and, later, the pace of the winding down of the testing infrastructure. While this covers the broad areas, it is not an exhaustive list of every issue and every occasion on which the Scottish Government sought to influence the UK government. Given the multiple levels at which such influence would have been attempted, it is not possible to provide such an exhaustive list.

50. I am asked if comments at paragraphs 20 and 42 of my Module 2 statement [NS4/005 - INQ000235213] about the operations of COBR meetings still represent my position. They do. I am asked to expand on the concerns they raise. In my view, had information and evidence been shared earlier, COBR meetings had been opportunities for genuine and open discussion that would then lead to the four UK governments forming conclusions in a collective manner – rather than being, as it appeared, opportunities for decisions already arrived at by the UK government to be rubber stamped – then it is possible that greater alignment might have resulted. To be clear, I do not think this would have resulted in a uniform approach across the four nations – and neither necessarily should it have done as the virus did not always spread uniformly – but on the occasions when alignment was not possible, it might

have allowed greater understanding of the reasons for divergence. Finally, I am asked how the statement in paragraph 27 about my aims for intergovernmental discussions accords with my comments in paragraphs 20 and 42. They are entirely in keeping – the fact that the way in which COBR operated meant I was not always successful, the aims were still sound.

51. I am asked if it would have been beneficial for me to attend the MIGs. No, I do not think it would have made any meaningful difference to the Scottish Government's pandemic response. These meetings were not conducted at Head of Government level and so it was entirely appropriate that ministers in my government attended alongside UK government/other DA counterparts. Also, while appropriate delegation is part and parcel of government at all times, the sheer scale of the workload associated with the pandemic meant it would have been impossible for me to do my job effectively without delegating tasks to other ministers in line with their portfolio responsibilities. This was as true in intergovernmental cooperation as it was in any other strand of the pandemic response.

52. I am asked if my comment in paragraph 39 of my module 2 statement [NS4/005 - INQ000235213] about MIGs is still my position. Yes, it is. The Scottish Government was concerned at the time that the standing down of the MIGs at the end of May 2020 when they had become reasonably well-established and were a reasonably useful forum for cooperation, would result in a loss of opportunity for the Scottish Government to engage with and influence the UK government. It is not possible to say now, however, whether engagement and joint working would have been better had they continued rather than being replaced by Covid-S and Covid O (though the Scottish Government had no participation in the former and only limited in the latter) and the CDL/Heads of Government calls (though these turned out to be a positive innovation and would have been so even if MIGs had continued).

53. I am asked if I agree with the DGSEA statement [NS4/001-INQ000215495] that the period from June 2020 saw a less intense rhythm of intergovernmental engagement. Yes, I do. As to why that was the case, the first point to make is that the frequency and rhythm of intergovernmental engagement is driven more by the wishes of UK government than by the DAs. However, by June 2020, it was also the case that the four governments had settled more into our own rhythms of operation and decision-making when it came to the operation of NPIs, where there was by then also some difference of opinion between the UK government and the DAs (it is perhaps worth

noting here, as an aside, that throughout the pandemic there was always quite a strong degree of alignment between the DAs) and the focus of intergovernmental engagement became more targeted on those areas where we were working on a cross UK basis, for example, testing infrastructure and vaccine procurement. That said, more engagement would have been helpful. I don't believe that it would necessarily have resulted in a more uniform approach across the four nations – we were all pursuing the approaches we thought most appropriate to the circumstances we faced – but it might have fostered a better understanding of why our approaches sometimes differed, and also more sharing of experience about the strengths and weaknesses of our respective approaches.

54. I broadly agree with the Office of the Secretary of State for Scotland that engagement between the Scottish and UK governments worked well in general. While there is inevitably a focus on what didn't work well and why, and I am candid in my views about those matters, there is a danger that this masks the fact that on a day-to-day basis cooperation on multiple levels and on a multitude of issues was constructive and effective.

55. Notwithstanding the above, the Inquiry will inevitably look at the challenges to intergovernmental working and the reasons for these. In summary, and in general terms, my view of the main challenges is as follows:

a) Disparity in the scale and resources of the DAs compared to the UK government. Due to its scale, the UK government does not operate as cohesively as the DAs (this is intended as a statement of fact not criticism), and the need to engage with multiple different UK government departments is resource intensive. In addition, agreement reached with an individual UK department can break down when it gets to the Cabinet Office or Number 10, and vice versa.
b) A lack of bandwidth on the part of UK government departments – understandable at times – which leads to engagement with the DAs being deprioritized.
c) A variable understanding and respect – across UK government departments – of the detail of the devolution settlement and the implications of it for their own policy reach and remit. While it would be impossible to quantify this or provide a comprehensive list of the occasions on which this hindered engagement, it is not a rare occurrence.
d) A mindset that considers the UK government position on any issue to be the orthodox or 'correct' one and any divergence by the DAs as being out of step or

motivated by politics. For example, throughout the pandemic the positions of the three DAs were often, if not identical, then very similar, with the UK government being the outlier – and yet the UK government behaved as if it was the DAs that were diverging. This can – and often during the pandemic, did - lead to a lack of willingness on the part of the UK government to understand, let alone accommodate, our different positions.

e) A lack of understanding on the part of the UK government that the DAs are not accountable to it but to our own Parliaments and populations.

56. On several occasions the Scottish Government did not timeously receive invites to, or agendas/papers for intergovernmental meetings. This obviously frustrated our efforts to engage meaningfully in these forums. The Office for the Secretary of State for Scotland has said that this was simply a result of the pace of the pandemic response and the unprecedented rhythm of meetings, and the short timescales involved. While this may have been a valid explanation in the early stages of the pandemic when the intensity of the pace and rhythm of decision making was genuinely unprecedented (indeed I commented earlier on the impact of this intensity on the Scottish Government's decision-making process during March 2020) it became an increasingly inadequate explanation as the pandemic progressed. By then, it was more indicative of the UK government's lack of consideration for the responsibilities and accountability of the DAs. Similarly, there was on occasion, a tendency for the UK Government to take decisions with cross border impacts without appreciating their practical implications, as noted by Transport Scotland in their corporate statement. With regards, for example, to decisions taken on international travel, it was not practically possible for Scotland to follow substantially different approaches with any effect, given the ability of people to travel into England and onwards to Scotland without further checks – although these concerns were raised with the UK Government by my ministerial colleagues, it did not result in any significant change. I cannot comment on whether there were challenges in ensuring that data used within the UK Government was UK wide and not driven by an England only understanding of policy issues. However, there were instances where we felt that the data for Scotland indicated a different approach was appropriate and - where possible within our devolved responsibilities – we took decisions accordingly. I did not often have direct dealings with UK Government civil servants so am unable to comment on their understanding and knowledge of devolution.

57. Throughout the pandemic the Scottish Government sought to adhere to a four nations approach to formulating our response. However, there was often a misconception about what a four nations approach meant in practice. There were some who assumed that it meant (or believed that it should mean) always adopting a uniform approach across all four nations. I think the UK government fell into this category. It seemed to assume that the approach it decided to pursue should be the one applied across all four nations. Because of the devolution settlements, many of the decisions it was taking – on NPIs for example – were for England only, but it often communicated these decisions as if they applied automatically across the UK. It acted as if its approach was the orthodox one and any divergence must be wrong or politically motivated, rather than legitimate outcomes of the DAs discharging our own responsibilities. There was also a sense that the UK government considered itself the senior partner in the four nations context and that the DAs were accountable to it, when the fact is that in devolved matters there is no hierarchy – we are each responsible within those areas of competence and accountable to our respective parliaments and populations for how we exercise those responsibilities.

58. My understanding of a four nations approach was rooted in the principles and statutory reality of devolution. It was that we would work co-operatively and collaboratively, sharing insight and experience, and where possible adopt a common approach; if our approaches diverged – either because of epidemiological or other health factors, and/or a difference of opinion about the appropriate interventions – we would develop a mutual understanding of the reasons, respect each other's positions, seek to avoid confusion in our communications, and be mindful of creating unintended consequences for other administrations; and discuss areas where reserved and devolved responsibilities intersected, so that the UK government in reaching decisions on reserved matters would understand the DA perspective and any impact on the exercise of our devolved responsibilities.

59. The Scottish Government, based on our understanding of what it meant – indeed, what it could only properly mean in the devolution context – did not at any stage depart from or, to the best of my recollection, reject advice in relation to a four nations approach. We operated within it – at times aligning our approach with the other three administrations and at other times making decisions that resulted in divergence. Some of the factors underpinning these decisions are set out at paragraphs 158 – 175 of the DG SEA corporate statement provided in June 2023 [NS4/001-INQ000215495]. At all times – to Parliament and/or through my daily media

briefings – we sought to explain the reasons for the decisions we took, what the implications were, and if they differed from decisions of the UK government for England, why that was the case. It is worth noting again, however, that on many of the occasions when the Scottish Government would have been described as diverging, our position was closely aligned with the other DAs, and it was the UK government that was an outlier.

60. I was always aware that, however sound our reasons for taking an approach at times that differed from that of the UK government in England, a potential downside was confusion amongst the Scottish public about the guidance and regulations they were being asked to follow. The dominance in media reporting of the decisions of the UK government – and the failure of parts of the media, particularly in the early phases of the pandemic, to be clear about the geographic reach of those decisions – meant that this was a risk. In my view, this made regular, clear, frank, and timely communication even more important.

61. At the very outset of the pandemic, I formed a view that building a relationship of trust with the Scottish public was essential, and that timely communication was a vital part of that. People were scared and anxious and were looking to their governments to offer reassurance – not in the sense of painting a falsely positive picture, but by being open and frank about our understanding of the situation and the uncertainties inherent in it, and by explaining clearly and quickly what we were asking them to do and why. We were asking people to make extraordinary sacrifices, but the effectiveness of these measures depended on rapid and high compliance. It was also the case that while the pandemic may have opened the eyes of the UK government and public to the realities of devolution – as commented on by Michael Gove in his Module 1 statement [NS4/010 - INQ000185354] – the Scottish people were already well versed in the responsibilities of the Scottish Government and were looking to us to offer leadership and assurance in what was an unprecedented situation.

62. The UK government seemed to take issue with approach I took to communication throughout the pandemic. This seemed to be particularly so in the initial phase. The implication was that I was trying to 'steal a march' on them or was motivated by other political reasons, as also suggested by Michael Gove in his module 1 statement. That was emphatically not the case. There was only one occasion that I recall reaching an agreement with the UK government about the sequencing of communications and that was on the evening of 23 March 2020. I agreed to wait until the Prime Minister had made an address about the decision of COBR to impose an effective lockdown

before I spoke to the Scottish media – and that is what I did. On other occasions, for the reasons set out in the preceding paragraph, I simply communicated decisions as quickly as possible. Also, the timing of my daily media briefings quickly became set at around noon every day. The fact that the UK government briefings happened much later in the day was its decision.

63. I think the first point of public disagreement with the UK government was on Sunday 10 May 2020, when it announced that it was replacing the 'Stay at Home' message with 'Stay Alert'. For context, it is important to note that this decision was not discussed in advance with the Scottish Government. I first became aware of it in any detail from a report in the Sunday Telegraph. I profoundly disagreed with the decision. I considered it premature given how fragile the situation remained and feared that it would squander the progress we had made in suppressing the virus through the 'Stay at Home' message. In reaching that view, I was taking account of data that suggested the R number remained high and, at that time, was possibly higher in Scotland than in other parts of the UK. Given that we still lacked effective treatments and vaccines, I feared that making such a change at that time would cause infection rates to increase again and that this would cause more severe illness, put more pressure on the NHS and, ultimately, cost lives.

64. It is for these reasons that the Scottish Cabinet at a meeting that afternoon decided to keep the 'Stay at Home' message in place, and shortly afterwards I communicated that at my media briefing. I did not set out to be explicitly critical of the Prime Minister. The relevant extract from my statement is as follows:

"You may hear the Prime Minister announce other immediate changes tonight for England – and that is absolutely his right to do so. I've just come from a Cobra meeting with the Prime Minister and the First Ministers of Wales and Northern Ireland. Now it's important to say that I don't expect the detail of these immediate changes that the Prime Minister will announce to be significant, and I predict that any differences with the position here in Scotland will be relatively minor. However, for the avoidance of doubt, let me be clear – except for the one change I have confirmed today, the rules here have not changed. We remain in lockdown for now and my ask of you remains to Stay at Home."

However, in answering questions about why the Scottish Government was not taking the same decision as the UK government – and, in the interests of continued compliance, mindful of my responsibility to set out the Scottish Government's

reasoning clearly - it was inevitable that my comments would be interpreted as criticism. The only way I could have avoided this was to quietly acquiesce in a decision that I thought to be misguided. That would have been a serious abdication of my responsibilities to the Scottish people.

65. My only other observation about decisions on 10 May 2020, is that they did not result in the Scottish Government being an outlier. Wales and Northern Ireland both opted to retain the 'Stay at Home' message too.

66. Notwithstanding the tensions between the Scottish and UK governments – and my focus on these in the preceding paragraphs, in response to the Inquiry's questions – it was nevertheless my sense that all of us, ministers, officials and advisers, were seeking to do our best to work together as effectively as possible. I do not think personal relationships got in the way of that, nor was it my impression at the time that the difference described in the preceding paragraphs impacted negatively on relationships.

67. The interactions between the Scottish and UK Governments were intense. They happened at multiple levels, involving large numbers of people, every day. My interactions, other than those with the Prime Minister, tended to be most often with Michael Gove who would be supported in these discussions, as I was, by officials and advisers, including Chris Whitty, Patrick Vallance and Jonathan Van Tam. I would like to put on record that I always found these three senior UK government advisers to be informed, helpful, courteous, and respectful of the positions and concerns of the DAs. My Cabinet Secretaries would engage directly with their counterparts. The most regular of these interactions would undoubtedly have been those of the four nation Health Ministers. There was one occasion that I had a bilateral call directly with Matt Hancock – this was on 10 September 2020 to discuss concerns about testing backlogs and the allocation of testing capacity across the UK. He was accompanied on the call by Dido Harding, head at the time of Test & Trace. I felt that my concerns were listened to and, to some extent at least, acted upon. My interactions with UK ministers were otherwise mainly in the context of four nations discussions.

68. I have been asked specifically about the Secretary of State for Scotland. He participated in most of the four nations discussions that took place but very rarely made any contribution. He had no role in the Scottish Government's response, and

he did not seem to me to play any significant role in the UK government response either. I did not have direct, one to one, engagement with the Secretary of State. It was more effective for the Scottish Government to engage directly with UK government counterparts. To go through the Scotland Office would have added an unnecessary and unhelpful layer of bureaucracy to intergovernmental engagement.

The other devolved administrations

69. Co-ordination with the other devolved administrations took place within the context of four nations, intergovernmental structures, but also bilaterally where necessary. I had a very good relationship throughout the pandemic with the First Minister of Wales and his minister/officials/advisers. I always felt that I understood the decisions the Welsh Government was taking and why and would hope that the same was true in reverse. As for Northern Ireland, its position as part of the island of Ireland, obviously meant that decisions of the Republic of Ireland were just as relevant to it, perhaps more so, that those of the UK, Scottish or Welsh governments. As result, our engagement with the Northern Ireland Executive (NIE) was perhaps not quite as close as it was with the Welsh Government – nevertheless I considered the engagement, including my interactions with the FM/DFM, to be good. I always had a good awareness and understanding of the decisions it was taking. Again, I hope the same was true in reverse.

Funding

70. The corporate statement provided by DG Scottish Exchequer in June 2023 [NS4/011 - INQ000215484] set out in detail how the Scottish Budget (i.e., the amount of money that is subject to the decisions of the Scottish Government and the approval of the Scottish Parliament) is made up; the factors that affect its overall size; the process that determines its allocation which is set out in the Fiscal Framework Agreement and Statement of Funding Policy; and the allocations that were made during the pandemic. The comments that follow are intended to summarise that information and add personal insight where appropriate.

71. The Scottish budget is comprised of a block grant provided by the UK government and calculated in accordance with the Barnett formula; taxes raised in Scotland – Income Tax, Land & Buildings Transaction Tax, Scottish Landfill Tax, and non-domestic rates; and limited borrowing.

72. Ministerial responsibility for allocating and managing the budget lies with the Finance Secretary – who for the duration of the pandemic was Kate Forbes – but this responsibility is exercised collectively as part of the Scottish Cabinet.

73. Standard funding arrangements continued to apply during the pandemic, but the amount allocated to the Scottish Government by way of the block grant through the Barnett formula (generating what is known as 'Barnett consequentials') increased substantially because of necessary decisions taken by the UK government to, for example, increase support for the NHS and provide support to businesses required to close or restrict operations during lockdown. The allocation of this additional money was for the Scottish Government to determine, and we took decisions to increase NHS funding and put in place a range of schemes to support businesses, communities, and individuals. We would have been unable to do so from within our pre-existing budget as this was already fully allocated, and the amounts of money involved could not have been raised from the limited devolved tax or borrowing powers at our disposal. If we chose to provide funding for initiatives within our devolved responsibilities that the UK did not match – or if there were devolved responsibilities with no corresponding duty in the rest of the UK, such as inter-island transport that I have been asked to comment on – we would have to budget for this from within our overall pot of money. We did so by re-allocating funding from other parts of the Scottish budget.

74. As well as increasing the funding available through the block grant, changes were made to aid forward planning. Traditionally, there is retrospective element to budget reconciliation that creates an inherent uncertainty in how much money the Scottish Government has at its disposal. However, in July 2020, it was agreed that at various points during the pandemic the UK government would guarantee upfront a minimum amount that would be made available to the Scottish government.

75. Also of relevance is the decision we took on testing infrastructure. Decisions taken by the UK government to substantially increase testing capacity – through the network of testing centres, drive thru and mobile facilities, and the Lighthouse processing laboratories – would ordinarily have generated Barnett consequentials for the DAs,

given that testing is a devolved responsibility. However, we agreed to participate in a UK wide testing network (in addition to the Scottish testing capacity funded from our own budget) and to forego Barnett consequentials as our contribution to direct UK government funding of the network. A similar approach was taken in relation to vaccine supply, whereby the UK Department for Business, Energy and Industrial Strategy carried out procurement of vaccines on behalf of the Scottish Government.

76. In addition to UK government decisions on matters that were devolved to the Scottish Parliament, therefore generating Barnett consequentials, the UK spent money in reserved areas on schemes that operated UK wide – this includes the Coronavirus Job Retention Scheme, known as furlough, the Self Employment Income Support Scheme, the Bounce Back Loan scheme, and the Coronavirus Business Interruption scheme. These were all UK wide schemes, operated by the UK government, and while the Scottish Government made representations about their detail and longevity, we had no direct role in their design or implementation.

77. Overall, the UK government was reasonably responsive to the views of the Scottish Government and, especially in the early phase, took vital and very substantial decisions that were essential to the pandemic response. However, there is no doubt that the pandemic highlighted the disparity and asymmetry that can arise in the interface between reserved and devolved responsibilities.

78. As the pandemic progressed, the UK government increasingly made funding decisions – and in particular decisions about the pace at which to reduce/withdraw pandemic related funding and schemes such as furlough – based on its assessment of the need, or otherwise, for ongoing NPIs. This assessment was based on the data/epidemiology for England and on the UK government's judgments on what level of infection it thought acceptable to have circulating in the community. In summary, if the UK government thought NPI restrictions needed to stay in place or be increased they could increase funding/extend furlough to provide the necessary support - and vice versa. However, the Scottish Government did not have a corresponding ability to increase funding/extend furlough if our assessment of the Scottish data/epidemiology or a different 'risk appetite' led us to the view that NPI restrictions should be extended or increased. In summary, each of the four UK governments was responsible for deciding on appropriate public health interventions within our own jurisdictions, but only one of the four had the ability to make funding decisions to support these interventions.

79. In my view, the imbalance and asymmetry described above needs to be addressed as a matter of urgency so that similar issues do not arise in any future emergency.

80. The Scottish Government made frequent representations to the UK government on funding. These were made through various channels – at COBR and other four nations meetings, in written communications, and in statements to Parliament.

81. In June 2020, the Scottish Government published a paper entitled "Ten principles that should underpin the UK Government's new approach" [NS4/012 - INQ000182949]. The purpose of the paper was set out as follows: "We propose ten principles that the UK Government should follow to balance delivering a further fiscal stimulus that grows the economy and reduces inequality with the need to manage the debt owed by households, businesses and the government." Although these principles related largely to reserved matters, they all impacted on the Scottish Government's ability to discharge our devolved responsibilities in relation to the ongoing pandemic response and our recovery from it.

82. None of the principles in the paper would – or should – have come as a surprise to the UK government. They covered issues that had been regularly raised with them. I do not think any of the ten principles were implemented in full by the UK government.

Conclusions

83. I consider that the Scottish Government procedures in place for considering, recording, and implementing core decisions were fit for purpose. As I have observed, the sheer pace and intensity of the situation we faced, especially in March 2020, meant that there were occasions when these procedures were not followed to the letter – however, overall, I believe that they were adhered to and that they worked well.

84. I was privileged to lead a team of Scottish Government Cabinet Secretaries, Ministers, Civil Servants, and advisers who worked tirelessly throughout the pandemic to keep the country as safe as possible. It was the hardest task any of us had ever faced. While there are things that with the benefit of hindsight, and if we had known then what we know now, we would do differently – and, speaking personally, I will always carry regret about that - I know that everyone involved did their best every

day in a situation that was unprecedented and extremely difficult. I had no concerns about the performance of any of them.

85. I would make the same comments about those working in the UK government. Despite the tensions and disagreements narrated above – and notwithstanding revelations since which have undoubtedly coloured my views – I had no doubt at the time that they, like us, were doing their best in a very difficult situation.

86. I have been asked if I think it would have been beneficial for the UK response to have been based on a pan UK Civil Contingencies Act 2004 approach. I do not. This would have denied us the ability to respond flexibly to a virus that did not spread uniformly at all times; it would have been unable to cater for the different NHS/public health structures across the four nations; and it would have diminished the democratic accountability of the four governments to the different populations we serve.

PART B – SOURCES OF ADVICE: MEDICAL & SCIENTIFIC EXPERTISE/DATA & MODELLING

Advisory Bodies

87. The Scottish Government received advice from a range of bodies during the pandemic. These included a number of UK wide bodies: the Scientific Advisory Group on Emergencies (SAGE); the Scientific Pandemic Influenza Group on Modelling (SPI-M); the Scientific Pandemic Insights Group on Behaviours (SPI-B); the New & Emerging Respiratory Virus Threats Advisory Group (NERVTAG); the Joint Committee on Vaccination & Immunisation (JCVI); and the UK Health Security Agency (UKHSA) and its predecessor, the Joint Biosecurity Centre (JBC). We also received advice from a number of Scottish bodies: Public Health Scotland; National Records for Scotland; the National Incident Management Team; and the Scottish Government Covid-19 Advisory Group (C19AG). C19AG had several sub-groups, covering Public Health Threat Assessment; Education & Children's Issues; Universities & Colleges; and Testing. Although not formally a sub-group, the Covid-19 Nosocomial Review Group reported regularly to C19AG. I consider that these bodies and individuals were effective, and the advice offered was of a high quality.

88. The main change to the advisory structure in Scotland came with the establishment of C19AG. While I had general confidence in the advice from SAGE I developed two

concerns over the initial weeks of our pandemic response: firstly, that SAGE advice, perhaps understandably, was insufficiently tailored to Scottish circumstances; and secondly, that there was no opportunity for me or other Scottish Government ministers to ask questions of SAGE members directly to interrogate and better understand the advice. For these reasons, I considered it appropriate to establish a Scottish advisory body to interpret and supplement the advice available to us from SAGE. I asked the then CMO, Dr Catherine Calderwood, to establish such a body, which she did, and it was announced on 25 March 2020.

Scottish Government Covid-19 Advisory Group (C19AG) and SAGE

89. C19AG was established by the CMO to "consider the scientific and technical concepts and processes that are key to understanding the evolving COVID-19 situation and potential impacts in Scotland". Professor Andrew Morris accepted Dr Calderwood's invitation of 16 March 2020 to chair the group. Professor David Crossman, the Chief Scientist (Health) was invited to serve as the Deputy Chair, and thereafter a number of other experts were appointed. The Group met for the first time on 26 March 2020, as quickly as possible after its commissioning and formation. At its first meeting, the Group agreed its terms of reference and the importance of quickly seeking reciprocity with SAGE and its sub-groups.

90. Members of C19AG were invited to serve by Dr Calderwood and were chosen on the basis of the scientific or technical expertise they could contribute. Membership of the Group included a wide range of independent members in addition to Scottish Government advisers. It included public health experts, clinicians and academics spanning the disciplines of epidemiology, virology, public health, behavioural sciences, global health, medicine, and statistical modelling. As Dr Calderwood noted in her Module 1 oral evidence, care was taken to include a diversity of views to ensure that there would be appropriate challenge within the Group. Independent members served on a pro bono basis and received no financial recompense for their contribution.

91. C19AG provided advice in writing to the Scottish Government in the form of papers setting out the consensus view of the Group. I was routinely copied into the Group's advice, as was the Deputy First Minister, the Cabinet Secretary for Health and Sport (subsequently Cabinet Secretary for Health and Social Care), the Director General for Health and Social Care and Chief Executive of the NHS, the National Clinical

Director, the Covid Public Health Director, and other senior officials involved in the pandemic response.

92. Meetings of C19AG typically followed soon after meetings of SAGE. SAGE papers and minutes provided valuable information on and insight into developments in the pandemic and were routinely shared with the Group at the same time as they were shared with the Scottish Government. Advice from SAGE was frequently discussed at meetings of C19AG. The Group's function was not to duplicate the work of SAGE but to complement it and interpret its advice for a Scottish context.

93. The work of C19AG evolved over time depending on demand and the phase of the pandemic. The Group initially met very frequently, meeting on seventeen occasions between 26 March and 28 May 2020. Thereafter, until the end of January 2021, meetings tended to be weekly, then around fortnightly until June 2021, and then monthly until the final meeting on 3 February 2022. Unusually, however, it met on three occasions in December 2021 in response to the emergence of the Omicron variant.

94. I did not attend any SAGE meetings. I did not attend routine meetings of C19AG, but it organised a number of 'Deep Dive' sessions on particular issues which I did attend, as detailed in this table:

Date	Topic
31/03/2020	Food supply
03/04/2020	Testing
14/04/2020	Care Homes
15/04/2020	Exit Strategy/ Testing
16/04/2020	Testing
27/04/2020	Testing
29/04/2020	Exit Strategy. "A Framework for Decision Making – Follow-up Publication"
11/05/2020	Transport
15/05/2020	Shielding
25/05/2020	Test and Protect
29/05/2020	Scientific
05/06/2020	High risk
29/06/2020	Physical distancing and superspreading
23/07/2020	Vaccines and Immunology

14/08/2020	Daily figures
24/08/2020	Data and National IMT
12/10/2020	Testing
16/12/2020	Winter Planning
04/02/2021	Scenario Planning
09/03/2022	Future of Covid

95. These were useful opportunities to consider some matters in depth, with the benefit of the expertise and insight of C19AG members. I was also able to ask the Group for specific advice on occasion – for example, in April 2020, to inform our thinking on exit/transition from lockdown, I asked it for advice on the level of cases at which it might be possible to start easing restrictions and the impact different approaches could have. In my view and experience, C19AG was a reliable and effective source of advice, and it worked well – both in terms of the advice it provided directly and through its sub-groups, either on its own initiative or commissioned, and in its reciprocity with SAGE, which enabled advice from the latter to be interpreted for the Scottish context.

96. The Module 2A Corporate Statement of C19AG [NS4/013 - INQ000215468] sets out the nature of its advice as follows (paragraph 13):

"Some of [the advice supplied by C19AG] was in response to requests for advice, communicated to the Group via the secretariat (who had a dedicated email address), while other advice was provided on the Group's own initiative. If there was not a consensus on the issue or on aspects of an issue, then the advice made clear where that was the case. Communication channels were clear, as the Group reported to CMO with excellent secretariat support, therefore ensuring effectiveness. It should be emphasised that the Group only provided advice to Government and did not make decisions. The Group did not produce bulletins, briefings, or other written guidance for the Scottish Government other than their formal written advice."

97. Paragraph 156 of the Module 1 DG Health and Social Care Corporate Statement (18 April 2023) [NS4/014 - INQ000184897] sets how SAGE advice was provided to the Scottish Government:

"In the early stages of the Covid-19 pandemic, SAGE provided a series of forecast assessments and analysis that informed briefing and decision making for the Scottish Ministers. That was shared through the Cabinet Office Briefing Rooms (COBR) process. Papers would be issued (in advance of COBR) from SAGE directly, and/or SPI-M (Scientific Pandemic Influenza Group on Modelling),and discussed at COBR. This information could then be used by the Directorate for Population Health to inform the policy decisions made by Scottish Ministers."

98. Paragraphs 21-24 of the Module 2a DG Health and Social Care Statement (experts) [NS4/015 - INQ000215470] sets out the relationship between SAGE and C19AG.

"A core principle of the C19AG was that it should have reciprocity with SAGE. This meant that the C19AG had access to papers from SAGE and its subgroups, while the SAGE secretariat were provided with copies of C19AG papers. The C19AG did not seek to duplicate the work of SAGE but to interpret this for the Scottish context. Andrew Morris attended SAGE in his capacity was Chair of the C19AG."

99. The C19AG Corporate Statement [NS4/013 - INQ000215468] said the following about SAGE advice:

"SAGE advice was held in high regard by members of the C19AG. SAGE provided significant advice on the fundamental science of COVID-19 which was immensely helpful. And, while their information and analysis rarely focused solely on the Scottish dimension, the C19AG had separate sources of information on Scotland, and the insight provided by SAGE analysis was always helpful in assisting the Group's understanding of the position in Scotland."

100. In my view, the C19AG/SAGE arrangement served the Scottish Government well in our pandemic response. SAGE was a well-established and trusted source of advice and C19AG was able to complement it by applying a Scottish lens and providing access to me and Ministers to interrogate the advice and deepen our understanding.

101. I have been asked to set out the roles played by the Chief Scientific Adviser for Scotland (CSA), Chief Medical Officer for Scotland (CMO) and Deputy Chief Medical Officers for Scotland (DCMOs) during the course of the pandemic.

102. The role of the CSA is set out at paragraphs 7-14 of the DG Economy (CSA) Corporate Statement (May 2023) [NS4/016 - INQ000187462]. I have included key paragraphs below.

"7. The CSA Scotland is responsible for ensuring Ministers and officials have access to science advice and evidence, to inform policy development. They are expected to provide independent science advice and challenge to Ministers and officials. They work closely with the Scottish Science Advisory Council (SSAC), of which they are an ex-officio member, to advise the Scottish Government across all areas of its work. This includes elements of resilience planning, including ensuring officials and Ministers have access to science advice in an emergency.

8. The CSA Scotland does not lead on issues of public health or clinical advice, including in an emergency, and had no role in this area immediately before the Covid-19 pandemic. During the pandemic (from late March 2020), the CSA Scotland contributed to collective advice in this area as a result of their membership of the Scottish Government Covid-19 Advisory Group (C19AG). In keeping with their role, the CSA Scotland was not personally asked to contribute to policy decisions in connection with the Covid-19 response, other than through the collective advice given by the Scottish Government's Covid-19 Advisory Group.

10. The CSA Scotland has no formal reporting line to Director General (DG) Health and Social Care or the Cabinet Secretary and Ministers for Health. Rather, for the time period of this request (2020-22) the CSA Scotland reported to DG Education, Communities and Justice and then DG Education and Justice. Over the same period the CSA Scotland had regular meetings with the Minister(s) for Further Education, Higher Education and Science, and subsequently the Minister for Higher Education, Further Education, Youth Employment and Training, for whom science is one of their portfolio responsibilities.

13. In response to Covid-19, the CSA Scotland took on additional responsibilities. These included:

- *Attending SAGE from April 2020 (the Chief Medical Officer (CMO)/Deputy CMO (DCMO) having been the lead Scottish Government attendee since January 2020)*

- *Being appointed a member of the Scottish Government's C19AG from its first meeting on 26 March 2020*
- *Being a member of the C19AG sub-group on Education and Children's Issues from its first meeting on 23 June 2020*
- *Being a member of the C19AG sub-group on Universities and Colleges from its first meeting on 19 May 2020."*

103. During the pandemic, my direct interactions were much more frequent with the CMO (and to a lesser but still important extent, the DCMOs) – these were often daily and, in the early phase, several times a day. During the pandemic, the CMO attended Cabinet, SGORR, 'Gold' meetings and Deep Dives. Dr Calderwood was the clinician in attendance at all my Covid media briefings during her time in post and attended morning meetings in advance of these. Later Dr Smith attended the briefings on occasion, but shared the responsibility with DCMOs, the National Clinical Director and the Chief Nursing Officer.

104. Paragraphs 6-7 and 32-33 of the Module 1 DG Health (CMO_CSO) Corporate Statement (February 2023) [NS4/014 - INQ000184897] sets out the roles of the Chief Medical Officer Directorate, CMO & DCMO as follows:

"*6. The CMOD seeks to achieve the best health and care outcomes for people by working with ministers and stakeholders to protect and improve public health, and to oversee the effectiveness of healthcare services in Scotland.*

7. The CMOD is responsible for:

- *Providing policy advice to Scottish Ministers on healthcare and public health.*
- *Leading medical and public health professionals to improve the mental and physical wellbeing of people in Scotland.*
- *Providing clinical advice on professional standards and guidelines.*
- *Investing in research, particularly related to the NHS.*
- *Encouraging young people to take up jobs in the medical and public health sector."*

"32. The role of the CMO, and their team, is as independent clinical advisers to government. The way the role of CMO is set up has the effect that it sits slightly separately to the rest of government. As a clinician and as a scientist, the CMO's first

duty is a professional and ethical one, to the regulatory body, which is the GMC. To remain as a medical doctor, the CMO cannot breach good medical practice which provides the CMO with their independence. In addition, an important part of the role of CMO is to be able to use judgement and experience to be able to communicate effectively and fully, so that commitment to professional and ethical requirements as defined by the GMC is not breached.

33. The CMO or a DCMO would be in attendance to provide clinical advice in SGORR. In terms of transparency with the public, the minutes of the meetings of the Covid-19 Advisory Group were published on the Scottish Government website and the CMO or DCMO attended dozens of lunchtime media briefings to allow public scrutiny by the media. It was considered important that senior clinicians like the CMO and the national clinical director were accessible."

105. As set out above, I was not advised directly by the CSA but had confidence in the knowledge that she was contributing to and through the work of C19AG and its sub-groups. The advice from the CMO/DCMOs was always clear, accessible, and transparent.

106. I always felt able to challenge and interrogate the advice of the CMO/DCMOs, and did so regularly, indeed routinely, to deepen my knowledge and understanding and provide as robust a basis as possible for the decisions Ministers were taking. Particularly in the early phase, when our knowledge of the virus was still developing, Dr Calderwood was very good at helping me understand what was known, and with what degree of certainty, as well as the inherent uncertainties in the situation. We were always clear that her role was to advise and mine was to decide, but she helped me understand different options and the possible consequences of them. Her advice was clear, candid and, given the nature of what confronted us, often very challenging. She also provided appropriate challenge to my thinking and decision-making and I very much encouraged this.

107. As set out earlier, the lack of opportunity to challenge and interrogate the advice of SAGE was one of the reasons I asked the CMO to establish C19AG, and I always felt I was able to do so in respect of its advice.

108. I have been asked what expertise was available within our advisory structures to take account of: health economics, the economy, ethics, education, and at risk-vulnerable groups.

109. Firstly, we had access to advice from the Scottish Government's Chief Economist who regularly provided input on the economic impacts of Covid. We also had advice from the Scottish Government's Chief Social Policy Adviser, who also chaired the C19AG sub-groups on Education & Children's Issues and Universities & Colleges. The Four Harms Group also became a part of our advisory structure. Four Harms (direct health harm, broader health harm, social harm, economic harm) was an approach developed to provide a rational basis for considering often conflicting harms – recognising that an intervention designed to suppress the virus and save lives could impact negatively in other ways. These assessments were led by the Four Harms Group which would bring together senior officials and advisers who could give input on the range of harms, together with other policy leads, analysts, and Public Health Scotland. Four Harms assessments enabled impacts, for example on groups with protected characteristics, to be discussed in relation to each of the harms. Decision-making throughout the pandemic was also supported by various types of impact assessment, including Business Regulatory, Equalities, Children's Rights & Wellbeing, and Island impact assessments.

110. With regard to ethics, an Ethical Advice and Support Framework to support frontline staff with decision-making was published. Had any ethical issues that engaged the Ministerial Code been raised, I could have sought input from those appointed to advise on such matters, Dame Elish Angiolini and James Hamilton, but no such issues were raised.

111. While no single body contained all perspectives, it is my view that the advisory structures available to the Scottish Government overall were sufficiently representative of various competing interests that would be affected by decisions taken in our pandemic response.

112. I had no concern about the adequacy or sufficiency of scientific or other expert advice. However, it developed over the course of the pandemic, as our knowledge of the virus increased and as Ministers' understanding of the type and range of evidence necessary to decision-making evolved. However, I was always very aware of the inherent uncertainties in the situation we were dealing with – especially in the early phases – and that as a result the science was rarely exact. I was also aware

that while the science could tell us what was likely to happen if we did certain things – for example, impose or ease an NPI – and model the impacts, it was for Ministers to make and be accountable for the decisions.

113. While it is for the bodies and individuals who offered advice to say how confident they were in it, they always appeared to me to be so. However, it was not confidence in an absolutist sense – those advising us were confident about articulating and explaining the uncertainties in, and sometime different interpretations of, the science and evidence base, and the range of possible impacts of the options we were considering. That was important in properly informing the decisions we were taking, and also in equipping me and other Ministers to communicate these uncertainties to the public – an important aspect of building the trust and understanding that was necessary for good compliance with NPIs. While I am not aware of any external assessment or peer review – indeed the C19AG Corporate Statement makes clear that the Group was "not involved in any internal or external reviews, lessons learned exercises or other reports" - there was no evidence apparent to me of 'groupthink'. Indeed – as Dr Calderwood noted in her Module 1 oral evidence – the membership of C19AG was chosen to reflect a diversity of opinion.

114. I was aware that in addition to – and to some extent, because of - the inherent uncertainties of dealing with a novel virus, there was conflicting scientific and medical opinion. I was always aware of that in considering the advice, information and modelling that was provided to me. I was acutely aware that science could not make decisions – it could only inform them. I chose to read widely from publicly available information, in addition to the advice provided through our own structures and would regularly ask advisers about anything that seemed relevant. I was able to do this with the CMO, DCMOs and NCD, and also in the Deep Dive sessions organised by C19AG. I encouraged those advising me to be clear if the advice being provided did not represent a consensus view, and to set out what the differences of opinion were. The process followed by C19AG in seeking to present a consensus view, being clear when that was not possible, and offering Ministers opportunities to discuss matters directly with its independent members is set out in its Corporate Statement, at paragraphs 13, 31 and 16 as follows:

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

(who had a dedicated email address), while other advice was provided on the Group's own initiative. If there was not a consensus on the issue or on aspects of an issue, then the advice made clear where that was the case. Communication channels were clear, as the Group reported to CMO with excellent secretariat support, therefore ensuring effectiveness. It should be emphasised that the Group only provided advice to Government and did not make decisions. The Group did not produce bulletins, briefings, or other written guidance for the Scottish Government other than their formal written advice.

"The C19AG aimed to present a consensus view in its advice to the Scottish Government. Where it was not possible to reach a consensus on a particular aspect then the advice provided by the Group made that clear. The advice provided by the Group is available at: Scottish Inquiry - Tranche 6 - Scottish Government COVID-19 Advisory Group."

"In addition to the regular meetings of the C19AG, a number of briefing meetings with Ministers were arranged, referred to as 'Deep Dives'. Professor Morris chaired these meetings and agreed the agendas for them with the secretariat, focused on issues of current interest to the Scottish Government where a better understanding of the science could be helpful to Ministers. These meetings provided the opportunity for the independent members of the Group to speak directly to Ministers and for Ministers to question experts about the science. The usual format was short presentations by Group members, based on the briefing papers provided for that meeting by the secretariat and members, followed by discussion and questions from Ministers. Any decisions made in relation to the issues discussed at these briefings were made by the Scottish Government and the Group's role, as with written advice, was only to advise, not to decide. Agendas and papers for these meetings can be found in the return: Scottish Inquiry - Tranche 6 - Scottish Government COVID-19 Advisory Group. On occasion, these meetings were arranged through the Scottish Government Resilience Room ("SGORR") and SGORR officials received copies of meeting agendas and papers, in addition to those who regularly received C19AG meeting papers."

I believe that these processes generally worked well and provided me with good quality advice that I was able to interrogate and from which I could understand any uncertainties of conflicts inherent in it.

115. I am asked if there were instances where medical or scientific advice or data modelling was provided but not followed and no I do not believe there were. However, in answering this question it is important to be clear that science and modelling could not take decisions for us, it could only inform these decisions. There were occasions when the scientific and medical advice/modelling was such that – in my view - only one option was realistically open to decision-makers. I would argue that going into lockdown on 23 March 2020 was in this category. However, on other occasions the function of the scientific/medical advice and modelling was to help us understand the impacts of different options and guide our decision, which would be taken on a balance of judgment. In our discussions, principally at Cabinet, a range of views would be expressed about what the best option might be, informed by the advice offered to us. However, there were no occasions when the decision reached by Cabinet was dissented from by our clinical advisers.

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

117. The Scottish Government had access to, and drew on, views, information, and advice from a range of representative groups, including those with a perspective on patients' issues. For example, the Scottish Government's Support for People Group brought together a range of interests focused on supporting those who were shielding. There was also extensive liaison with social care stakeholders. And there was ongoing and regular discussion and consultation with a range of external organisations throughout the pandemic, including trade unions. There was also engagement in later phases with groups representing bereaved families.

Data and modelling

118. Data was assembled and provided to Ministers by the Covid Health and Social Care Analysis Hub, the Covid-19 Modelling and Analysis Hub, and the Covid Testing and Vaccine Modelling Group. Data would be provided directly and also included in advice from the CMO, C19AG, and other advisors.

119. Data was drawn from several sources: from Public Health Scotland on Covid-19 cases, tests, deaths and vaccinations; from National Records of Scotland on deaths

where Covid-19 was mentioned on the death certificate; from NHS Boards on patients in hospital and ICU with Covid-19; from care homes on confirmed cases of Covid-19 amongst care home residents and staff, and the visiting status of care homes; from schools on attendance and absence for Covid-19 related reasons; from NHS Education for Scotland (NES) on NHS staff reporting absent due to Covid-19; from the Office for National Statistics on infection rates from the Covid-19 Infection Survey; and from local authorities on the support offered to those in need or self-isolating during the pandemic.

120. I received data on a daily basis on the number of tests carried out, positive cases, percentage positivity, the number of people with confirmed or suspected Covid newly admitted to and in (a) hospital and (b) ICU, and the number of people with Covid who had died within 28 days of a first positive test. This was later supplemented by data on numbers vaccinated.

121. National Records for Scotland reported on a weekly basis on the number of deaths from Covid based on a positive test or reference on a death certificate. I also received data on a weekly basis from the ONS Infection Survey, which included an estimate of the R number. Later, I also received data from wastewater samples.

122. The data detailed above was published and disseminated through the daily media briefings.

123. Public Health Scotland published much more detailed data, and this was all available to Ministers. The extract below from their website under 'Covid-19 Statistical Data for Scotland' details the information provided, although not all it was available from the outset – for example, PHS started to include equalities data from March 2021.

'This dataset provides information on number of new daily confirmed cases, negative cases, deaths, testing by NHS Labs (Pillar 1) and UK Government (Pillar 2), new hospital admissions, new ICU admissions, hospital and ICU bed occupancy from novel coronavirus (COVID-19) in Scotland, including cumulative totals and population rates at Scotland, NHS Board and Council Area levels (where possible). Seven day positive cases and population rates are also presented by Neighbourhood Area (Intermediate Zone 2011). Information on how PHS publish small are COVID figures is available on the PHS website.

Information on demographic characteristics (age, sex, deprivation) of confirmed novel coronavirus (COVID-19) cases, as well as trend data regarding the wider impact of the virus on the healthcare system is provided in this publication. Data includes information on primary care out of hours consultations, respiratory calls made to NHS24, contact with COVID-19 Hubs and Assessment Centres, incidents received by Scottish Ambulance Services (SAS), as well as COVID-19 related hospital admissions and admissions to ICU (Intensive Care Unit). Further data on the wider impact of the COVID-19 response, focusing on hospital admissions, unscheduled care and volume of calls to NHS24, is available on the COVID-19 Wider Impact Dashboard.'

124. Ministers were also briefed by the CMO and the NCD on suspected mutations and the emergence of new variants.

125. I have been asked to about comments from Public Health Scotland about the lack of care home data. I do not currently have sight of the full context within which these comments have been made. However, I do recall early in the pandemic that there was discussion about a need to collect further data in relation to care homes. I understand that the DG Health and Social Care corporate statement dated September 2023 [NS4/017 - **INQ000346089** provides more detail on data gathered and used to inform Covid decision making at different points in the pandemic and the specific steps taken to increase the data available with regards to care homes.

126. I consider that the data provided gave Ministers a detailed understanding of rates of infection and transmission, the burden of illness and death caused by Covid, and the risks and realities of new variants. From 1 March 2022, HPS also provided data on re-infections, and this was applied retrospectively to earlier data.

127. Data was disseminated to me on a daily basis via my Private Office. It was also included in other papers and briefings, including for Cabinet, SGORR, 'Gold' meetings and Deep Dives.

128. I believe that I developed a good understanding of the data and modelling provided to me, including the limitations and uncertainties inherent in it. I was able to interrogate the data, ask questions of clinical advisers, and get more information/explanation if and when I felt it necessary. This was important to provide me with a sound basis on which to reach decisions, but it was also vital to my ability to communicate with the public in a clear, open, and transparent manner.

129. I consider that the systems for the collection and dissemination of data amongst and between the Health and Social Care Directorate, other Scottish Government directorates, NHS National Services Scotland (NSS) and Public Health Scotland worked effectively. This was aided by the COVID-19 Data and Intelligence Forum, which was set up around June 2020 to ensure effective coordination and coherence across the various Covid-19 data and intelligence streams that flowed within the Scottish Government and between Scottish Government, PHS and NSS. The reason for this view, from my perspective, is that the systems provided Ministers with detailed and granular data, and modelling that allowed us to understand possible impacts of different scenarios and options, in a coherent way. This informed our decision-making and allowed us to communicate to the public our understanding of levels of infection, impacts, trends, and the rationale for the decisions we were taking.

130. I have been asked about the reliability of the mathematical modelling of epidemiological outcomes that was made available to us. Modelling was made available to Ministers regularly throughout the pandemic, giving us important insight into the possible impacts of the different policy options open to us – from doing nothing through to extensive NPI restrictions. This modelling informed the decisions we took. Particularly in the early phase when a significant concern was the 'overwhelming' of the NHS, modelling showing the impact of different levels of infection on admissions to hospitals and ICU was a key factor in the decisions we took. To cite just one example of how modelling translated into, not just strategic decision-making, but operational activity: in late March 2020, at a time when intense global demand for ventilators was slowing down supply, we were concerned by modelling indicating that our baseline and surge ICU capacity could be exceeded – this led to a decision to embark on a programme of repurposing anaesthetic machines. In my experience, the modelling provided was of a high quality. However, conclusions about its reliability need to be considered in the context of certain factors:

i) Modelling is an iterative process and the outputs from it depend on the inputs. Throughout the pandemic there was an ongoing process of fine-tuning and re-modelling to take account of changing assumptions and different policy options.

ii) The modelling told us what could happen in certain scenarios and that allowed us to take preventative action to avoid the worst-case outcomes materialising.

That means we cannot say, with any certainty, whether or not – had we not acted as we did - the modelling would have proven to be accurate.

131. The Four Harms approach – referred to earlier in this section – enabled us to take account of wider health, economic, and social harms from Covid. While the range of data and impacts being considered as part of the wider harms approach, and the degree to which impacts emerged during the course of the pandemic, did not facilitate their inclusion in a single, mathematical, model, the Scottish Government sought to share the range and types of evidence which underpinned its decision making, in published papers in May 2020 and December 2020 and in February 2022.

132. I have been asked there was sufficient modelling of the impact on vulnerable and at-risk groups. Ministers were acutely aware throughout the pandemic of our duties under Equalities legislation and of the need to do impact assessments. In addition, the following extract from paragraphs 34-41 of the DG Communities Corporate Statement [NS4/018 - INQ000215482] may be helpful in understanding the process by which we ensured these matters were taken account of in our decisions-making:

34. In the context of the pandemic, policy advice on Equality and Human Rights, with particular regard to differential impacts on groups with protected characteristics, contributed to and informed the overall formulation of SG policy and supported decision-making by individual portfolio Ministers and, collectively, by the Scottish Cabinet.

35. EIHRD officials were in attendance at the Communities and Public Services Ministerial Group (CPSMG) that was established on 2 April 2020. The meetings initially took place twice a week initially, becoming weekly by July and fortnightly in October. The CPSMG was led by the Deputy First Minister and attended by all education, communities and justice ministers, along with Directors-General and Directors from those areas. In addition, the Chief Social Policy Advisor, Chief Social Researcher, Chief Scientific Advisor, Director-General Exchequer and communications officials were also invited.

36. This was a key forum to enable a co-ordinated and collaborative approach to social issues relating to the pandemic, particularly in relation to Harm 3. This included discussions on policy approaches in relation to services within the relevant ministerial portfolios such as student hardship, prison release, etc. It was

also used to look at evidence on how Covid-19 impacts were being experienced differently across different groups such as black and minority ethnic people. In addition, EIHRD provided updates to the group on how equality and human rights approaches were being 'mainstreamed' across Scottish Government i.e. that equality impacts were considered by Directorates across Scottish Government during policy development and prior to implementation.

37. *Inequalities also featured in the weekly briefings provided to Ministers as part of the four harms process in weekly Cabinet papers and in the four harms evidence papers which were also published. Scottish Government's four harms approach is set out in further detail in the M2ASG01 DG Strategy and External Affairs statement submitted to the Inquiry in draft on 23 June 2023, specifically in the section entitled "Scottish Government's overall approach to using NPIs". The section entitled "The process of decision making" sets out how the Four Harms Group existed to enable the development of well-rounded material to support Ministerial decision making at Cabinet as well as setting out the development process for Cabinet papers.*

38. *Due to the pace of activity, requests for advice came from policy teams through a mixture of emails and use of Skype/Teams messaging on an ad hoc, but frequent – often daily – basis. Whilst much of the engagement was through the Mainstreaming team, other queries were raised directly with equality policy teams using their known contacts or looking up responsibilities on the staff directory.*

39. *EIHRD also scrutinised draft legislative provisions for what would become the Coronavirus (Scotland) Act 2020 for potential equality and human rights impacts in March 2020, aiming to ensure that the effects of the legislation were fully compatible with the Convention rights and that particular groups were not disproportionately affected by the legislative response to the pandemic. EIHRD also engaged with colleagues on the Coronavirus (Scotland) (No.2) Act 2020 and Coronavirus (Extension and Expiry) (Scotland) Act 2021 – the Equality Impact Assessments for these key pieces of covid legislation have been published on the gov.scot website. EIHRD was also engaged as legislation was further amended and updated subsequently, for example, providing input that led to the exemption in regulations from mandatory face coverings for individuals leading acts of worship.*

40. EIHRD's advice on equality and human rights recognised the potential for groups with protected characteristics as set out in the Equality Act 2010 to be adversely and disproportionately impacted and the need for potentially vulnerable groups to be considered when making policy decisions on non-pharmaceutical interventions. The impacts on different groups were summarised in papers prepared by the Communities Analysis Division and published in June 2020, provided. This collection of papers supplemented the equality and human rights considerations routinely included in four harms papers and Cabinet papers, previously provided to the Inquiry. Within those protected characteristic groups, EIHRD differentiated smaller elements e.g. not all disabled people would be affected by communications that were not inclusive in the same way that deaf/blind people would be. Similarly, Gypsy/Travellers' accommodation arrangements placed them in a different position to other racial groups. EIHRD advice based on the working knowledge of officials about groups falling within their policy remits. The officials tailored their advice according to the specific policy or legislative proposal and its potential to impact on very specific groups.

41. There was, of course, a very clear recognition of how policies would affect two specific vulnerable groups i.e. older people and disabled people with existing health conditions. Considerations of policy impacts on those groups were a significant part of thinking about Harm 1 of the four harms approach (including direct health impacts on individuals) when making decisions on measures to prevent or reduce transmission in the community and thereby reduce risk to those vulnerable groups.

133. I have been asked if I ever used the phrase 'following the science". I am sure that there were occasions when I did so. However, as the pandemic progressed, I became increasingly uncomfortable with how that phrase was being used by UK government ministers i.e., to suggest that they had no option but to take a particular decision and/or that the 'science' provided an objective and factual validation/justification for the decision. It seemed to me to be trying to absolve ministers of agency and responsibility, and I was concerned that it was neither an accurate nor an honest representation of the reality of government decision-making. I was also concerned that it frustrated rather than aided efforts to build public understanding of the complexities and uncertainties of the decisions being taken. So, while I am sure there are instances of me using that phrase as shorthand, I know

there were also many occasions, at media briefings and in parliament, when I tried to set out the much more accurate position – that while science informed our decisions, it was Ministers who decided, and that decisions were often – by necessity – based on judgment as well as science.

Other sources of information and advice

134. The Scottish Government received an invite from the Cabinet Office on 23 June 2020 to participate in an introductory discussion with the International Comparators Joint Unit (ICJU). The ICJU was a body led by the Foreign & Commonwealth Office and the Cabinet Office, and its remit was to assess information on the different approaches comparator countries were taking to the Covid-19 pandemic, with a focus on non-pharmaceutical interventions. This was intended to inform the UK response. The Cabinet Office indicated an intention to more routinely share with the Devolved Administrations the assessment products produced by the ICJU. The stated purpose of the introductory discussion, therefore, was to set out the context, discuss the remit, approach and subjects that had been assessed by the ICJU, and establish a mechanism for sharing these products with the right people in the Devolved Administrations.

135. ICJU advice was subsequently shared with relevant policy teams/leads on various aspects of Covid response and was a generally useful source of information in the preparation of the advice that ministers received.

136. The Scottish Government also had access to information and advice published, or made available to the UK government, by the World Health Organisation. The following extract (paragraph 66) from the DG Health and Social Care Corporate Statement [NS4/019 - INQ000215488] explains the flow of information:

"…the UK has a seat as a member state on international organisations, such as the World Health Organisation (WHO) and the World Health Assembly (WHA). Whilst Scotland is not a member state in its own right, information provided by these relevant international organisations was provided to the Health Protection Network and the CMO."

137. The Scottish Government had access to analysis and assessment of the joint Biosecurity Centre across its three core functions: gathering and analysing data

about Covid-19 infection to inform analytical products; provision of assessment or guidance to help inform decisions about measures that it may be appropriate to implement to control the spread of Covid–19; and provision of advice on the Covid-19 alert level. This formed part of the overall suite of evidence, data, modelling, and advice that informed our decisions. The decision to merge the JBC into the UK Health Security Agency was one taken by the UK government, and I have no insight into the specific reasons for that. However, the agency/political agreements that governed the operation of the UKHSA in relation to the Devolved Administrations worked well and the merger did not reduce the quality of the information provided.

138. Scottish Government officials provided analysis – drawing on both Foreign & Commonwealth reporting and open-source information – of the approaches being taken in other countries. This included information on borders, NPIs, school closures/re-openings, test/trace/isolate, and Covid certification. This was one of many sources of information that helped inform the decisions Ministers took. However, decisions taken for Scotland always reflected the specific conditions, context and data on the progress of the pandemic within Scotland and our judgement on what course would minimise the harm resulting from the virus in line with the Four Harms framework. The political and geographic character of the countries cited – Taiwan, Singapore, New Zealand – is different to that of Scotland.

139. Over the course of the pandemic there was regular and intensive engagement with a wide range of interest groups and stakeholders. Much of this engagement was done by Cabinet Secretaries and Ministers with stakeholders within their own portfolio areas. I would see read-outs of meetings where relevant. I also met directly with different business and sectoral groups, on one occasion with university principals, and through SGORR with local authority interests, and with Police Scotland on issues relating to compliance and enforcement. There were ongoing efforts to ensure that the voices of different interest groups and stakeholders were taken account of in our decision-making, particularly at the key points of review of NPIs. Where views were expressed by individual groups to a given minister or official which fell outside their direct responsibilities, these would have been passed on to those responsible for the relevant policies. However, given the diversity of the views expressed to us and, understandably, the often-contradictory nature of them, it would not have been possible to act on all of them.

140. I met with Scottish members of the Covid Bereaved Families for Justice group on 22 March 2021. The meeting was agreed for me to hear directly from the members of the Group about their experiences, reflections and requests for government. A summary of that meeting is included in a briefing provided [NS4/020 - INQ000292533]. The main outcome of the meeting was to discuss further the Group's call for and expectations of a stand-alone Scottish public inquiry.

141. I understand that the Deputy First Minister met with the Group in order to continue discussions on the establishment of a Scottish public inquiry on the following dates: 22 March, 17 August, 24 August, 23 September, 25 October, 24 November, and on 14 December 2021, immediately before the announcement that this Inquiry would be established.

142. I understand that Humza Yousaf, as Cabinet Secretary for Health and Social Care, met with the Covid Bereaved Families for Justice Group on 17 August 2021, along with the then Deputy First Minister, John Swinney. I understand from the record of that meeting that the Group asked that the Scottish Government emphasise a more accurate understanding of Covid symptoms. The definition of symptoms was a matter for clinical advice: over the course of the pandemic the relevant NHS Inform page for Scotland was regularly updated to reflect the latest evidence. I am not aware of whether members of the Scottish Covid Bereaved raised points relating to nosocomial deaths with Humza Yousaf as Cabinet Secretary for Health and Social Care between August and November 2021. Significant efforts were made to reduce nosocomial infection throughout the pandemic, and this is a particular focus for Antimicrobial Resistance & Healthcare Associated Infection (ARHAI) Scotland within NHS Services Scotland.

Operation of advisory mechanisms and conclusions and lessons learned

143. I have set out in preceding paragraphs the structures through which advice was provided to Scottish Government decision makers, the nature of that advice, and my opinions about its quality, transparency, reliability, limitations, and uncertainties, as well as the forums that were used for communication amongst and between decision-makers and advisers. It is undoubtedly the case that mistakes were made in our decision-making and that had our state of knowledge been different at certain points, so too might the decisions taken have been different. I will expand on these issues in later parts of this statement. However, overall, I believe that structures that we had in

place and the flow of information they enabled worked effectively and allowed us to reach the best decisions possible in what was an extremely challenging, largely unprecedented, and deeply uncertain set of circumstances. Where we need to adapt and improve these structures, we did so – the establishment of C19AG being a case in point – and, of course, as our state of knowledge about the virus developed, so too did the depth and reliability of the information and advice we received.

PART C – INITIAL UNDERSTANDING WITHIN THE SCOTTISH GOVERNMENT & RESPONSES TO COVID-19 IN THE PERIOD FROM JANUARY TO MARCH 2020

Initial understanding of the nature and extent of the threat

144. I was aware of media reports about the developing situation in Wuhan, China in January 2020. The first briefing I received from Scottish Government officials was on 17 January 2020 [NS4/021 - INQ000130900], when I was copied into a note to the Minister for Public Health, Sport & Wellbeing from the Health Protection Division. It gave me such information as was available at the time. It advised of a cluster of pneumonia cases in Wuhan associated with a novel coronavirus. It noted that as of the day before there had been 41 confirmed cases in China (and two deaths), 1 in Thailand and 1 in Japan. It also advised that there was a suspected case in Liverpool. It noted that the novel coronavirus had been classified as an Airborne High Consequence Infectious Disease and added to the list of airborne HCIDs. It described the risk to the UK public as low and noted the view of the World Health Organisation that there was no evidence so far of significant person to person spread. It advised that Health Protection Scotland (later part of Public Health Scotland) was monitoring the situation with Public Health England and international partners, including WHO.

145. I was not aware of communication between the CMO and Professor Mark Woolhouse or other experts before C19AG was established, although I would assume that any relevant information would have been included in the briefings provided to Ministers.

146. There was no direct contact between the Scottish Government and the World Health Organisation to any significant extent. Scotland is not a member state of the WHO, nor of the World Health Assembly. The UK is the member state and disseminates information to the Devolved Administrations through the CMOs. There was regular communication with the UK government and other devolved administrations from the first indication of the cases in Wuhan. A note on 22 January 2020 to the Cabinet

Secretary for Health & Sport and the Minister for Public Health, Sport & Wellbeing, which I was copied into, advised as follows:

"10. A national incident team has been set up and is being led by the Department of Health and Social Care (DHSC). A daily call will take place between PHE, DHSC and the devolved administrations. SG officials will continue to dial in to these calls." This contact intensified as the situation developed and was supplemented by Ministerial engagement through COBRA from later in January.

147. As stated above, the first briefing I received was on 17 January 2020. There was a further update on 23 January [NS4/022 - INQ000245831]. I received a more substantial briefing on 24 January 2020. This briefing included the latest case numbers from China and other countries, as reported by the WHO; advised that there were as yet no confirmed cases in the UK and that the first tests of individuals in Scotland under assessment had been negative; confirmed that a UK Situation Reporting (SitRep) system had been set up; advised that steps were being taken to establish testing facilities in Edinburgh, followed by Glasgow and Dundee; set out the arrangements for treatment/transport of any positive cases; and advised that a contingency supply of facemasks was being released and distributed from national stockpiles. The briefing (I comment further on this briefing at paragraph 149 below) also included the following references to the state of scientific knowledge about the virus:

"14. We now know that people carrying the virus are only infectious to other people when experiencing symptoms.

19. The New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) will convene on Tuesday to opine on severe case management and treatment options. Further information will flow as greater understanding of the science behind the viral behaviour and response to potential treatments is developed."

148. As well as briefings from within the Scottish Government – which were informed by up-to-date scientific considerations and developing understanding - I read many publicly available articles and reports in the period from January to March 2020. I did not retain a list of these, but they helped develop my understanding of the situation and inform questions that I asked officials and advisers, including the CMO.

149. My assessment of the situation as January progressed – and certainly by the time the Cabinet first discussed Covid on 4 February [NS4/024 - INQ000238704] - was that the situation was extremely serious. The WHO had declared a Public Health Emergency of International Concern on 30 January and the four UK CMOs had subsequently raised the assessment level from low to moderate. However, it is also correct to say that there was a significant degree of uncertainty in the advice being provided during January, February and into the very early part of March about the likely severity of the situation in the UK; and about the key characteristics of the viral behaviour being exhibited by Covid-19. Taking these key issues in turn:

a) **How Covid-19 was transmitted:** initial briefing on 17 January, based on WHO classification, stated that the virus was airborne. However, certainty on this point subsequently seemed less absolute, and references tended to be to 'respiratory' rather than 'airborne' transmission. Public Health England guidance published on 30 January 2020, stated as follows*: "We do not know the routes of transmission of WN-CoV; however, other coronaviruses are mainly transmitted by large respiratory droplets and direct or indirect contact with infected secretions. In addition to respiratory secretions, other coronaviruses have been detected in blood, faeces and urine. Under certain circumstances, airborne transmission of other coronaviruses is thought to have occurred via unprotected exposure to aerosols of respiratory secretions and sometimes faecal material."* Indeed, as late as 7 July 2020, the WHO – at a media briefing – while acknowledging the possibility of airborne transmission, stressed that there were multiple possible routes, and that the science was still unclear. I did understand very early on that the virus could be transmitted by someone touching eyes, nose, mouth after contact with an infected surface.

b) **Whether Covid-19 could be spread person to person asymptomatically:** the initial advice I received (see extract from January 24 briefing above) was that asymptomatic transmission was not possible. My Private Office replied on my behalf and at my request with the following query*: "FM read information online in the last 24 hours - inc references to an article in yesterday's Lancet - suggesting the opposite of this i.e. that people may be infectious before being symptomatic. What is the very certain statement in para 14 based on?*" I received further advice from PHS on 25 January [NS4/023 - INQ000292534] This included the following extracts: *"…it is likely that person to person transmission, when it does occur, mostly involves transmission of virus from people with symptoms" and "…infected people with symptoms (e.g., someone who is coughing) are much*

more likely to spread virus around than someone who is infected but free of symptoms." The evidence and advice on asymptomatic transmission remained uncertain until around April/May 2020 after which there seemed to be more of an acceptance that asymptomatic transmission was an issue.

c) **The fact and significance of community transmission:** in terms of 'fact', it is the case that as late as 3 March, it was thought that there was not sustained community transmission in the UK. The conclusions of the meeting of the Scottish Cabinet held on that day [NS4/025 - **INQ000232901**] noted as follows: *"At present, there was little evidence of community transmission in the UK, and new cases tended to be in clusters…"*.

However, there was most definitely an understanding of the 'significance' of community transmission. The Cabinet meeting on the 10 March [NS4/026 - **INQ000238706** noted the following:

"Judgements about the next stage of the response in Scotland (and across the UK) would, however, reflect the manner of transmission rather than raw numbers: if there was evidence of sustained community transmission (where no clear source was apparent), then this would suggest that containment was no longer possible and that the response should move into the next, 'delay' phase. Based on experience elsewhere, it was likely that this would happen in the near future."

d) **The significance of exponential growth in transmission:** there was always an understanding of the significance of exponential growth and that this would represent a situation out of control. This was reflected in the phases of UK wide Action Plan published on 3 March [NS4/027 - INQ000131020] – when it was considered that 'containment' was no longer possible, the objective would then be to 'delay' i.e., to slow down growth and prevent it being exponential.

e) **The significance of the R number (and the need to keep it below 1):** similar to my comment at d) above, there was an early understanding of the significance of the R number and the need to keep (or get it) under 1 to prevent exponential growth. For example, a SAGE paper dated 4 March [NS4/028 - INQ000182836] is explicit on this point as follows: *"8. Preventing an epidemic requires the reproduction number (the average number of people a person will infect) to be reduced below 1 and maintained there".*

f) **The potential severity of the consequences of infection:** while the initial understanding – which evolved on the downside over March/April – was that for most people the symptoms were likely to be mild there was nevertheless an understanding that for a significant proportion, the consequences could be

severe. For example, the Reasonable Worst Case Scenario (RWCS) information provided by SAGE was reported to the Scottish Cabinet on 10 March [NS4/029 - INQ000238706] – this suggested that 8 percent of those infected would require hospital treatment, and of those admitted to hospital, 19 percent might require ventilation.

g) **The groups most likely to suffer serious consequences as a result of infection:** there was early understanding that this would include the elderly (the RWCS suggested an over 80 fatality rate of 20 percent, compared to 1 percent for the population as a whole); and those with other underlying health conditions. Initially, the at-risk group included all those covered by the seasonal flu programme.

150. I am asked if I consider that the essential features of the virus and disease were properly understood by me and core decision makers in the period between January and March 2020. I consider that the answer to this question to be yes, as far as this was possible, but subject to the fact that knowledge about the virus was still developing. As set out above, we did not in that period fully understand the extent to which asymptomatic transmission was possible. I believe that our understanding was reflective of the scientific consensus at this time but, nevertheless, it turned out to be wrong.

151. Between January and March, a considerable amount of work was done to ensure that Scotland was as prepared as possible for the situation that was developing. Information about Scotland's resilience structures was provided in extensive written and oral evidence during Module 1. Ministerially led meetings of the Scottish Government Resilience Room (SGORR) were held on 29 January, 17 February, 25 February, 1 March, 2 March, 16 March, 19 March and 30 March 2020. I chaired all of these, with the exception of 17 February (NOTE: in my Module 1 statement [NS4/030 - INQ000182606], I say that I chaired all SGORR (M) meetings in this period – on further checking, I note that the meeting on 17 February was chaired by the DFM as I was visiting communities in the south of Scotland which had been badly affected by flooding). There were also official led meetings of SGORR held on 29 & 31 January, 6, 14, 24 & 28 February, and 6, 17, 20, 23, 25 & 31 March 2020. The purpose of the SGORR meetings was to assess the state of our preparedness and commission any necessary actions to strengthen it. The paper discussed at Cabinet on 10 March summarises the work being done across government, including action to increase NHS capacity.

152. I am asked if I and others in the Scottish Government properly appreciated 'the seriousness of the spreading virus' and if we acted appropriately. Subject to my comments in paragraph 150 about asymptomatic transmission and in paragraph 149 (c) about community transmission, the answer to these questions is yes. I believe that we had a good understanding of what was known about the virus at the time, albeit the fact that significant uncertainties remained, and based on our understanding, we acted appropriately.

153. I am asked if there was an understanding within the Scottish Government that Covid-19 was akin to influenza and if I shared this view. There was no assumption as far as I was concerned that the severity and means of transmission would be identical to flu. Indeed, a Health Protection Scotland briefing note dated 8 January 2020 (not seen by me at the time) was explicit that the virus was not flu. However, in light of the initial uncertainties around Covid-19, it was the case that a number of protocols, assumptions and contingencies associated with flu were used – for example, the list of those considered potentially vulnerable was taken from the influenza Green Book; the RWCS assumptions were based on a flu pandemic, and the Flu Pandemic Plan was used as a starting point for resilience planning. This is summarised in the UK wide Coronavirus Action Plan published on 3 March 2020 [NS4/027 - INQ000131020] as follows: *"there is similarity between COVID-19 and influenza (both are respiratory infections), but also some important differences. Consequently, contingency plans developed for pandemic influenza, and lessons learned from previous outbreaks, provide a useful starting point for the development of an effective response plan to COVID-19. That plan has been adapted, however, to take account of differences between the two diseases."*

154. I consider that the declaration of a Public Health Emergency of International Concern by the WHO was an appropriate and timely intervention and it contributed to a heightening of concern and preparedness in Scotland and across the UK. For example, it was quickly followed by the four UK CMOs raising the alert level from low to moderate to "escalate planning and preparation in case of a more widespread outbreak." It is unlikely that there was any direct contact between the Scottish Government and WHO on an official basis about the declaration as contact is mediated through the UK government which is the member state. However, the

declaration was reported to the Scottish Cabinet on 4 February [NS4/024 - INQ000238704].

155. All early briefings and Cabinet papers drew on input from the CMO, based on her discussions with her counterparts in the other UK nations. The advice and recommendations which resulted from these discussions for implementation in a UK context took account of the WHO advice and guidance issued over the course of January/February.

156. I am asked if I was aware by the end of January 2020 that 'a potentially fatal new respiratory disease was spreading through the UK'. I was fully aware of the potential, indeed likelihood, for this to become the case, and I believe this understanding was shared across key decision makers in the Scottish Government. However, there were no identified cases in Scotland until early March, and we did not have evidence of community transmission in the UK prior to that.

157. I am asked about the extent to which I was made aware during February 2020 of the number of people in Scotland who might become infected with Covid-19, and about planning for a Reasonable Worst-Case Scenario (RWCS). Papers for the Scottish Cabinet meeting on 4 February 2020 [NS4/024 - INQ000238704] noted that the Scottish Government's preparations were based on *"the reasonable worst-case scenario of a situation similar to an influenza pandemic".* A paper prepared for SGORR, dated 17 February [NS4/031 - INQ000233538], contained RWCS figures. It assumed that up to 50% of the population (2.7 million people in Scotland) could experience symptoms; up to 4% of symptomatic patients (approximately 110,000 people) could require hospital care and that 25% of those (approximately 27,000 people) could require level 3 critical care; and that up to 2.5% of those with symptoms (approximately 68,000 people) could die. The minutes of the Cabinet meeting of 3 March 2020 [NS4/032 – INQ000232901] – in the context of discussion about the first identified cases in Scotland – also contain this reference to a RWCS: *"There was widespread misunderstanding of what a 'reasonable worst case' scenario might mean in practice. For example, an estimate of 200,000 cases in Scotland could be spread over a number of months and did not imply that they would all happen at once. This said, the impact on the health service and wider society was likely to be significant, and the extent and nature of preparations should not be concealed."*

158. By the end of January 2020, the priority that Covid-19 was being given by the Scottish Government was high and rapidly increasing. It would be wrong to say that it was the only priority at that stage as the implications of Brexit, as well as the normal day to day business of government, continued to occupy us. However, it was certainly an issue that was increasingly central to our thinking by that point.

COBR/SGORR

159. COBR is a UK government body and decisions about when it should be convened and on what basis are for UK ministers.

160. While it was not a decision for me, it is my view that the standing up of the COBR arrangements in late January 2020 was an appropriate step to take at that time. The Scottish Government's response was to ensure that we participated at all meetings to which we were invited. We also took the decision to activate the SGORR arrangements at the same time and I chaired the first Covid-19 related SGORR (M) meeting on 29 January.

161. I have been asked about my non-attendance, and that of the then Prime Minister, at the early COBR meetings (the first COBR I attended was 2 March 2020). I addressed this in my Module 2 statement [NS4/005 - INQ000235213] as follows:

"The attendance of my Health Secretary at the first five COBR meetings was considered appropriate as these meetings were chaired by her counterpart, the UK Health Secretary and attended by relevant Health Ministers of the other devolved governments. This was entirely in line with past practice. It is normal for heads of administration to delegate participation in inter-governmental meetings to lead portfolio Ministers. In my judgment, this has no impact on the effectiveness of governments' response to risks and threats. Specifically, in relation to early Covid planning, it is my firm view that the attendance at COBR of health ministers in January and February, rather than of me (or indeed the then Prime Minister) had no impact on decisions taken. It is part of the role of lead portfolio Ministers to report to heads of administration so that we may judge when our direct involvement is necessary, proportionate, and justified. Indeed, to illustrate the point about past practice, as the Scottish Health Secretary during the 2009 Swine Flu pandemic, it was me – not the then First Minister – who attended COBR meetings, as these were chaired by the then UK Health Secretary rather than the then Prime Minister.

162. The decision to convene COBR (M) on 2 March and for the Prime Minister to chair it was taken by the UK government. My view was that it was an appropriate step at that time, and I attended the meeting remotely from the Scottish Government Resilience Room, along with the CMO.

163. SGORR was activated on 29 January 2020. This was proposed by the Cabinet Secretary for Health and Sport and agreed by me. The hours of operation and staffing within SGORR increased as the situation deteriorated. Information sharing during this stage was delivered by SGORR through daily Situation Reports (SitReps) with different versions for internal and external use. Actions agreed at SGORR meetings drove awareness of the increasing threat and catalysed early preparatory actions across the Scottish Government and our key partners in this initial period. I understand the Inquiry has details of SGORR, including how it functions, and details of the SGORR (M) meetings and copies of SGORR papers including the SitReps.

164. I have been asked about the comment in my Module 2 statement [NS4/005 - INQ000235213] to the effect that COBR would be the best structure to use in any future pandemic to support four nations' working. I consider this would be the case on the condition that the operation and accountability of COBR was altered to ensure parity of status for the Devolved Administrations within our spheres of competence. This is not possible within COBR as currently established.

165. I have been asked about the Scottish Government's understanding of the respective decision-making responsibilities between us and the UK government in relation to the pandemic response at the start of 2020. I would submit that the Scottish Government fully understood the scope of our very significant responsibilities within devolved competence. We were the primary decision makers on many of the principal strands of response, including NPIs, the management of the NHS, the impact of schools, and the detail of support schemes for individuals and businesses. We also understood the need to liaise closely with the UK government on areas of reserved responsibility such as fiscal and economic interventions and the management of borders, as well as to overall co-ordination of our responses as far as possible.

166. I am asked about the operation of SGORR. SGORR was first activated in response to Covid-19 on 29 January 2020, on the recommendation of the Cabinet Secretary

for Health & Sport and subsequently approved by me. By the time of the first lockdown in March 2020, the activation involved two shifts per day, seven days a week, under a Head of SGORR. Each shift including a Team Leader, Briefing Manager, Information Officer, Technical Support Officer, and a Staff Officer.

167. SGORR was not established in response to Covid-19 – it is a long-standing Scottish Government resilience structure. It was activated as part of our response – indeed, SGORR exists when activated in response to an emergency or major incident. SGORR performs a similar function – within areas of devolved competence – to COBR at a UK level. Its function is to co-ordinate the response – within the Scottish Government and between the Scottish Government and partner responders - to emergency or major incident situations in Scotland. It can also be activated to co-ordinate the response to emergencies/major incidents outside Scotland but with impact on our responsibilities. Where substantive collective decision making is required as a result of SGORR discussion, that occurs within the standard decision-making structures of the Scottish Government, as described within the corporate statement provided by DG SEA in June 2023 [NS4/001-INQ000215495].

168. SGORR can be activated at any time of the day, all year round. There is a small team of officials – the Response Team - that oversee SGORR facilities, systems, and processes. When SGORR is activated, they assume roles within the structure and draw on support from volunteers from across Scottish Government – the Support Team - who are trained in performing SGORR functions. The team within SGORR are not subject-matter experts – they manage the administrative functions and information management processes that are common to all emergencies/major incidents.

169. The manner in which SGORR facilitates decision making depends on the nature of the emergency/major incident being responded to, but will usually involve:

- ensuring that the right people are present.
- ensuring that the right information is in available to decision-makers.
- arranging and hosting meetings – at the right time and at the appropriate frequency.
- providing effective meeting facilitation.
- establishing clear roles and responsibilities.

- allocating tasks and setting out clear timelines for their completion, and systematically following up on their completion.
- ensuring that connections are made within the Scottish Government and between the Scottish Government and other organisations as appropriate in the organisation and beyond.

170. SGORR does not have exclusive or shared responsibility for the areas of government policy discussed at meetings. Instead, it provides a forum for high-level discussion and briefing. It does not assume the lead for policy areas' portfolio areas. It does not make decisions – rather it brings together those who do to coordinate their activity.

171. SGORR facilitates two forms of meetings – SGORR (Officials) and SGORR (Ministerial). Meetings of SGORR (O) are attended by officials who responsibilities/expertise on the emergency/major incident being responded to. contribute to the matter at issue. Meetings of SGORR (O) are chaired by a senior official - either the Head of SGORR, the Deputy Director for Resilience or their Director. Meetings of SGORR (M) are supported and facilitated by one of the officials referred to above. These are chaired by the First Minister if s/he is in attendance or, if not, by the DFM or another senior Minister. As noted above, I chaired all but one of the SGORR (M) meetings held in the January to March 2020 period. Information gathered at or through SGORR fed into the decisions arrived at by Cabinet.

172. I have been asked about the process for preparing and disseminating SGORR Situation Reports (SitReps). The following summarises the process in relation to Covid-19 (which was broadly the same as the process in any scenario): Situation Reports were compiled by the SGORR team on the basis of information received from other policy areas or partners. The purpose of the reports was to create a shared situational awareness. Content was sourced in template fashion from through hubs set up to represent particular policy areas. For example, DG Health and Social Care Directorate would provide information on the NHS. Deadlines were set for the provision of information and the SGORR team would 'chase' responses if these were missed. The SGORR team would also perform checks on the quality and consistency of information. Reports were signed off by the on-shift Head of SGORR and issued in two formats with strict handling instructions. The unredacted version was for internal Scottish Government use and situational awareness. The external version was redacted down to a level that could be shared with partners to enable them to plan

and respond to the emergency. SitReps were issued to a wide range of Scottish Government personnel, including Scottish Ministers and the Scottish Government's Executive Team.

Pre-lockdown response

173. The precautionary measures taken by the Scottish Government in the pre-lockdown period – such as the issuing of respiratory and hand hygiene guidance – were the same as those taken by the UK government. The four UK governments published the Coronavirus Action Plan on 3 March 2020 [NS4/027 - INQ000131020], which contained links to advice for the public. This was supplemented in Scotland by a paper setting out information on SGORR, the role of the CMO for Scotland, the amendment of Scottish public health regulations to make Covid-19 a notifiable disease, the Scottish Resilience Partnership, and where to find Scotland-specific public health advice.

174. Given the state of our knowledge and advice, the precautionary measures taken in the pre-lockdown period seemed at the time to be appropriate and proportionate. Given what we now know – knowledge that was developing all the time – particularly about the potential for asymptomatic transmission, and the possibility that the extent of community transmission was greater than we believed it to be, I think it can be argued that more stringent measures should have been taken more quickly. That is, however, to apply hindsight and assume knowledge that we did not at that time have.

175. Surveillance for Covid-19 in the period from January to March 2020 took the form of testing of suspected cases within the agreed definition and, later, of those with respiratory/flu like symptoms, even if they had no history of travel to affected areas. Testing for suspected cases began in Scotland on 24 January 2020. Papers for the Cabinet meeting of 28 January noted the following:

"As of 26 January 2020, the UK Government reported that a total of 73 people have tested negative for the coronavirus in the UK. It has been agreed that UK Chief Medical Officers (CMOs) will be the custodian of patient data, and all administrations will report only the numbers of concluded cases and the number of positive and negative cases. There will be no reporting publicly of the numbers under investigation at any given time although this number will be shared across the four nations for planning purposes. Updated UK figures will be received daily at 1.00 p.m.

This is a continually evolving situation. At 9.00 a.m. on 27 January, a total of seven cases had been concluded in Scotland, all of which proved negative. These are included in the 73 cases tested across the UK. Four other cases in Scotland are under investigation."

On 6 February, UK CMOs advised that testing in the UK should be widened from individuals with symptoms who had recently travelled from China to also include those travelling from other areas with known outbreaks. A SitRep from 13 February noted as follows:

"In light of new evidence of human-to-human transmission beyond China, the UK CMOs advised that UK testing for novel coronavirus should be widened from individuals in the UK showing possible symptoms of the novel coronavirus who had recently travelled from China or had contact with individuals who had been in China to also include individuals in the UK who have travelled from Thailand, Japan, Republic of Korea, Hong Kong, Taiwan, Singapore, Malaysia or Macau and are showing possible symptoms of novel coronavirus. This was informed by SAGE advice."

Steps were taken by the Scottish Government during February and March to speed up the processing of tests in Scotland and extend the reach of surveillance testing.

On 10 February, the CMO confirmed that two new laboratory facilities, one in Edinburgh and one in Glasgow, would begin to process all tests from Scotland, with only positive tests being sent to Colindale in London for confirmatory testing – prior to this all tests from Scotland had been sent to Colindale for processing.

On 28 February, details of community and drive-thru test sampling facilities in different health board areas were shared.

On 1 March, the CMO confirmed that sample testing of people with flu like symptoms, even if they had not travelled to affected areas, would be carried out by a surveillance network of 41 GP practices across Scotland – the purpose of this was to give early indication of any evidence of community transmission.
In addition, she confirmed that patients admitted to critical care units with pneumonia would be tested.

On 15 March, the CMO confirmed that the programme of surveillance testing would be extended to GP practices covering 1.2 million people across all NHS Board areas in Scotland.

These changes were put in place in line with advice provided to me and Cabinet on the significance of surveillance and testing activity at this stage in the pandemic and appropriate resources were provided for this purpose. The general importance of testing and tracing for surveillance purposes was underlined by the CMO at the Cabinet meeting of 10 March. The conclusions of the meeting noted as follows:

"The Chief Medical Officer emphasised 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 sit at the apex of a 'pyramid' of a far higher number of undetected cases: this was likely to be indicative of the start of sustained community transmission."

176. I am asked when the Scottish Government decided that it should prepare for a Reasonable Worst-case Scenario (RWCS). The meeting of COBR on 29 January – attended by the Cabinet Secretary for Health & Sport and the CMO - agreed to *"increase planning for a reasonable worst-case scenario, using the National Security Risk Assessment pandemic flu assumptions as a starting point, with the additional information that the elderly and those with existing health conditions will be disproportionately affected'.*

177. The Cabinet Office circulated a presentation on 4 February setting out planning priorities under the RWCS planning assumptions, which would have been presented to SGORR.

178. As set out earlier, papers for the Scottish Cabinet meeting on 4 February 2020 [NS4/033 - **INQ000238704** noted that the Scottish Government's preparations were based on "the reasonable worst-case scenario of a situation similar to an influenza pandemic". A paper prepared for SGORR, dated 17 February [NS4/031 - INQ000233538], contained RWCS figures.

179. The note of a meeting of SGORR (O) on 6 February [NS4/034 - INQ000221682] also indicates that RWCS assumptions were part of the Scottish Government's planning. It states as follows:

"[I]n the absence of specific scientific information relating to the novel coronavirus (where work is continuing globally) the expert advice was that Governments in the UK should continue to plan using pandemic flu Reasonable Worst Case Planning Assumptions."

180. It is important to be clear, however, that preparing on the basis of a RWCS does not imply an acceptance that such a scenario was inevitable. Our objective was to suppress the virus as much as possible and therefore mitigate its consequences and so avoid the RWCS materialising – while also prudently planning should the worst happen.

Flattening the curve

181. I am asked to what extent 'flattening the curve' was part of the Scottish Government's response strategy. Flattening the curve was terminology used to describe a strategy of suppressing the virus as much as possible in the context of there being sustained community transmission – this was intended to reduce the overall burden of infection at any one time to avoid the NHS being overwhelmed and also to minimise as far as possible the number of people becoming infected before treatments/vaccines were available. The minutes of the Scottish Cabinet meeting of 24 March [NS4/035 - INQ000078531] describe it as follows:

"16. In the longer term, it would be critical both to find effective anti-viral drugs and, ultimately, a vaccine, which meant that it was logical, in the meantime, to suppress the outbreak as far as possible. Social distancing remained the most effective means of reducing the spread of the outbreak and of reducing the peak number of infections across the population ('flattening the curve'), so that the NHS could cope with demand."

182. As the pandemic progressed, the terminology may have changed but the objective of maximum suppression remained a core part of the Scottish Government's strategy. In the early phase of the pandemic, this was the UK government's strategy too. It was only later – and I will cover this in later sections – that the Scottish and UK

governments differed in our view of the extent to which we should suppressing the virus versus learning to 'live with it'. Data on the virus was extremely important and I'll come on to talk about its role in decision making.

Herd Immunity

183. I am asked to explain my understanding of the term 'herd immunity'. It is important to be clear that 'herd immunity' is a term with a well-established scientific meaning – i.e., resistance to the spread of an infectious disease within a population based on a high proportion of people having immunity as a result of previous infection or vaccination.

184. However, in the UK, the term became very loaded as a result of the suggestion that the UK government considered seeking to achieve herd immunity by effectively letting the virus run amok so that a high percentage of people became infected and acquired immunity in that way.

185. I cannot speak for the UK government but seeking to achieve herd immunity in that way was never part of the Scottish Government strategy – either initially or subsequent to the first lockdown – and nor did we consider it as a potential strategy. We did, of course, hope that herd immunity might be achieved over the long term, principally through vaccination – and in that sense, the term is likely to have featured in our discussion – but at no point did we consider letting the virus circulate freely enough to achieve it through natural infection. On the contrary, even after community transmission was established and cases were rising rapidly, our objective – indeed the very purpose of lockdown and subsequent restrictions – was to suppress the virus as much as possible and minimise the number of people who became infected. While there continued to be, for quite some time, significant uncertainties about the clinical consequences of the virus, it became obvious reasonably early on that for some people, including some with no previous underlying health conditions, it was potentially very severe and even fatal. In my view, therefore, to have pursued a deliberate strategy of achieving herd immunity through infection would have been deeply wrong.

186. While shielding for vulnerable people was part of the Scottish Government approach, this was part of an overall strategy to suppress the virus as much as possible. In my view, a strategy of seeking to shield the vulnerable while allowing the virus to

circulate freely amongst the general population would have been practically ineffective – the nature of our society and household composition would have made it impossible to effectively protect the vulnerable – and as a result, morally indefensible.

187. I am not aware of SAGE advice that actively recommended a strategy of seeking herd immunity through infection. There was no recommendation from the C19AG to that effect either. The C19AG Corporate Statement states the following:

"36. The notion of herd immunity was one of many issues discussed by the C19AG. The Group did not provide formal advice on this issue and did not make decisions about the Scottish Government's strategic response to COVID-19."

188. On the 12 March, the Scottish Government – in line with the other UK governments – moved from the containment to the delay phase of the Coronavirus Action Plan and advised people with symptoms to stay at home for seven days. These decisions were taken at a meeting of COBR (which I attended) on the basis of advice from SAGE. The following extracts are from papers circulated by the UK government Cabinet Secretariat ahead of the COBR meeting [NS4/036 - INQ000101336]. The papers also included modelling of the possible impact of interventions.

"SAGE have considered six possible social and behavioural interventions to delay the outbreak based on the clinical evidence. The impacts have been modelled. They advised four for implementation in the coming 3-4 weeks:
(i) individuals stay at home for 7 days from the point of displaying mild symptoms - to delay the peak.
(ii) household stay at home for 14 days from the point that any member of the household displays symptoms - to delay the peak.
(iii) most vulnerable individuals stay at home for a period of 13-16 weeks - to reduce deaths and delay the peak.
(iv) significant reduction of social contact by the over 70s and at risk groups - to reduce deaths and delay the peak.
Implementing all measures at the right times in the outbreak has the greatest combined impact: 50-70% reduction in peak hospital bed demand; 35-50% reduction in deaths. The measures generate a range of other economic and social impacts."

"We recommend COBR:

● Note SAGE advice that interventions 1-4 should each deliver benefits by delaying and flattening the peak and/or lowering overall deaths and would deliver greatest overall benefit as a package.

● Agree to implement intervention 1 (individuals staying at home) now; and interventions 3 and 4 (protection for the most vulnerable groups; and social distancing for the over 70s and those with chronic conditions) in 1-3 weeks'time. This is intended to ensure that each measure impacts at the right point to delay the "peak" and reduce deaths among more vulnerable groups respectively, and to allow support to vulnerable groups to be put in place.

● Decide whether to implement the revised approach to intervention 2 (household stay at home); and if so whether to do so now alongside intervention 1, or delay until 1 - 3 weeks' time.

● Decide whether to announce today that the change in advice to "stay at home" applies immediately, or from Monday 16 March to allow revised public health advice and other preparations to be made.

● Agree to announce today that we will implement interventions 3 and 4 in 1-3 weeks' time when the overall effect would probably be better.

● Discuss the approach to the two interventions (on school closures and mass gatherings) not advised by SAGE for adoption now.

189. It was considered on the basis of the advice that asking those with symptoms to stay at home for seven days was an appropriate step to take at that time and that taking additional steps slightly later would maximise their impact. As can be seen from the SAGE advice, the optimal timing, as well as the substance of interventions was a key consideration. The Coronavirus Act 2020 was not in force at this time and while I cannot recall exactly, this is likely to be why this was addressed in guidance rather than regulation being considered.

190. The move from the containment to delay phase reflected the fact that sustained community transmission was established, and that strict containment was therefore no longer possible. However, the delay phase still involved efforts to suppress transmission as much as possible, hence asking people with symptoms to stay at home.

191. At that point, it was decided to target available testing capacity – which, although being expanded was still limited – to those admitted in hospital with clinical or radiological evidence of pneumonia; acute respiratory distress; or flu like illness. This was intended to ensure that those most vulnerable/unwell were accessing appropriate care as quickly as possible, and so giving them the best chance of recovery.

192. The decision not to test symptomatic people more generally was certainly made necessary in part by limited testing capacity. However, the advice to stay at home was for anyone with symptoms and not only for those confirmed positive with Covid-19, so it also wasn't dependent on testing or contact tracing. It is also worth reiterating that, at this stage, we did not have the knowledge that we later had about the extent of asymptomatic transmission.

193. Nevertheless, work continued to expand testing capacity. We also returned to contact tracing – with a significantly enhanced capacity – to support the transition out of lockdown.

194. The Scottish Government decided on 12 March to cancel all indoor or outdoor events of more than 500 people. The decision was taken by me and the Cabinet Secretary for Health & Sport, with input from the CMO. The decision was based on a combination of clinical and practical considerations, as set out in the following paragraphs.

195. Firstly, while the CMO was clear in her view that cancelling mass gatherings, particularly those outdoors, would not have a significant impact on transmission – and she advised us not to overstate the impact – it was not the case that there would be no impact at all. It seemed to me that mass gatherings carried a risk of potential outbreaks that would be better avoided, given the stage the pandemic was at.

196. Second, I was concerned about the impact on our emergency services of handling mass gatherings at a time when they were coming under increasing pressure from the wider impacts of Covid-19. Indeed, this was the principal reason for taking this decision when we did (although I accepted advice that giving a window before implementation would be sensible - we announced on 12 March that the cancellation would take effect from 16 March). I requested and received the following advice note ahead from Scottish Government officials ahead of the 12 March COBR meeting:

- *The safety and security of mass gatherings demands significant resource commitment from Police Scotland, Scottish Fire and Rescue Service and the Scottish Ambulance Service.*
- *Business continuity considerations that Police Scotland, SFRS and SAS may experience as a result of COVID-19 could mean that all emergency services may have to prioritise the service that they are able to provide.*
- *Police Scotland has indicated that operational prioritisation may mean that they would not provide resource to police mass gatherings. Police Scotland has reported that decisions not to police mass gatherings would be based solely on operational prioritisation such as the need to attend 999 calls.*
- *We need to help our services to prioritise their critical functions. At a time when we will be asking the public to restrict their activities, it is critical that Government is also seen to be taking steps to protect public services' ability to function.*
- *As existing powers are not suitable for placing restrictions on gatherings and events, we have instructed in the UK COVID Bill specific provision to allow the Scottish Ministers to make directions to prohibit or otherwise restrict events or gatherings. Unlike the situation in England, the powers will vest in Ministers - rather than local authorities.*
- *The latest position for the UK Bill is that all powers will require to be switched on after Royal Assent (which we understand will be on the 31 March) by commencement regulations. The exercise of the powers will be contingent upon Ministers making a declaration of a "serious and imminent threat to public health".*
- *Arrangements for ensuring safety at this weekend's events will already have been made, as will the public's arrangements to travel and attend (for example the Rangers v Celtic football match on Sunday). Cancelling this weekend's events at such short notice could raise public safety concerns. A window before implementation would be desirable.*

197. Third, I was increasingly concerned about the risk that negative public perceptions about mass gatherings continuing might undermine our general public health advice – in simple terms, for as long as people were able to gather in crowds at concerts or football matches, they might doubt the need to change other behaviours in their

personal lives. Indeed, questions of that nature were increasingly being asked of decision-makers.

198. By the time of the COBR meeting on 12 March [NS4/036 - INQ000101336], I was firmly of the view that cancelling mass gatherings was an appropriate step to take. I would have preferred all four nations to have done so at that time – as it turned out, the others followed suit reasonably quickly – but my primary duty of care and responsibility was to the Scottish people.

199. The decision to close schools was one of the hardest taken in the course of the pandemic, given the significant impact we knew it would have on the education and wellbeing of children and young people. The following extract from minutes of the 17 March Cabinet meeting [NS4/037 - INQ000078529] give an insight into the factors being considered:

"(c) Very active consideration was being given to the possible closure of schools and other educational establishments, but the evidence was not yet clear. The epidemiological evidence did not suggest that this measure would slow the transmission of COVID-19 down to a great extent (and might in fact cause some additional infections – for example by increasing children's exposure to grandparents over 70).

(d) Although the young generally appeared to suffer only mild symptoms if infected by the COVID-19 virus (unlike for influenza), there were children in 'at risk' groups, such as those suffering from asthma, and the effect on NHS capacity would not be negligible if a high proportion of them became infected. It was also unclear whether or not children and young people played a significant role in the transmission of the virus, even if they remained asymptomatic. These were difficult questions to weigh up in deciding whether or not to keep schools open.

(e) Practical considerations would also intervene. For example, if parents chose not to send their children to school, or if staff were to fall ill, or had to self-isolate as a result of an existing health condition or caring responsibilities, there would be little alternative but to close some schools, at which point questions of consistency would come into play, within and between local areas. In order to maintain public support, it would not be desirable for the impression to arise that the process of school closures was occurring in a disorderly and uncontrolled fashion. The importance of retaining

the confidence (and compliance) of the general public in the national response to COVID-19 should not be lost from view.

(f) There was therefore a very difficult balance to maintain, and hard decisions lay ahead: some children (particularly those living in challenging domestic circumstances) would remain better off – safe, well fed, and clean – in a school environment, despite the risks arising from the virus. In addition, keeping the children of essential workers (especially NHS staff) at home might reduce effective staffing capacity and thereby compromise efforts to counter the outbreak.

(g) The debate on school opening was ongoing, and it seemed likely that the balance of evidence would change – possibly over coming days. Mr Swinney had spoken to his counterpart, the UK Secretary of State for Education, and this remained a live and challenging issue for the four UK nations. The challenge across the UK would be to keep children safe, educated, and fed, while also allowing emergency workers to do their jobs.

(h) If schools were to close in the near future (as seemed very possible), it would be hard to see them opening again before a considerable period had elapsed – perhaps not even in the autumn – and this would have profound implications for the examination diet, university and college admissions, and for childcare – notably for parents in the health professions and other essential occupations – so any step in this decision would need to be considered very carefully. Discussions about options were ongoing with COSLA, the Association of Directors of Education in Scotland and the professional associations.

(i) As far as the exam diet was concerned, there were three options: to go ahead as planned, to delay until July/August, or to offer alternative methods of certification based on coursework, prelim results, and estimated grades. Delaying exams might also delay the start of university terms, which would have a significant impact on university operations and incomes.

200. The situation was so fast moving that, by the following day, we considered the closure of schools to be unavoidable. I set out the reasons as follows in the 18 March news release announcing the decision:

"This has been one of the hardest decisions we have faced so far as we tackle the coronavirus. SAGE – our expert scientific advisers – are examining new advice that

is very likely to tell us to close schools. We also know more and more schools are approaching a point where they have lost too many staff to continue as normal."

201. It was also the case, understandably, that concerned parents were increasingly 'voting with their feet' and not sending children to school.

202. The decision to require cafes, pubs, and restaurants to close was made and announced by the Scottish Government on 20 March, the same day as the other UK governments, not on 19 March as suggested in the questions posed to me by the Inquiry. This decision was taken at a COBR meeting on the afternoon of 20 March, informed by SAGE advice, and announced shortly thereafter.

203. The decisions taken by the Scottish Government up to and including lockdown on 23 March 2020 were informed by scientific advice on their impact and optimal sequencing/timing. The decisions were, of course, for Ministers to make. Speaking personally, if I could turn the clock back and know then everything we came to know as the pandemic progressed, I would have wanted to introduce lockdown measures a week or so earlier. That we did not do so is a regret I carry. That said, three points of caveat and context are necessary: first, it is a view based on hindsight, not foresight; second, it is not possible to say with certainty what difference it would have made to the overall situation – as the data has become more refined, the gap in outcomes between the UK and comparator countries (including Italy, cited in the question) is not as wide as once thought; and third, given the need for the UK government to provide the resources for schemes like furlough, it would have been virtually impossible in practical terms for Scotland to have entered full lockdown earlier than the UK government decided appropriate.

Super-spreader events

204. I am asked a number of questions about mass gatherings. I have set out in preceding paragraphs the Scottish Government's rationale for cancelling mass gatherings of over 500 people from 15 March. In briefing I received ahead of COBR on 12 March, I was provided with a list of large-scale events scheduled in the period from then to 7 April [NS4/038 - **INQ000383485].** Events from 15 March were covered by the decision we took on 12 March.

205. I am asked specifically about the Scotland v France rugby match that took place at Murrayfield on 8 March 2020. This event was the subject of considerable discussion, including between me and the CMO. I asked her for advice on whether or not that event should be cancelled, and she provided it to me on 3 March [NS4/039 - INQ000292536]. I also had a face-to-face discussion with her about it on 3 March. In summary, the advice, which was informed by input from Health Protection Scotland, was (i) that there was limited evidence of risk from open air events; (ii) that with supporters from France already in Edinburgh or en-route, there was a risk that cancelling the match would lead to people gathering in indoor places instead – with a greater risk of transmission; and (iii) it would be better to focus on communicating advice about good public health behaviours instead.

206. After discussion, during which we reflected on the approach being taken in other countries to mass events, I accepted this advice and agreed with the CMO that she would undertake a media event at Murrayfield to highlight the recommended public health behaviours, including on hand hygiene.

207. It may also be worth adding that I am not aware of any evidence to suggest that there was any significant transmission associated with the match – although it is also appropriate to point out that the first death in Scotland from Covid was someone who had attended it.

208. I am asked about the Wales v Scotland rugby match scheduled for 14 March in Cardiff. The decision on whether or not to cancel this match was not one for the Scottish Government. In any event, it was called off on 13 March.

209. I am asked about the NIKE conference that took place in Edinburgh from 25 – 27 February 2020. The first point to make is that I (nor, as far as I am aware, anyone else in the Scottish Government) had no knowledge about this conference ahead of it happening, so we had no discussion about whether or not it should proceed.

210. I first became aware of it on 3 March when the first case associated with it was identified. I was satisfied at the time that all appropriate steps had been taken to protect public health. An Incident Management Team had been established and full contact tracing was carried out. Whole genome sequencing carried out later on the sub-lineage associated with the conference indicated that the action taken by the IMT

had been successful in curtailing onward transmission. The following extract from the DG Health and Social care Corporate Statement [NS4/014 - INQ000184897] sets out the situation in more detail:

"The Nike Conference

450. The Nike Conference took place in Scotland from 25 to 27 February 2020. The first case of Covid-19 confirmed in Scotland was not until 1 March 2020. On that date, there had been no positive cases in Scotland linked to the conference. Health Protection Scotland (HPS) were alerted on 2 March 2020 that an individual who was now overseas, but who had been at the conference, had tested positive. On 3 March 2020, HPS recorded a positive case in Scotland of an individual who had been a conference delegate. That case and the details of the potential outbreak was confirmed to Scottish Ministers on the evening of 3 March 2020. Details of that case were then included in a news release issued on 4 March 2020 and included in the Scottish Government's normal case reporting schedule.

451. Twenty-three primary cases were linked to the conference and 16 secondary cases were subsequently identified. HPS led on the management of this outbreak which included an International Incident Management Team (IMT) and they subsequently undertook an assessment of this, providing a detailed report on 5 October 2021. This concluded that following Whole Genome Sequencing (WGS) of the severe acute respiratory syndrome, coronavirus 2 (SARS-CoV-2) virus identified a particular sub-lineage B-S16 associated with the conference. Sub-lineage B-S16 has not been detected in Scotland since April 2020. They concluded that the '…WGS results strongly suggest that the actions taken by the incident management team (IMT) to manage the outbreak were successful in curtailing onward transmission.'

452. The decision making on the Nike event was led by HPS, NHS Lothian and Edinburgh City Council, CMO and officials from the Health Protection team (which became Covid-19 response Team). An IMT was established and led by HPS, which included representatives from Scottish NHS Boards, NHS Lothian, West of Scotland Specialist Virology Centre (WoSSVC), Public Health England and PHE National Incident Coordination Centre (NICC). An IMT report on the Nike conference outbreak was published in October 2021.

211. The decision not to initially make public the connection between some of the early cases in Scotland and the NIKE conference later became the subject of significant scrutiny. That decision was based on advice from the CMO – to be clear, this advice

was considered and accepted by me as reasonable in the circumstances. The CMO's advice was based on what was considered to be international sensitivities and, more so, concerns about patient confidentiality given the small number of cases and the availability of a delegate list.

212. Perhaps the most important point to make is that the decision on whether or not to make public the link with the NIKE conference had no impact whatsoever on the public health management of the outbreak. The actions would have been the same whatever that decision had been.

PART D – TESTING

213. As First Minister, I was involved in, and ultimately accountable for, all aspects of the Scottish Government's testing and contact tracing strategy. This included surveillance testing, the initial establishment of Covid-19 laboratory processing facilities and scale up of testing in Scotland; the targeted use of testing during the initial lockdown period; the more substantial scale up of NHS Scotland sampling and processing capacity and Scotland's participation in the UK-wide testing network; the development of a comprehensive test, trace, isolate strategy to support exit from lockdown; and the establishment and development of Test & Protect. Our evolving approach to testing and contact tracing was regularly considered as part of wider Covid-19 discussions at meetings of the Cabinet. I received periodic advice on the capacity, scale up, use and objectives of testing from the CMO, C19AG and SAGE. Account was taken of advice from a number of sources including the World Health Organisation (WHO), scientific journals and other publications. Advice evolved in the early months of 2020 as understanding of SARS Cov-2 increased, including the transmissibility and asymptomatic nature of the virus. I asked the CMO to provide weekly updates to Cabinet to help ensure Cabinet had access to the latest advice and a shared understanding of the virus.

214. On 29 March 2020, I agreed to the establishment of the Scottish Testing Oversight Group (which later became the Scientific Advisory Board on Testing - SABoT) to oversee the ongoing development of our Covid-19 testing strategy.

215. I understood from the outset of the pandemic that testing would be a key part of our overall response to the pandemic. However, the use and purpose of testing changed

as the pandemic progressed and as both our testing capacity and scientific understanding of transmission, including asymptomatic transmission, increased.

216. At risk of over-simplifying, I would describe three broad strategic phases for the use and purpose of testing:

(i) in what the Coronavirus Action Plan described as the Contain phase i.e. before we had evidence of sustained community transmission, in addition to general surveillance (I summarise the early approach to surveillance testing at Part C of this statement), testing and contact tracing was used in an attempt to break all possible chains of transmission and contain the virus to avoid community transmission taking hold.

(ii) when widespread community transmission became established, and the level of infection was high, it was considered that testing and tracing of everyone with symptoms was not feasible and would not be effective. This was anticipated in the Coronavirus Action Plan: *"there will be less emphasis on large scale preventative measures such as intensive contact tracing. As the disease becomes established, these measures may lose their effectiveness and resources would be more effectively used elsewhere"*. In this phase, instead of an approach focused on testing and isolation of symptomatic/positive cases amongst the general public, all those with symptoms were instead advised to stay at home for seven days and, then, as of 23 March lockdown, everyone (with limited exceptions) was asked to stay at home. In this phase, testing was used for more targeted purposes – i.e., to support clinical care and diagnostics for those admitted to hospital with clinical or radiological evidence of pneumonia; acute respiratory distress; or flu like illness. This was intended to ensure that those most vulnerable/unwell were accessing appropriate care as quickly as possible, and so giving them the best chance of recovery; and to support the return to work of key workers. At this stage, testing capacity was still very limited and while this was not the only reason for the different approach to testing, it is possible that greater capacity would have led to a later shift from the first phase described above to this second one, and/or to more extensive use of targeted testing.

(iii) when levels of infection had fallen to low levels again as a result of lockdown a test, trace, isolate approach was implemented to support the gradual lifting of restrictions while keeping case numbers as low as possible. Details of our approach in this phase were set out in the Scottish Government's Covid-19 Test, Trace, Isolate, Support strategy published on 4 May 2020 [NS4/040 - **INQ000383488]**; implemented through the Test & Protect system from 28 May 2020; and developed in

the Testing Strategy – Adapting to the Pandemic paper published on 17 August 2020 [NS4/041 - INQ000147448].

217. I am asked about the limited availability of tests in January and February 2020, and the timeline for the development of diagnostic tests.

218. At the start of the pandemic, Scotland – like many other countries – had limited laboratory testing capacity. At that stage, our system was geared towards testing and tracing in small public health outbreaks, rather than at pandemic scale. Also, this was a novel virus. In my view, one of the key questions arising out of the pandemic is the extent of baseline infrastructure for testing that should be maintained in 'normal' times to make rapid build up of capacity much quicker in any future pandemic. However, it is important to recognise that this would come at a not insignificant cost – with an associated opportunity cost – that the public may question out with the reality of a pandemic.

219. In any event, at the start of the pandemic, there was no capacity in Scotland to process Covid-19 tests. Initially, from the start of Covid-19 testing on 24 January 2020, all test samples from Scotland were sent to Colindale in London to be processed.

220. Steps were taken quickly to establish laboratory capacity in Scotland and on 10 February it was confirmed that two new lab facilities were open in Scotland – one in Edinburgh with the capacity for 100 tests per day and the other in Glasgow with the capacity for 250 per day. Initially, positive tests were still sent to Colindale for confirmatory testing. By 30 April 2020, NHS labs were operational in all 14 Scottish health board areas.

221. Testing capacity increased progressively from the start of the pandemic, from zero in January 2020 to a capacity of 65,000 tests a day by the end of 2020. This was achieved across two strands of Scottish Government activity – NHS Scotland lab capacity and a fair share of the capacity being created through the UK Lighthouse lab network (which we were contributing to financially through foregone Barnett Consequentials).

222. Key milestones in this build up of capacity were as follow: by 1 May, there was capacity for 8,350 tests a day (4,350 through NHS labs – exceeding an initial target

of 3,500 – and 4,000 through the Lighthouse network); by August, there was capacity for 35,000 tests per day across both strands; and by the end of 2020, 65,000 per day.

223. I am asked about Matt Hancock's 100,000 tests per day target. While I cannot comment on the delivery of it from a UK government perspective, the Scottish Government's priority was to ensure a fair share of UK capacity (given our funding contribution to it) and that between it and NHS Scotland capacity, people in Scotland had access to testing comparable to people in other parts of the UK. I consider that we achieved these objectives. I am also asked if work to reach the testing per day targets interfered with work to establish Test & Protect and I do not consider this to be the case – testing capacity at the target levels was essential to the effectiveness of Test & Protect.

224. Much of the commentary around testing was focused on laboratory processing capacity, but it was also important to increase access to sampling facilities which happened in various ways – community hubs, regional testing centres, mobile and drive thru facilities, PCR home testing kits and, later, widespread access to LFD testing.

225. I am asked about my understanding of Public Health Scotland (PHS) surveillance and tracing. At the start of 2020 Scotland had processes in place for surveillance and tracing appropriate for smaller public health incidents. However, as the scale of the Covid-19 challenge emerged, the need to expand the PHS capacity in surveillance and testing became clear. I agreed with the Cabinet Secretary for Health and Social Care that additional funding would be provided to PHS to enable it to put in place enhanced surveillance from April 2020 [NS4/042 - INQ000261557]. Work to strengthen Scotland's contract tracing capability was undertaken alongside this.

226. PHS led the enhanced surveillance programme in Scotland which encompasses community surveillance, including PCR testing, and antibody surveillance testing, to assess the spread and prevalence of the virus. The data collected from this was extremely valuable and helped inform our decision making. More detail of the various strands of surveillance already in place or planned were set out in the Testing Strategy – Adapting to the Pandemic paper published in August 2020 [NS4/041 - INQ000147448], as follows:

"Community surveillance testing includes PCR testing of people who have mild or moderate illness to help us understand levels of active disease, and antibody testing to improve our understanding of how many people have been infected with the virus.

Public Health Scotland (PHS) is leading the Enhanced Surveillance of COVID-19 in Scotland (EsoCiS) programme on behalf of Scottish Government which encompasses this PCR and antibody testing, in addition to other surveillance measures.

In a significant expansion of population level surveillance testing, Scotland will also participate in the ONS COVID-19 Infection Survey, which will represent the single biggest expansion of asymptomatic testing for surveillance purposes to date in the pandemic, building to 15,000 individuals tested every two week rolling period. This equates to approximately 9,000 households.

The survey will involve all participants providing throat and nose swabs to test whether they currently have the virus. A subset of the sample will also provide blood samples, which will be tested for antibodies to COVID-19. Individuals will be asked to take tests every week for the first five weeks and monthly for a period of 12 months in total. Each participant is also asked a short set of questions concerning socio-demographic characteristics, symptoms, whether self-isolating or shielding, and whether the participant has come into contact with a suspected carrier of COVID-19.

Critically, the information from the study will be linked to the Community Health Index (CHI) enabling future linking to other health datasets in Scotland and further analysis. Given much is yet to be understood about the long term health impacts of COVID-19 on those who have recovered from infection, and how these impacts vary by different groups of people, this data linkage will be critical in providing evidence in these poorly understood areas which will directly support the effective long term management of those who may still suffer from post COVID related health harms.

In healthcare, Scotland is participating in the SIREN study which seeks to understand whether the presence of COVID-19 antibodies protects people from future infection and also to provide evidence of prevalence of COVID infection among healthcare workers across Scotland.

In a significant expansion of healthcare worker surveillance testing, the aim is to recruit 10,000 NHS workers in Scotland to the study, covering all health boards. Each healthcare worker will be PCR and antibody tested every 2 weeks over a 12 month period. This will help our understanding of the body's immune response to COVID-19 and track prevalence rates within that population.

In schools, in addition to the testing of individuals with symptoms and increased testing that takes place in the context of an outbreak, we will implement testing of a sample of the school population for the purposes of surveillance. This testing as part of our surveillance approach will play an important role in supporting the safe return and ongoing safe operation of our schools.

Testing for surveillance will involve a sample of the school population being tested for COVID-19 and for SARS-CoV-2 antibodies at intervals to determine if they have evidence of current or past infection.

These surveillance studies will include school worker testing and surveys, and school pupil cohort surveillance, which will provide data that can be used for providing incidence and prevalence estimates to understand any level of infection or exposure in schools. Any positive tests found would be further tested for whole genome sequencing to understand where any transmission may have occurred."

227. I am asked about the rationale behind Test & Protect, why it was developed separately to the UK Government's Test & Trace, and the extent of its operations by the launch on 28 May 2020.

228. Test & Protect was Scotland's approach to implementing the 'test, trace, isolate, support strategy' published on 4 May. The overall approach was summarized in my Foreword to the publication as follows:

"A key aspect of this next phase is the "test, trace, isolate, support" approach. We will test people in the community who have symptoms consistent with COVID-19. We will use contact tracing, a well-established public health intervention, to identify the close contacts of those cases, who may have had the disease transmitted to them. We will ask and support those close contacts to self-isolate, so that if they do develop the disease, there is less risk that they will pass it on to others. And we will make sure that support is available to enable people to isolate effectively."

It was an approach designed to assist with a return to more normal living while continuing to keep the virus – suppressed to low levels by lockdown – under control, manage outbreaks, and help deal with further expected peaks in infection.

229. As set out in the Module 2A Corporate Statement by DG Health and Social Care provided (23 June 2023) [NS4/057 - INQ000315534], Test & Protect was *"led by the NHS in Scotland, and was a collaborative, multi-public agency partnership comprising PHS, territorial Health boards, NSS, the Scottish Government and Local Authorities. This included a significant partnership with the UK Government testing programme. Test and Protect was anticipated to have a positive impact across all groups in society by reducing transmission of Covid-19 and reducing deaths and serious illness caused by the virus. It was a fundamental part of the Scottish Government's strategy to mitigate the severe impacts of Covid-19 on public health and adapted as the pandemic progressed, scientific evidence on the nature of transmission of the virus emerged, and new technologies became available."*

230. Scotland has a public health/health protection infrastructure distinct from that in other parts of the UK, so it was vital that Test & Protect was rooted in and able to utilise and build upon existing capability and local partnerships.

231. As indicated above, work had been underway since April to enhance and expand contract tracing capability. Ahead of the launch of Test & Protect on 28 May 2020 a number of pilots had been undertaken by territorial health boards which meant that by day one the system was fully operational with all health boards using the national contract tracing system.

232. The Inquiry has asked that I provide context to an issue covered at my daily media briefing on the 14 September 2020 [NS4/043 - **INQ000383490]** in relation to testing. In my opening remarks I stated that *"we now have very serious concern that the backlog of test results being faced by the UK lab network - which the Glasgow Lighthouse Lab is part of - is starting to impact on the timeous reporting of Scottish results."*

233. In the preceding days there had been reports in the media about a backlog of tests across the UK as a result of an increase in demand. This was around the time that English schools had returned, and it was possible that this was a contributing factor to the increase in demand.

234. I needed to address this at the daily briefing as the testing figures reported on the 14 September were not complete, and an explanation was required to explain why we were seeing a reduction in positive cases reported. The incompleteness was due to longer turnaround times in the UK network for tests undertaken on the previous day. Up until this point the network had been working well. Given that a significant proportion of testing in Scotland was undertaken through the UK network, I was concerned that any sustained deterioration in the turnaround time for test results would have a serious impact. Whilst Scottish Government officials were closely engaged with UK counterparts about the day-to-day operation of the UK testing network, many of the controls lay with the UK Government. Therefore, my priority at this point was to work constructively with the UK Government to ensure that this issue was being addressed as quickly as possible and that it did not become more serious.

235. Over the preceding weekend, the Cabinet Secretary for Health and Social Care had been in dialogue with Matt Hancock as there was concern that the UK Government was considering limiting access to testing in Scotland to help mitigate the increased demand. This was resisted by the Cabinet Secretary, who also engaged with her counterparts in Wales and Northern Ireland, who advised they were experiencing similar issues.

236. I spoke directly with Matt Hancock and Dido Harding, head of the UK testing system, on the evening of 14 September and sought both an assurance that Scotland would continue to get fair access to the UK wide laboratory capacity and an understanding of how it was intended that the issues would be resolved. Over the following days there was improvement to the UK network turnaround as the backlog was addressed, and processing returned to normal.

237. I am asked for my views on what worked well in relation to testing and what could have been improved. As the preceding paragraphs demonstrate, it was inevitable that in a system of such scale, and built relatively quickly from a standing start, there would be practical and logistical challenges. However, overall, the system worked well and at the scale and pace necessary for the situation we faced. The main issue was the standing start and the limited availability of testing in the early stages of the pandemic. While I am not convinced that greater and earlier availability would have fundamentally changed the approach taken – particularly given the state of scientific knowledge at the time – it may have expanded the options open to us for more

targeted and tactical use of testing. What level of baseline capacity it is feasible and desirable to maintain in 'normal' times is therefore, in my view, one of the key questions arising from the pandemic.

PART E – DECISIONS IN RELATION TO NPIs

General questions about NPIs

238. Paragraph 15 of my module 2 statement [NS4/005 - INQ000235213] describes the overall context for our decisions in relation to NPIs as follows:

> *"Covid-19 posed an unprecedented systemic threat not only to the health of those susceptible to infection, particularly those most vulnerable, but also to healthcare systems, economic activity, and wider society: these were the 'four harms' identified by my government in our Covid-19: Framework for Decision Making, published on 23 April 2020, to help shape our strategic response. It is worth noting that although inequality was not listed as a standalone harm, the Scottish Government was acutely aware of the manner in which the effects of Covid-19 exacerbated existing inequalities whilst creating new ones. The complexity of the systemic challenge posed by the rapid spread and evolution of a novel virus, meant there was no one right response; and it was not possible for any government, my own included, to get every decision right. It is also the case, given the nature of the challenge faced, that there were few, if any, 'harm free' decisions open to governments. Measures to curtail the spread of infection reduced direct health harm but, in the process, caused isolation and loneliness, economic upheaval and disruption to education. Conversely, not imposing or later lifting restrictions might lessen these wider impacts but only at the expense of possibly increasing harm to health. For governments, both within our own jurisdictions and working together where necessary, the challenge was to constantly balance risks and benefits and take rapid decisions to reduce overall harm as much as possible."*

239. To expand upon this, at the point at which lockdown was imposed on 23 March 2020, the R number was well above 1 – possibly as high as 4 - and the virus was spreading exponentially. The Scottish Government's acute concern about the burden of morbidity and mortality that could result meant that mitigating the direct health harm of Covid-19 was our over-riding priority at that time. This resulted in the decision to

impose lockdown measures, a very significant intervention intended to protect lives and the ability of the NHS to cope. However, it was quickly apparent that Covid-19 was not just a health crisis, but also an economic crisis and a social crisis. The harm it would cause was multi-faceted. As well as the direct harm resulting from infection, it would cause indirect health harms and severe damage to livelihoods and education. It would also widen existing inequalities, potentially creating new ones too, and exacerbate social isolation. We therefore realised very quickly that we had a duty to take all these different aspects of harm into account as we responded to the pandemic, with an overarching aim of reducing overall harm as much as possible. We also realised that an approach of balancing different harms, often accepting trade-offs between them, would require a rational framework within which we could take decisions.

240. This led to the publication on 23 April 2020 of *The Framework for Decision Making* [NS4/003 - INQ000131025] which introduced the Four Harms approach that the Scottish Government thereafter followed. In my foreword to that publication, I describe our over-arching aim as follows:

"Our challenge therefore is to work out if and how we can continue to suppress [the virus] and minimise its harms, while restoring normality to our everyday lives. We will always take a careful approach that seek to protect life and reduce harm".

241. The Four Harms approach marshalled the many and varied harms of the pandemic unto four broad categories:

- HARM 1: direct COVID-19 harm
- HARM 2: other health harm caused by the pandemic
- HARM 3: societal harm
- HARM 4: economic harm

242. This categorisation was not perfect, but it did give us a rational basis, at a strategic level, to take account of the different harms and the impacts of them on different groups/sectors in the population. It also gave us a structure in which we could make better sense of the various complexities inherent in the situation i.e., the harms were often 'non-linear' – they didn't increase or decrease at a steady pace over time; relative harms were not static but adjusting all the time, for example as vaccination started to reduce direct health harm; different harms often moved in different

directions, for example re-opening schools would reduce the harm of lost education, but increase prevalence of the virus, and so trade-offs were often necessary. The Four Harms approach helped us simplify – or at least rationalise – some of the inherent complexity, but it did not remove all uncertainty and so a significant degree of judgment was also necessary.

243. A Four Harms Group was established to help operationalise the Four Harms approach in our decision-making process. The Group typically met on a Friday to contribute to the advice and options for decisions that Cabinet would consider the following Tuesday. I have described the decision-making process in more detail earlier in this statement. In addition, paragraphs 72 to 85 of the corporate statement provided by DG Strategy and External Affairs dated 22 June 2023 includes a more detailed section on the Scottish Government's overall approach to NPIs.

244. I am asked the extent to which views as to the period of time the public would comply with them influenced decisions about the type and duration of NPIs, including the national lockdowns. My view is that this was more of a consideration in the period before the first national lockdown on 23 March 2020. Earlier in this statement I refer to the advice from SAGE about the pre-lockdown measures covering both the substance and optimal timing of these. At this stage, it was not at all clear – we were in unchartered territory – how well or for how long the public would comply with restrictions to everyday life. This meant there was a concern that introducing restrictions too early might limit their effectiveness should compliance have waned before the optimal timing. However, this concern, certainly in my mind, had reduced by the time of lockdown. By then there was deep anxiety about the possible impact of the virus, and it was clear that, provided there was clear communication about what they were being asked to do and why, the public would be highly compliant. This did not lead to us keeping restrictions in place longer than necessary – as set out above, we were acutely aware of the wider harms involved – but it did mean that concern about non-compliance was not a significant factor over most of 2020. It became more of a consideration again later, as other harms and 'lockdown fatigue' took a greater toll.

245. However, understanding social attitudes towards the virus and the decisions being taken by Scottish Government was a priority for us throughout the pandemic. We had access to regular polling data to help us understand how attitudes were changing and the impact this was having on compliance with, and the effectiveness of, NPIs. I

understand that a corporate statement from DG Corporate dated 14 August 2023 sets out in more detail the advice we had on behavioural science, and the public opinion data that was collected.

246. I am asked to what extent consideration was given when making decisions about NPIs to: the identity of those most at risk from Covid-19; the risk of long Covid; the risk of asymptomatic transmission; the risk of airborne transmission.

247. In relation, firstly, to those most at risk. In March 2020, the Scottish Government established the Shielding Programme to identify, protect, support, and advise people considered to be at highest risk of severe illness should they contract Covid-19. Those officials charged with overseeing this programme routinely provided information and advice to me, and to the Cabinet as a whole, to inform and support NPI decision making. As discussed in the preceding paragraphs, it was necessary to take account of multiple factors and harms in reaching decisions about NPIs.

248. In relation to long Covid, I do not recall exactly when this was brought to my attention as a clinical condition. However, in August 2020, the Scottish Government published a framework for Covid-19 rehabilitation [NS4/044 - **INQ000343305**]. It is also certainly the case that uncertainty about the severity and longevity of the clinical impact of Covid-19 was a factor in our cautious approach to easing NPI restrictions.

249. In relation to the transmission risks, I have commented on our understanding of the risks of asymptomatic and airborne transmission earlier in this statement. Throughout the pandemic, our decisions, including those on NPIs, were guided by the latest clinical advice and scientific evidence provided by SAGE and C19AG, including on the nature of transmission.

250. I have been asked to comment on a reference in the Corporate Statement of DG Strategy & External Affairs [NS4/001-INQ000215495] to the "hammer and the dance" concept. This concept is set out in an article written by Thomas Peuyo, entitled "Coronavirus: Why You Must Act now" [NS4/045 - INQ000131039], and argues that it is essential to first establish firm control over an outbreak that could otherwise overwhelm a population ('the hammer'), before pursuing a strategy for the careful release of restrictions ('the dance'). This health protection concept was discussed at a deep dive session on social distancing that I had requested, and which took place on 6 April 2020. I understand the Inquiry already has the paper from this meeting.

While the concept that the article explores was central to the Scottish Government thinking (I do not recall anyone who advised us demurring from it) it would be wrong to say that Mr Pueyo himself advised us. I had no direct dealings with him and I am not aware of anyone else in the Scottish Government doing so.

251. In the period between the imposition of the first lockdown in March 2020 and the announcement of steps to ease the lockdown in May 2020, it was clear that Covid-19 was a very serious public health risk, and indeed was exacting a heavy toll. On 20 May 2020, the day before the Scottish Government published its proposed roadmap out of lockdown [NS4/046 - INQ000256709], National Records of Scotland (NRS) confirmed that the total number of deaths associated with the virus was 3,546. However, by that stage, it was also evident that lockdown had stemmed transmission. The numbers in hospital with Covid had reduced significantly, and the number in ICU was a quarter of what it had been at the peak. While still too high, the number of deaths was also falling week on week – by that stage it had fallen for three consecutive weeks and the number reported by NRS for the most recent week was just over half that in the final week of April. It was also estimated that the R number at that time was between 0.7 and 1. Taking all of this into account, my view was that while progress had been made it was still fragile – the upper estimate of the R number hovering at 1 was evidence of that – and so the transition out of lockdown, while important and necessary given other harms, required to be careful and cautious.

252. I am asked about lessons from other countries during this period. Given that Covid-19 was a global pandemic, we paid close attention to what was happening in other countries, and the approaches taken by other governments, to inform our own decision-making. Cabinet papers regularly included information both on how the other UK nations were responding to the pandemic, and also how countries around the world were responding. SAGE and C19AG also drew on international scientific and clinical data to help inform our understanding of the virus. I asked Scottish Government officials to pay particularly close attention to countries considered to be handling the pandemic well to ascertain what we might learn. While some countries, New Zealand being the obvious example, were pursuing a strict zero Covid/elimination strategy, what struck me most about the international comparisons was how similar the approaches of different countries were. The precise detail and timing of interventions varied, but the toolbox of interventions was broadly the same. One lesson from international best practice was the importance of good, clear, and

honest communication to help build public understanding and maintain trust. I felt very strongly that this was important and ensured that it was ingrained into the Scottish Government response.

253. To help us audit the effectiveness and impact of lockdown and other NPIs and the harm associated with these, data was collected from a range of sources. This included data on case numbers, hospital/ICU admissions and deaths; data on vulnerable children and, as schools returned, school absences; data on shielding; data on enforcement of restrictions; and data from regular polling. This data helped us understand the state of the pandemic, public attitudes and concerns, and some of the impacts of the steps being taken to stem transmission. Some of this data was provided to me daily, some weekly, and some would have been included in the papers to inform Cabinet decisions. All of it was factored into consideration of the effective deployment of NPIs to reduce the transmission of the virus, while minimising overall harm.

254. The corporate statement from the DG Strategy & External Affairs dated 22 June 2023 [NS4/001-INQ000215495], states that *"decisions on whether any legal restrictions or requirements should be applied were made by Cabinet – or on occasion, by the First Minister under a specific delegation from Cabinet."* It should be stressed that such delegation would be on issues of detail not strategic direction, and it allowed account to be taken of the most up to date data which, on some occasions, would only be available after Cabinet. In reaching any delegated decisions, I would take account of the views expressed at Cabinet and consider the advice of officials, as well as clinical and other expert advisers. On any occasion where this happened, the paper under consideration explicitly sought Cabinet's agreement, and the delegation was recorded in the minutes. Cabinet papers have already been provided to the Inquiry. A more detailed explanation, including examples of delegation being exercised is set out in paragraphs 34 – 37 of the draft addendum statement provided by DG SEA on 8 September 2023.

255. I do not recall the exact date that Long Covid was first brought to my attention. However, in August 2020 the Scottish Government published a framework setting out the priorities and objectives for Covid-19 rehabilitation. It stated as follows:

"We are beginning to understand more about the likely long-term physical and psychological effects of the pandemic in Scotland. These are wide ranging and as

yet unquantifiable, but rehabilitation is critical in ensuring that people are appropriately supported during their recovery so that they can regain their health and wellbeing and reach their potential so that we can flourish as a nation." [NS4/044 - **INQ000343305**

An advisory board was established to oversee implementation of the framework, and it sought input from charities and specialist and clinical groups to help develop our understanding of the views and experiences of people experiencing symptoms of long Covid. The board also sought expert advice from C19AG. Officials from the relevant policy area would have provided advice on long Covid to Ministers to inform wider decision making.

256. The Inquiry has asked specifically about NPIs which impacted religious worship. When lockdown was imposed, restrictions on gatherings for religious purposes were the same way as for other large gatherings. As with all NPIs, decisions on those which impacted on religious worship, were informed by scientific and clinical advice and taken in the context of the Four Harms approach. Scottish Government officials and Ministers engaged with faith and belief groups to further inform decisions affecting places of worship and share our understanding of the latest scientific advice. The input of faith and belief groups was highly valuable.

NHS capacity

257. Having been the Health Secretary in the Scottish Government, I was very familiar with the pressures faced by NHS Scotland in normal times, and with the impact unexpected events can have on it. There is no doubt that we were seriously concerned at the outset of the pandemic about the potential for the NHS to be overwhelmed by the consequences of the virus and the sheer number of people needing hospital and ICU care. This concern was heightened by some of the images being seen at the time from hospitals in Italy. Protecting the ability of the NHS to provide care for those with Covid and other urgent health needs was therefore a key priority. Putting the NHS on an emergency footing and pausing non-urgent elective care was one of the ways we sought to do so. But protecting the NHS – as well as protecting health and saving lives – also depended on suppressing transmission and so concern for the NHS was a factor in the decisions we took about lockdown and NPIs, as illustrated in the initial strapline 'Stay Home, Protect the NHS, Save Lives'. In assessing the impact of different infection levels – and projected levels – on the

NHS, we drew on a range of data and modelling on hospital and ICU admissions and occupancy, length of stay, and acuity of illness. While the NHS and was under very acute pressure as a result of the pandemic – and remains so today – it was never 'overwhelmed' in the sense we initially feared and so, to that extent, the steps taken to avoid it were effective. However, the toll of the pandemic on those who work in the NHS cannot be overstated.

258. The construction of the NHS Louisa Jordan must be seen in the context of the concern described in the preceding paragraph about the risk of the NHS being overwhelmed. It was considered that additional, contingency capacity was needed to mitigate this risk. The NHS Louisa Jordan had a baseline capacity of 300 beds, with the possibility of further scale up if required. However, as a result of efforts to suppress the virus and additional capacity in existing hospitals, a requirement for the NHS Louisa Jordan to treat Covid-19 patients did not materialise. However, it was utilised to support the pandemic effort in other ways. The hospital was used for over 32,000 healthcare appointments, the training of more than 6,900 healthcare staff and students, and the administration of over 370,000 vaccinations. The site also provided facilities for the Scottish Blood Transfusion Service and supported more than 500 donations. Had there been a need for Covid-19 patients to be treated in the hospital at any point during the pandemic, there were plans in place to pause these activities to allow for this.

259. The construction of the Louisa Jordan was an important contingency against the risk of NHS capacity being overwhelmed. Alongside this NHS Boards undertook took a number of steps to maximise capacity. This included increasing the number of intensive care unit (ICU) beds. Not having sufficient ICU capacity was identified early on as a risk that needed mitigation. This involved sourcing additional ventilators and repurposing operating theatre anaesthetic machines for use as ventilators if required. Ensuring the NHS workforce had access to personal protective equipment (PPE) was also a priority. Stocks across health boards were monitored to help support distribution of PPE. It is important to acknowledge the concerns raised by staff at points during the pandemic about both the supply of PPE and the specification of, for example facemasks, recommended for use. Steps were taken on an ongoing basis to address these concerns as they arose.

Schools

260. By March 2020 we were facing exponential growth in infections. Without significant intervention to stem transmission, many more people would have become ill, many more lives would have been lost and the NHS would have been overwhelmed, which would have compounded the health impact of Covid-19 even further. It was essential to act and that is why the decision was taken, very reluctantly, to close schools to all pupils (with some limited exceptions – children considered vulnerable, children of key workers, and pupils completing coursework for national qualifications). The scientific advice was clear that school closure would have an impact on stemming transmission, over and above that of other NPIs – and this proved to be the case. It was also the case that by mid-March 2020, staff absences were significant as a result of infections/self-isolation, and keeping schools open was becoming more practically challenging. Also, many parents worried about their children being exposed to a virus we still knew little about were – understandably – choosing to keep them at home. It was for all of these reasons that, notwithstanding the very real concern about the impact on education and wellbeing, the decision was taken on 18 March to close schools. The Scottish Government worked closely with Local Government to make arrangements to support remote learning. For many pupils the experience of remote learning was better in the second lockdown than the first.

Vulnerable and at-risk groups

261. The Scottish Government has established procedures in place to ensure that the requirements of the Equality Act 2010 are complied with. It is an essential part of the policy and decision-making processes of the Scottish Government that proper consideration is given to equalities and the needs of vulnerable and at risk groups. As set out earlier in this statement, the Scottish Government adopted a Four Harms approach to help balance different factors and reduce harm overall. Within this framework, consideration was given to the needs and perspectives of vulnerable and at-risk groups. In April 2020, the Cabinet Secretary for Social Security & Older People wrote to all Cabinet Secretaries and Ministers underlining the requirement to give proper consideration to Equalities legislation in all of our actions and decisions during the pandemic.

262. The Framework for Decision making [NS4/003 - INQ000131025] set out the Scottish Government's principles and approach to managing the pandemic, particularly in relation to NPIs. It stated as follows: "we will consider how our decisions impact on all parts of society".

263. The Four Harms approach informed and guided decision making from April 2020 through to the lifting of the last legal measure in April 2022.

264. Advice from the Four Harms group was incorporated in the weekly Covid-19 Cabinet paper and informed decision making throughout the pandemic. In addition, equality impact assessments and as appropriate, other forms of impact assessment were undertaken to help ensure that impacts on different groups were considered and understood as part of the overall decision making process. These were published on the Scottish Government website, and I understand that the Inquiry has been provided with copies of these and papers from the Four Harms group.

265. The decisions that had to be taken over the course of the pandemic – and the impact of these – were incredibly difficult. Every decision had consequences, and none were harm free; and there is no doubt that the impact was not uniform across the population. Many people who were already vulnerable suffered most. The Four Harms approach provided us with a mechanism to help ensure that a balanced approach was taken, as far as possible, and that due consideration was given to vulnerable groups as part of the decision-making process. And at all times the Scottish Government sought to ensure that where additional support was required by vulnerable or at-risk groups, it was provided - through the Covid-19 shielding programme for example. However, there is also no doubt in my mind that amongst the key questions arising from the pandemic are if, how, and to what extent vulnerable and at-risk groups could have been better protected.

266. The Inquiry has asked for my response to a statement provided by Age UK which states that "social care was a secondary concern for the Scottish Government when compared to the NHS". If that was the perception or experience of anyone relying on social care, the reasons for that need to be reflected on seriously by the Scottish Government. However, notwithstanding my earlier reflections on the fear of the NHS being overwhelmed, I do not agree that social care was a secondary concern. It certainly wasn't so in my mind, and I know it wasn't in the mind of the Cabinet Secretary for Health & Sport, the CMO or other decision makers. We were just as anxious to minimise the impact of Covid-19 on the social care sector as on the NHS. We were also aware of the often disproportionate impact on older people of the decisions we were taking. Scientific evidence and clinical advice identified that older people were at higher risk from Covid-19. But we knew there were also at higher risk

of loneliness and isolation as a result of lockdown measures. There was therefore a need to ensure that we struck the best possible balance between restrictions that would protect older people from contracting the virus and minimising the impact of these restrictions on the social interactions essential to wellbeing. That was not an easy balance to strike, and I doubt that any government got it absolutely right all of the time. Ministers and officials engaged throughout the pandemic with the social care sector and groups representative of older people. This engagement helped inform our decisions and those of other public bodies. Specific concerns were raised about access to PPE, given demands on supply chains, and the Scottish Government took steps in April 2020 to ensure access when necessary, through local PPE Hubs.

267. The Inquiry has asked me to comment on parts of a statement from Save the Children Fund UK which questions whether children were adequately considered in our decision making. I recognise and deeply regret the significant impact that Covid-19 has had on children and young people. However, at all times during the pandemic the Scottish Government gave deep consideration to the impact that decisions were having on children and young people and the likely long-term implications. None of these decisions were taken lightly. Ministers met regularly with key stakeholder groups and a number of forums were established to provide advice on specific issues affecting children and young people. This included a dedicated sub-group of C19AG. All of this advice was carefully considered as part of the decision-making process.

268. The Inquiry has asked me to comment on part of the Scottish Women's Aid statement to the effect that the Scottish Government gave insufficient consideration to the impact of decision making on women and children, particularly those experiencing domestic abuse. The impact on this group was considered by Ministers from the outset, and we explicitly recognised and sought to address the increased vulnerability of women and children to domestic abuse when there was a legal requirement to stay at home. For example, at the start of lockdown, in late March 2020, I announced additional funding for Scottish Women's Aid and Rape Crisis Scotland to support the Domestic Abuse and Forced Marriage helpline. The issue of domestic abuse featured often at media briefings, and, on at least one occasion, the Chief Constable attended to give assurance about the continued priority being given by the police to tackling domestic abuse. The Scottish Government worked closely with local authorities, the police and other partners to ensure that the safety and

wellbeing needs of women and children experiencing domestic abuse continued to be prioritised.

269. The Inquiry has asked me to comment on part of the Inclusion Scotland statement stating that the Scottish Government gave insufficient consideration to the impact on disabled people and/or their rights. The impact of Covid-19, the restrictive measures being put in place, and how these were affecting disabled people was considered in depth throughout the pandemic. Scottish Ministers and officials engaged with key stakeholder groups in order to understand their concerns on an ongoing basis, to help inform and shape the decisions being taken.

270. The Inquiry has asked me to comment on part of the Clinically Vulnerable Families statement to the effect that the Scottish Government response gave insufficient consideration to the impact on those who were clinically vulnerable. Early on in the pandemic the four nation CMOs agreed the definition of clinically extremely vulnerable (CEV). Scottish Government established a CEV group to liaise with the CMO's office, on an ongoing basis as new evidence emerged, about the definition of groups at highest risk of severe illness or death from Covid-19. The impact of the pandemic on those identified as being part of this group was recognised and considered as part of the decision-making process. The Covid-19 shielding programme was established to provide further support and guidance to this group, and to make sure their needs were considered as part of the decision-making process.

271. As I have reflected throughout, decision-making in the context of the pandemic required careful and, at times, almost impossible balances to be struck. While we gave detailed consideration to all of the impacts and implications of the decisions we were taking, the nature of these decisions meant that none of them were harm free or without consequences. There was ongoing monitoring and review of the measures put in place, and the views and lived experience of key groups and stakeholders, alongside impact assessments and consideration of the Four Harms, helped us reach decisions that were as balanced as possible. We did not get it right all of the time – but the responsibility to get it as right as possible weighed heavily on all of us.

Vulnerabilities relating to pre-existing health conditions

272. The definition of Clinically Extremely Vulnerable (CEV) was agreed upon by the four UK CMOs at the start of the pandemic. The following six categories of people were identified as being at highest risk of severe illness from Covid-19:

- Solid organ transplant recipients
- People with specific cancers
    - People with cancer undergoing active chemotherapy or radical radiotherapy for lung cancer
    - People with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment
    - People having immunotherapy or other continuing antibody treatments for cancer
    - People having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors.
    - People who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs.
- People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe chronic obstructive pulmonary disease (COPD)
- People with rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as severe combined immunodeficiency (SCID), homozygous sickle cell)
- People on immunosuppression therapies sufficient to significantly increase risk of infection
- People who are pregnant with significant congenital heart disease

The CEV Group established by the Scottish Government liaised with 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.

273. A programme was established to ensure that those being advised to shield were supported and provided with appropriate information and guidance. The Shielding programme got clinical advice from the Clinical Leads Advisory Group (CLAGS). CLAGS 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 Deputy NCD for Scotland but was not itself a decision-

making body. As indicated in the preceding paragraphs the four UK CMOs were also providing clinical advice around CEV. During the pandemic, advice for those shielding was reviewed and updated as our understanding of the virus developed. The guidance sought to be as clear as possible about what we were asking people to do and why. The Inquiry has asked if a greater level of protection for those deemed to be CEV –which, of course, would have involved more severe restrictions - would have allowed the rest of the population to live more freely. It is difficult to know what whether this would have been the case, though I am very doubtful about it given the nature of our society. However, the ethics of an approach that expected a minority to accept even more stringent restrictions to their everyday freedoms so that the majority could live without restrictions, or with significantly fewer, would have been highly questionable in my view.

Decisions relating to the first lockdown

274. The Scottish Government's objective in responding to the pandemic was to protect as far as possible the Scottish population from the harms of Covid-19 and minimise the loss of life. On 3 March 2020 the four UK governments of published a Coronavirus Action Plan. The anticipated phases of the plan were as follows:

- **Contain**: detect early cases, follow up close contacts, and prevent the disease taking hold in this country for as long as is reasonably possible
- **Delay**: slow the spread in this country, if it does take hold, lowering the peak impact and pushing it away from the winter season
- **Research**: better understand the virus and the actions that will lessen its effect on the UK population; innovate responses including diagnostics, drugs, and vaccines; use the evidence to inform the development of the most effective models of care
- **Mitigate**: provide the best care possible for people who become ill, support hospitals to maintain essential services and ensure ongoing support for people ill in the community to minimise the overall impact of the disease on society, public services and on the economy.

275. By 12 March 2020, it was clear that there was community transmission in Scotland and, accordingly, the Scottish Government response moved from 'contain' to 'delay'. The WHO had declared Covid-19 a pandemic the day before. As March progressed further, it became clearer that with the level of infection rising – and an R number

likely above 1 – the objective of saving lives and minimising harm demanded more significant intervention. On the 15 March guidance was published giving effect to the announcement on 12 March that gatherings of 500 people or more should not take place in Scotland. On 17 March, the Scottish Government asked people to minimise social contact as much as possible. On the 19 March the Deputy First Minister made a statement in parliament confirming the decision announced the previous day to close schools and nurseries in Scotland. On 20 March there was a four-nation agreement to close all pubs, restaurants, gyms, and other social venues across the UK. And at a COBR meeting on the evening of 23 March it was agreed that the situation was so severe and escalating to the extent that there was a need to move immediately to became known as 'lockdown' – the most significant aspect of which was the 'stay at home' message. The 'Stay at Home' requirements were that no-one should leave home except for certain limited purposes including:

- to commute to work if working at home was not possible and workplace was permitted to remain open.
- to shop for necessities.
- to assist older and vulnerable people; and
- to exercise outdoors, alone or with household members.

On 24 March 2020, the Scottish Parliament gave legislative consent for the UK Coronavirus Bill, which included emergency powers for Scottish Ministers. The Scottish 'lockdown' regulations – The Health Protection (Coronavirus) (Restrictions) (Scotland) Regulations 2020 - were made under these powers on 26 March 2020 and came into force immediately. All of these actions were taken based on the emerging scientific and clinical evidence and advice at the time.

276. I fully supported the introduction of lockdown measures on 23 March and considered that it was essential and urgent for this decision to be taken at that time. It was clear that individuals and businesses would need significant economic support as a result of lockdown, and that this would need the UK government to provide the Devolved Administrations with the necessary financial resources, given that our own fiscal powers and levers were insufficient to the scale of the challenge. However, my view was that the threat of direct Covid harm was by that time so great that the overriding priority must be to protect health and save lives, and that whatever action was necessary as a result, including the provision of financial support, would simply have

to be taken. Covid-19 was first and foremost a public health emergency, and whilst it was recognised that the decision to go into lockdown would have a significant impact on the economy, the priority at the time was to mitigate the impact on health and lives.

277. My view at that time was that to maximise compliance and effectiveness, it was preferable for the UK administrations to move together as far as possible. It was also the case that the Scottish Government would not have had the financial wherewithal to provide the financial support that lockdown required. However, as I set out in my Module 2 statement [NS4/005 - INQ000235213], in the days leading up to 23 March, I was increasingly concerned that we needed to move faster, and indeed Scotland started to do so. I took two decisions for Scotland that we were prepared to pursue unilaterally if necessary – though as it turned out (perhaps partly as a result of the Scottish Government taking these decisions but probably more as a result of the rapidly deteriorating public health situation) the UK Government followed suit fairly quickly.

278. The first of these decisions was to cancel all indoor or outdoor events of 500 people or more. The Scottish Government took this decision on 12 March, and I intimated it to COBR that afternoon.

279. The second decision – announced on 18 March and confirmed to the Scottish Parliament on 19 March – was to close all schools and nurseries in Scotland from the end of that week.

280. In my judgment, by the time the 'lockdown' decision was taken, the evidence available to me and other decision-makers indicated that, though unprecedented, it was a necessary, proportionate, justified – and by that stage, urgent - response to a serious threat, particularly in relation to the risk that the capacity of the NHS might be overwhelmed by the proportion of those infected requiring hospitalisation, and the rapid growth in those numbers which would be caused by unmitigated exponential growth in infections. Subject to my comments above about the different timing of certain decisions in the days leading up to 23 March, the collective judgment (which I was fully part of), informed by expert advice, was that applying 'lockdown' substantially earlier might have risked the response appearing disproportionate and therefore reduce its effectiveness, if not complied with. As I have reflected on already in this statement, we were in unknown territory when it came to judging what the

public's tolerance to restrictions might be. There was therefore an anxiety about getting, not just the substance, but the timing of interventions right. However, by 23 March it was also clear that waiting substantially – even a few days - later to impose lockdown would have risked further exponential spread of a novel virus posing a significant threat to human health and life. While hindsight might now suggest that an earlier 'lockdown' would have been preferable – and indeed, even by 23 March, I was carrying regret that we had not taken that step sooner - we were taking what seemed in all the circumstances at that time to be the best and most balanced decisions possible on the basis of the evidence, information and advice available to us.

281. I am asked if I think lockdown could have been avoided had earlier interventions been adopted. My view is that once sustained community transmission was firmly established, lockdown was inevitable as no interventions short of that, including a mass testing programme, would have been sufficiently effective to stem transmission and drive the R number below 1 again – while trying to protect the NHS and save lives. The question is could community transmission been avoided? I think it is very hard to answer this question definitively, especially as community transmission may have been established earlier than we thought was the case. However, for it to have been achieved would have required full closure of borders and effectively a zero Covid approach from January 2020. It would have been extremely difficult – probably impossible – for Scotland to have taken such an approach independently of the other UK nations.

282. I am also asked was consideration was given to the adoption of strategies other than lockdown, including greater protection of the most medically vulnerable. My view is that once community transmission was established, lockdown was necessary to drive transmission down and prevent an even greater burden of morbidity and mortality. As the timeline from mid to later March shows, other measures short of lockdown were introduced – but it became clear these were not sufficient. As far the most medically vulnerable are concerned, it is important to be clear that what is described as 'greater protection' for them would have meant even more stringent restrictions for them as the price to be paid for fewer restrictions for the rest of us. As I comment above, it is difficult to know whether an approach like this would have been effective - though I am doubtful about it given the nature of our society. However, the ethics of such an approach would have been highly questionable in my view.

283. I am asked about my use of the term 'effective lockdown' in the media statement I made on the evening of 23 March 2020 following the COBR meeting. I used this term deliberately as I thought it essential for the purposes of maximum compliance to communicate both the substance and severity of the lockdown decision in a clear, accurate and unambiguous manner - and that using this term (effectively calling a spade a spade) was the most effective way of doing so. The public were already using the term 'lockdown' and understood that it meant staying at home. It seemed to me sensible, in communication terms, to be consistent with terminology already being used; and conversely, that not using that terminology might give a false impression that our advice differed from what people understood lockdown to be. I am asked by the Inquiry why I decided to 'deliberately use inconsistent terminology from the Prime Minister'. My motivation was not a desire to be different, but to communicate as effectively as possible in the circumstances we faced. Also, as I have commented on before, my accountability was to the Scottish Parliament and people – not to the UK government or Prime Minister – and my responsibility was to do at all times what I thought was in the best interests of Scotland's response to the pandemic.

284. Work on an 'exit strategy' from lockdown began almost immediately after 23 March. The Framework for Decision Making [NS4/003 - INQ000131025] – incorporating the Four Harms approach – was published on 23 April. This considered how to *"recover to a new normal, carefully easing restrictions when safe to do so while maintaining necessary measures and ensuring that transmission remains controlled, supported by developments in medicine and technology"*.

285. This was followed by publication on 21 May of the Coronavirus (COVID-19): Scotland's route map through and out of crisis [NS4/046 - INQ000256709].

286. The route map set out the Scottish Government's approach to easing restrictions in a careful and appropriately cautious manner. It set out a four phased approach to exiting lockdown and described the process of moving from phase to phase as follows: *"we will look at the cumulative and overall impact of those measures, and of ongoing restrictions. We will not consider changes in isolation, but in all areas, assessing the impacts, positive and negative, across the aggregate of decisions and across all four harms. We will consider:*

- *the scale of impact, in terms of the numbers of people and businesses likely to benefit;*

- *whether the approaches will protect and support the groups and individuals in society most in need of support, their impact on protected characteristics, and the extent to which they would help to reduce inequalities in outcomes; and*
- *evidence about the impacts of the current measures and any relevant wider evidence from other countries and scientific research."*

The route map was regularly reviewed and updated as we moved through the different phases of the pandemic, but the underlying approach remained the same.

287. I am asked about the impact of the resignation on 5 April 2020 of the CMO, Dr Catherine Calderwood. Dr Calderwood was central to the development of the Scottish Government's pandemic response and to the public communication of it in the early phase. She was also the principal conduit of clinical advice to me. Her advice was always candid, clear, and accessible. I had a high degree of trust in the advice she gave, but also felt able to challenge it when necessary – she provided important challenge to my thinking too. Her position within the Scottish Government, and the strength of the working relationship I had developed with her, meant that her resignation was a significant loss and keenly felt, both by the organisation and by me personally – albeit that her successor, already closely involved in the pandemic, provided continuity. Importantly, Dr Calderwood's decision to resign when she did ensured that confidence in the Scottish Government public health advice was not undermined. Indeed, it is to her credit – and in stark contrast to the behaviour of others later in the pandemic – that she put the integrity of the pandemic response ahead of her own interests.

288. During the period January to September 2020 there was confidence that a vaccine would be developed but considerable uncertainty about the likely timescales for development, and manufacturing of supplies in sufficient quantity. Confidence that treatments capable of reducing the risk of death from Covid were on the horizon increased in June 2020 when dexamethasone was approved for use on the NHS. Nevertheless, uncertainties remained around treatments too. As a result, the focus remained very much on NPIs as the principal line of defence against Covid-19.

Continuation of the first lockdown

289. I am asked to what extent 'Zero Covid' was considered during Spring/Summer 2020. I was of the view that 'Zero Covid' in the period before a vaccine was available was

an aim worth striving for. I knew that our circumstances – particularly if the rest of the UK was not following suit – meant it was unlikely to be completely achievable for any sustained period of time. But by aiming to drive infection levels as close to zero as possible, it was likely that we would keep them lower that we would otherwise do. I believed that this would both reduce the direct harm from the virus, and also create safer conditions in which to resume economic and social activity and allow us to control the virus in a more targeted way through testing/contact tracing and outbreak control. To look at it from the other perspective, it seemed to me that being too lax with restrictions too early and allowing the virus to circulate too freely, would cause more direct harm and, because of heightened public concern and levels of sickness that accompanied rising infection levels, make it harder to get life back to normal. In other words, I did not agree that letting the virus run free was the price we had to pay (or, given the morbidity and mortality associated with that, prepared to pay) to get back to normal – my view, instead, was that high levels of infection frustrated our efforts to return to normal and that driving towards zero Covid made a sustained return to life as we knew it more possible.

290. The Inquiry has asked about the decision-making process with regard to the following:

- "16 April 2020 – After reviewing the lockdown with all nations in the UK, the decision was made to extend it for another three weeks until 7 May;
- 7 May 2020 – Extension of the lockdown restrictions in Scotland for another three weeks, with indication they could be changed if there is evidence it was safe to do so; and
- 11 May 2020 – in a national address to Scotland at the beginning of the seventh week of lockdown, you asked the nation "*to stick with lockdown for a bit longer – so that we can consolidate our progress, not jeopardise it…I won't risk unnecessary deaths by acting rashly or prematurely*."

As set out in the first section of this statement, strategic decisions of this nature were discussed and taken by the Scottish Cabinet, with delegation to me and other Ministers when appropriate and expressly agreed. The decisions of 16 April and 7 May were agreed by Cabinet in principle [Cabinet minutes from 14 April NS4/047 – INQ000078535 and Cabinet minutes from 5 May NS4/048 – INQ000078540] but the

detail and the final 'call' were delegated to me to ensure that the latest data was taken account of.

291. The development of the Scottish Government's *Coronavirus (COVID-19): framework for decision making*, published on 23 April 2020 [NS4/003 – INQ000131025], was based on our up to date understanding of the epidemiology of the virus. The strategic aim was to minimise the overall harm of the pandemic and it was recognised that this required a multi-faceted approach. The Framework therefore introduced the Four Harms approach described earlier in this statement. To recap, the four categories of harm were:

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

292. It was also recognised that the harms caused by the Covid-19 pandemic were not felt uniformly by everyone. Equalities considerations were integral to all of the four harms and our overall decision making. It was therefore not considered appropriate to have it reflected as a stand-alone harm. The Four Harms approach was built into all decision making from this point forward. A fuller explanation of the Four Harms framework and the approach taken is set out in paragraphs 72 to 85 of the DG SEA Corporate Statement dated 22 June 2023 [NS4/001-INQ000215495].

293. The Inquiry has asked specifically about reference in the strategy to the lifting of restrictions being phased. At that point the scientific consensus was that the severity of the virus and the significant impact of lockdown in suppressing it, meant that the exit would need to be phased if we wanted to avoid a rapid and significant reversal of progress. In a media briefing on 23 April 2020, I said the following: *"Social distancing and limiting our contacts with others will be a fact of life for a long time to come – certainly until treatments and ultimately a vaccine offer different solutions. So that means possibly for the rest of this year and maybe even beyond."* This was based

on evidence at that time that, without a vaccine, there would be need for some time for continued restrictions to be in place.

294. The Framework was published on the Scottish Government website, and I used the media briefing that day to set out its contents and the thinking behind it. The media briefings, also often referred to as the 'daily briefing' (although they typically did not take place at weekends) were our primary and most direct form of communication with the public. They were broadcast by the BBC and attended by print and broadcast journalists and reached a wide audience.

295. On 28 April 2020, the Scottish Government published guidance recommending that people cover their faces while on public transport or in public places such as shops. Whilst there was limited evidence at the time, what evidence we did have indicated that face coverings could offer some protection in enclosed spaces where multiple people were mixing, and physical distancing was difficult. In light of the increasing concern at that time about asymptomatic transmission, we considered this to be an important, additional mitigation against transmission by those who did not know they had the virus. I explained the guidance and the rationale for it at the media briefing on 28 April 2020 [NS4/049-INQ000292537].

296. The Inquiry has asked me to expand on the following comments I made on 29 June 2023 in Module 1 oral hearings:

"But speaking on behalf of the government I led at the time, it was never the case that we simply accepted there is a level of harm that is going to be done by this virus and we accept that. We were always – in fact it became, later on, one of the points of difference between the Scottish and the UK Government, the extent to which we were still seeking to suppress as opposed to live with the virus."
"It is also the case that I don't think for any responsible government it can ever, in a context like this, be either trying to suppress or dealing with the consequences. You have to do both."

As I hope is clear from the information and reflections that I have provided earlier in my statement, the focus of the Scottish Government during the period was on suppressing the virus. However, despite efforts to suppress it, the virus was having consequences, across all four harms, and they also had to be addressed and

mitigated. It was never a choice between trying to suppress the virus and dealing with its consequences – we had to do both.

297. The availability of vaccines was the turning point that enabled us to focus more firmly on getting back to normal. Until then Scottish Government relied on NPIs to help suppress the virus. The use of these was kept under review to ensure legality, necessity, and proportionality. The Route map indicated the order in which we hoped to lift the NPIs/restrictions, and the Framework provided a rational basis on which decisions could be taken. When the UK Government took the decision on 13 May 2020 to begin easing some restrictions in England, Scottish Ministers decided, on the basis of evidence and a four harms assessment, that certain measures should remain in place in Scotland.

Effectiveness of the first lockdown

298. The objective of the Scottish Government was to suppress and minimise the impact of Covid-19 on the people of Scotland. A significant amount of data was collected in order to allow Ministers to understand the effectiveness of the measures that were put in place, and to support decisions on easing restrictions. Each week Cabinet was provided with the latest data available information to inform our decision making and assess the impact of the measures being implemented. An assessment of what might have happened had different or earlier decisions been taken in the period around the time of the first lockdown has not been undertaken.

299. The Four Harms approach took account of the consequences of Covid-19 restrictions not directly related to the spread of the virus, including economic, social, and non-Covid health related harm. Advice from the Four Harms group was included in the material provided to Ministers in weekly Cabinet papers. It was important in all of our decisions about the imposition/easing of NPIs, that there was consideration across all of the harms.

300. On 2 July 2020 the Scottish Government published the Equality and Fairer Scotland Impact Assessment: Evidence gathered for Scotland's Route Map through and out of the Crisis. It provided a summary of the impact of Covid-19 on Protected Characteristics and Socio-Economic Disadvantage [NS4/050- INQ000182723]. This was followed in December 2020 by a second Equality and Fairer Scotland Impact which considered the phase 3 measures [NS4/051- INQ000182799]. Information on

the impacts of Covid-19 on different groups was cascaded to Ministers and officials across government, to ensure that it was considered in policy development and decision making.

Conclusions and lessons learned

301. The decisions relating to the pandemic were the hardest that I – and Cabinet colleagues – had ever been faced with. That was in large part because of the different and competing harms involved. It was vital to consider the impacts across different sectors of the economy and groups within society, including those people at higher risk from the virus. Consideration was also required as to the likely degree and duration of adherence to requirements and restrictions. The Scottish Government took very seriously the need to communicate effectively to maintain trust in our approach.

302. I believe that the ability to make use of devolved powers to respond to the pandemic in Scotland made a significant, positive difference. Consequently, I believe that it was right, during the emergency phase of the pandemic, that the UK Government (in the absence of a devolved government for England) was taking decisions in devolved policy areas that were in principle tailored to the needs and circumstances of England as it saw them.

303. A review focusing on the experience of health and social care organisations within Scotland was published in August 2021 [NS4/052 – INQ000147474]. This review focused on the first six months of the formal pandemic response, ranging from March 2020 to September 2020. It contained 10 key themes summarising some of the lessons learned from the first six months of the pandemic. These included:

- Diagnosis and contact tracking
- Modelling of COVID-19 need, demand and consequences
- Rapid establishment of extra physical capacity
- A supply chain that keeps moving
- Digital front door is becoming the normal front door
- Programme and project management
- Workforce augmentation
- Governance, compliance and risk management
- Public Engagement and Education
- New models of care

304. Throughout this period a vast amount of knowledge was gathered about the epidemiology of the virus and the Scottish Government put in place structures and frameworks to support the gathering of evidence and making of decisions. These were used to help inform the subsequent management of the pandemic. The Framework for Decision Making and Four Harms approach [NS4/003 - INQ000131025] were extremely effective in supporting ongoing decision making.

PART F – Decisions relating to easing of first lockdown: 29 May to 7 September 2020

General

305. The decisions taken by Cabinet to start easing the first lockdown were in line with the principles and phased approach set out in the Framework for Decision Making and Route Map respectively. The Route Map had set out a four-phase approach to lifting restrictions, conditional on the state of the pandemic. Ministers were also legally obliged at least once every 21 days to review the need for any requirements under regulation 2(2) of the Health Protection (Coronavirus) (Restrictions) (Scotland) Regulations 2020. There was a legal duty under regulation 2(3) for Ministers to terminate a restriction or a requirement as soon as it was considered no longer necessary to prevent, protect against, control, or provide a public health response to the incidence or spread of the virus.

306. All of the decisions on restrictions that were taken during this period were informed by the Four Harms approach in the Framework for Decision-making, which stated that:

> *"The four harms approach enables us to take into consideration the many ways in which COVID-19 is impacting on the people, economy, and services of Scotland, providing a basis for an overall assessment to be made of the harms individually and collectively. It helps to maintain a comprehensive view of the harms caused by the implementation of individual and groups of restrictions. It provides a powerful tool for the development of policy response as options can be assessed together to judge their cumulative impact on the population as a whole and on different groups in the population. It enables us to deliver our aim of suppressing the virus to very low levels while minimising the broader harm it causes, and it recognises that suppression of the virus is an essential component of any strategy to rebuild the economy and address societal impacts."*

307. Our decisions were informed by advice from a range of advisory groups and experts. These included SAGE and C19AG, the CMO, the Chief Statistician and the Chief Economist, and underpinned by data on the transmission and impact of the virus in and on Scotland. On occasion, the detail of our decisions and the timing of them differed from other parts of the UK, most notably England. When this was the case, we sought to be clear in guidance and public messaging about the position in Scotland. I would also make this clear in my media briefings. At all times I sought to communicate to the public the rationale for the decisions being made in Scotland. At times I felt UK Ministers could have been clearer on whether their announcements were UK wide or applicable to England only. Scottish Government officials were in regular contact with counterparts in the other UK administrations and sought to keep them advised of the decisions being taken for Scotland.

The steps taken to ease the first lockdown.

308. The Scottish Government's Route Map detailed four phases of exiting lockdown [NS4/046 - INQ000256709]. Progression from one phase to another was dependent on certain criteria being met. These were based on WHO advice. The WHO criteria for the easing of restrictions were:

1. Evidence shows that COVID-19 transmission is controlled.
2. Sufficient public health and health system capacities are in place to identify, isolate, test and treat all cases, and to trace and quarantine contacts.
3. Outbreak risks are minimized in high vulnerability settings, such as long-term care facilities (i.e., nursing homes, rehabilitative and mental health centres) and congregate settings.
4. Preventive measures are established in workplaces, with physical distancing, handwashing facilities and respiratory etiquette in place, and potentially thermal monitoring.
5. Manage the risk of exporting and importing cases from communities with high risks of transmission.
6. Communities have a voice, are informed, engaged and participatory in the transition.

309. On 28 May 2020 I announced the move from Lockdown to Phase 1 would begin the following day, The move to this stage was made possible by sufficient progress in meeting the criteria set out in the Route Map. The move to Phase 1 also coincided with the launch of Test & Protect (covered in Section D of my statement).

310. Over subsequent weeks the evidence showed that sufficient progress had been made to support a decision to move into Phase 2. This was announced on 18 June 2020 and began to take effect from 19 June 2020. However, the move to Phase 2 itself happened in stages, to avoid triggering a rapid rise in cases and being forced to go backwards in the Route Map.

311. It was then announced on 9 July that the move to Phase 3 would begin the following day. Again, a staged approach was taken as this had proved successful in moving to Phase 2.

312. The moves between phases were announced by me in statements to the Scottish Parliament, with further detail made available on the Scottish Government website. I would take the opportunity of media briefings in subsequent days to underline key message and address any points of detail.

313. I understand the Inquiry has been provided with the Route Map documents. These provide full details of the different phases, and the supporting evidence for moving from one phase to the next.

314. I have been asked about the shift in our public messaging from 'Stay at Home' to 'Stay Safe' as we entered Phase 2 of the Route Map. In Phase 2, as more of society e.g., some shops and leisure facilities were opening up and people were able to go to more places, a blunt 'Stay at Home' message no longer accurately reflected the reality of the situation and the advice we were giving. Instead, we wanted people to adopt safe behaviours when they were out and about. The updated messaging was informed by public attitudes research and the new strapline 'Stay Safe' was the simplest, clearest, and most effective way of encapsulating what we were now asking people to do.

315. As part of the move to Phase 3 on 10 July, the decision was taken to make the requirement for people to wear a face covering in shops mandatory in Scotland. This was considered a necessary and sensible step to help reduce transmission risks at a

time when people were going out and about more and the physical distancing requirement in retail had been reduced from 2 to 1m. This decision was also influenced by the WHO statement a few days earlier to the effect that, while its position remained that the virus was spread by droplet transmission, they could not rule out the possibility of airborne transmission in crowded, enclosed or poorly ventilated spaces. For this – as with all decisions- Ministers considered it in the context of the Four Harms approach.

316. On 23 June 2020 the Deputy First Minister advised the Scottish Parliament of the intention to work towards re-opening Scottish schools. The C19AG Sub-Group on Education and Children's Issues was established to support decision making. I understand the Inquiry has already been provided with the papers from this group, which includes scientific advice for the safe re-opening of schools and the resumption of school transport published on 16 July. On 30 July, I confirmed that infection rates had remained sufficiently low for schools to reopen from 11 August, with all pupils returning to classes full-time from 18 August.

317. The Inquiry has asked why the decision was not taken to impose stricter travel restrictions and border controls during the summer of 2020. As set out earlier in this statement, Ministers were required to ensure that any restrictions were necessary and proportionate, and there was insufficient evidence to justify such measures. Travel restrictions within Scotland, and between Scotland and other parts of the UK were imposed when required - for example, during the localised outbreak of the virus in Aberdeen in August 2020, the Scottish Government issued travel guidance advising that residents of Aberdeen should not travel more than five miles for leisure or recreational purposes and that, while they could continue to travel for work or education, were advised against other travel. Those residents elsewhere were advised not to travel to Aberdeen. This action was considered necessary to help reduce transmission of the virus in Aberdeen.

318. Case numbers started to rise again in August 2020. This was due - at least in part – to the re-opening of schools and easing of other restrictions. However, the situation was not uniform across Scotland and so it was not considered necessary or proportionate at this stage to re-introduce nation-wide restrictions. Instead, regional guidance was issued when necessary to help limit spread within particular geographical areas, and from them to neighbouring areas.

319. It was standard practice, when local outbreaks occurred, to establish a local Incident Management Team, to manage and oversee the response, IMTs provided regular updates to Scottish Government through the SGORR team and other officials as appropriate. Meetings of SGORR (M) would be convened as necessary – and routinely chaired by me - to update Ministers and provide a means for us to ask questions and contribute views. These meetings would be attended by representatives of the IMT and other relevant bodies. This was the approach used to manage outbreaks at the Motherwell Sitel site in July 2020, in Aberdeen in August 2020 and in Glasgow in September 2020. When considered, the Scottish Government would issue specific guidance and messaging to support the local response, as happened in the Aberdeen outbreak.

Eat Out to Help Out

320. Eat Out to Help Out was a UK government initiative, designed, implemented, and funded entirely by the UK government and applied across all four nations. The agreement of the Scottish Government was neither required nor sought. Hospitality businesses applied directly to the UK Government to register for the scheme and claims were made to HMRC. I was not involved in the development of the scheme and cannot recall any direct engagement with the then Prime Minister or Chancellor about it prior to implementation in August 2020 or indeed subsequent to that, although there was frustration about the lack of engagement ahead of the scheme being announced.

321. Data on Covid-19, including case numbers was reported on a daily basis and so any impact of the scheme would have been captured as part of that. There was no need to commission separate scientific advice, and we did not do so. The measures implemented since March 2020 had, by July, driven case numbers to very low levels. On some days, the number of confirmed positive cases was in single figures (although we understood that the actual number of cases would have been higher than that). 'Covid-free' was not a specific term we set out to use – or did use to any extent – but I did regularly make the point that having driven infection levels so low, we should be careful in easing lockdown not to trigger a resurgence.

322. As I have indicated earlier in this statement, the Scottish Government was focused on suppressing the virus and being as careful as possible not to undo progress we eased lockdown restrictions. In my view, Eat Out to Help Out was not at all helpful in

this regard. It risked an increase in transmission – and I think almost certainly did contribute to the rise in infections through August and into September. Whilst I welcome any investment in the Scottish economy, in my view the money spent on the scheme could have been used to support the hospitality sector in a more sensible manner.

Conclusions and lessons learned

323. No analysis was carried out on what the outcomes might have been had different or earlier decisions been taken. All restrictions implemented in Scotland in were considered as part of the Four Harms approach. Good structures and processes were in place to gather data and information to inform this approach. Networks established earlier in the pandemic enabled stakeholders, including vulnerable or at-risk groups, to share lived experience about the virus and impact of restrictions. This provided an important source of information to Ministers and officials.

324. During this period, decisions were supported by the Route Map which gave the public a clear indication of what to expect, and what was required to move from one phase to the next. The compliance of the public with advice and guidance enabled us to move through the different phases with a degree of confidence, but we quickly learned that any easing of restrictions would have an impact on the spread of a highly infectious virus, and that levels of public concern remained high. During this period, the public wanted government to be careful and cautious and not move too quickly out of restrictions.

PART G – DECISIONS RELATING TO THE PERIOD BETWEEN 7 SEPTEMBER 2020 and END of 2020

325. The level of infection, evidenced by the number of confirmed positive cases, was rising again in the period from 7 September through to the end of 2020, albeit that this was not a straight trajectory. To illustrate: on 7 September the 7-day average number of cases in Scotland was 174. By 31 October this had risen to 1,113. By 30 November, it had reduced to 797. And by the end of the year, it had risen again to 1,935. The focus during this period was therefore on managing, stabilising and, as far as possible, reducing the transmission of the virus and the burden of morbidity and mortality associated with it. In the continued absence of a vaccine, targeted and careful use of NPIs was the principal way of achieving this.

326. As set out already in this statement, Scottish Government decisions on NPIs were informed by scientific and clinical advice from a range of sources including C19AG, SAGE and the CMO. Decisions were then taken in the context of the Four Harms approach, supported by the work of the Four Harms Group established in October 2020 [NS4/053 - INQ000103003]. Ministers also had to be satisfied that any decisions on NPIs were lawful – this meant that we had to judge them to be necessary, proportionate, and justifiable. NPIs required to be reviewed every 3 weeks.

327. I have been asked about a comment made at the daily briefing on 7 September 2020 about the need to 'put the brakes' on moving to phase 4 of the Route Map. The quote in full is as follows:

"Later in the week, we will have the latest three-week review of the national restrictions which continue to be in place. I will confirm the outcome of that review to parliament on Thursday. However, it is worth remembering that we can only, under our own route map, move from phase 3 of our route map – which is where we are right now – to phase 4, if, and I quote, "the virus is no longer considered a significant threat to public health". From the all the latest statistics, it is clear that will not be the case. And it may be, while no decisions have finally been taken yet, that we have to put the brakes on some further changes too."

328. At that point Scotland was experiencing an increase in confirmed case numbers – indicative of an increase in prevalence of the virus – and the data also indicated that this was being driven by infections in younger age groups. This was of significant concern to us, especially as we were approaching winter and in this context, it seemed to be sensible to 'put the brakes on' any further significant easing of restrictions at this time. As I had strived to do throughout the pandemic, I also though it important to be upfront and clear with the public about our assessment of the situation.

329. On 10 September 2020, I informed the Scottish Parliament of the outcome of the latest review of restrictions. I advised that Cabinet had decided to keep existing restrictions in place for a further 3 weeks and set out additional measures that we considered necessary to reduce the transmission of the virus. This included limiting the number of people permitted at social gatherings indoors and outdoors to six, and

a requirement for customers in indoor hospitality venues to wear face coverings when not eating. The decision not to move to level 4 of the route map and to introduce further restrictions was taken on the basis of advice provided to Cabinet. The relevant Cabinet paper [NS4/054 - **INQ000078366** stated as follows:

"The Chief Medical Officer's assessment is that the Phase 4 criterion has not been met. Indeed, there are indications that the disease activity has increased during this review period and, as such, the threat has not receded but increased"; and

"From the insights into the recent outbreaks in Scotland we know that there are a number of key sources of transmission risk. These include, but are not limited to, indoor hospitality, social gatherings, and car sharing. Further advice is being commissioned from SG experts on appropriate countervailing measures."

330. Full details of these decisions and the evidence underpinning them was published on the Scottish Government website. I also set out the detail of and reasons for the decisions at the following day's media briefing.

331. Over the following week the number of positive cases continued to rise. I provided a further update to the Scottish Parliament on 22 September setting out the additional restrictions that we considered necessary at that time to control the virus. I explained as follows: *"In mid-July, we were recording an average of nine new cases every day. Around four weeks later, that had risen to an average of 52 a day. Three weeks after that, it was 102. And as of today, the average daily number of cases is 285. We have also seen an increase in the percentage of tests coming back positive. In late August, that percentage was consistently below 1%. Today it is over 7%. The R number is above 1 again, possibly as high as 1.4."*

332. While this was a far less rapid rise than had been seen in March 2020, it was nonetheless of a magnitude that we considered could not be left unchecked.

333. As result, I advised in my statement to Parliament on 22 September that in an effort to bring the R number down, Cabinet had judged it necessary to introduce further restrictions. I had taken part in discussions with the other UK governments nations and the measures we were taking in relation to hospitality were broadly similar to those outlined by the Prime Minister for England i.e., the introduction of a 10pm curfew. However, advice from our CMO and NCD was that this measure alone

would not be sufficient to drive the R number down. Cabinet therefore also decided to restrict mixing between households. The Cabinet conclusions were summarised as follows:

"Preliminary data suggested that the tighter regional restrictions currently in place across west central Scotland might be starting to slow the rate of increase in new cases, which now appeared linear rather than exponential. By extending household restrictions nationwide, by means of an early package of preventative measures, it seemed reasonable to hope that the rate of increase in new cases might also begin to decline nationally. The aim must be to bring the 'R' number once more below one, but it was as yet unclear how long this might take".

334. I explained that these steps were necessary as part of an overall trade off to get the R number down while protecting schools, the NHS, and the economy:

"Firstly, we are determined to keep schools open and young people in education. That is vital to the health, wellbeing, and future prospects of every young person across our country. Second, we must restart as many previously paused NHS services as possible, so that more people can get the non-COVID treatment that they need. Our NHS must be equipped this winter to care for those who have COVID - and it will be. But it must be there for people with heart disease, cancer, and other illnesses too. And third, we must protect people's jobs and livelihoods - that means keeping businesses open and trading as normally as is feasible. To achieve all of that, we must stop the virus from spiraling out of control and we can only do that if we accept restrictions in other aspects of our lives."

335. This announcement was made by me to the Scottish Parliament and reinforced at the following day's media briefing. Details of the announcement and underpinning rationale were also published on the Scottish government website.

336. On 24 September 2020, Universities Scotland issued advice designed to reduce transmission of the virus on campuses and amongst the student population. The advice asked students living in student or shared accommodation to consider those they shared with to be a household group and over the coming weekend to refrain from socialising with people outside that group. It also asked students not to visit

pubs, restaurants, and cafes. I set out the rationale for this in the media briefing on 25 September as follows:

"There are a number of campus outbreaks across Scotland and we want to do everything we can to stop them spreading further. And staying away from hospitality this weekend is one of the ways in which students can help. The incubation period of this virus means that the exposure people have had in the last few days means that we will see campus cases continue to rise in the days to come. But if we take steps now to limit the interaction over the next few days, we can help stem that flow and make sure outbreaks don't spread any further. So that's the reason for that advice this weekend. After this weekend, we'll ask the same of you as of everyone else. Try to limit your social interactions in pubs and hospitality but when you do go, you should be in groups of no more than six from a maximum of two households. We are also asking students to download the Protect Scotland app. It isn't mandatory – but it is strongly encouraged, and your university can ask you to do so – because, particularly when you may not know everyone you are meeting, it is an effective way of alerting people that they have been in contact with someone who has tested positive for Covid. In the last two weeks, more than 800 people have been notified by the app to isolate."

337. Scientific advice, endorsed by SAGE, and published been earlier that month had noted the *"significant risk that Higher Education could amplify local and national transmission, and this requires national oversight"*. These restrictions were intended to reduce that risk as students returned to University/College.

338. On 7 October 2020 I advised the Scottish Parliament of the Cabinet's decision that further temporary restrictions were required to help suppress the virus. By this point the number of new confirmed positive cases had reached more than 1,000 in a single day - the highest daily figure to date. The new measures announced were:

Nationwide (excepting central belt areas):

- Hospitality (food and drink): all premises may only open indoors between 6am and 6pm, with no sales of alcohol.
- Hospitality (food and drink): premises may open outdoors until 10pm, with sales of alcohol (where licensed).
- Takeaways (including from pubs and restaurants) can continue.

- Evening meals may be served in accommodation for residents only, but no alcohol can be served.
- Current meeting rules, maximum of six people from two households, continue to apply.
- Specific life events, such as weddings and funerals, may continue with alcohol being served, with current meeting rules for these events (20 person limit in regulated premises only).

Central belt area focusing on five health board areas (Ayrshire & Arran; Forth Valley; Greater Glasgow & Clyde; Lanarkshire; Lothian):

- All licensed premises will be required to close, with the exception of takeaway services.
- Cafés (unlicensed premises) which don't have an alcohol licence will be able to open between 6am and 6pm.
- Takeaways (including from pubs and restaurants) can continue.
- Evening meals may be served in accommodation for residents only, but no alcohol can be served.
- Specific life events, such as weddings and funerals, may continue with alcohol, with current meeting rules for these events (20-person limit in regulated premises only).
- No group exercise classes for indoor gyms and sports courts, pools with an exemption for under 18s.
- No adult (18+) contact sports or training, except professional sports, indoor or outdoor.
- No outdoor live events.
- Snooker/pool halls, indoor bowling, casinos and bingo halls are to close.
- Public transport use should be minimised as much as possible, such as for education and work, where it cannot be done from home.
- Current meeting rules, maximum of six people from two households, continue to apply.

Additionally, from the forthcoming weekend, shops across Scotland were asked to return to two metres physical distancing and reintroduce mitigations from earlier in the pandemic, including one-way systems. These new measures began at 6pm on Friday 9 October and ran for 16 days, until 6am 26 October.

339. The evidence for these decisions was set out in a paper produced by the CMO, CNO and NCD [NS4/055- INQ000232734]. It stated as follows:

"The position in Central Scotland is of particular concern. Several Health Board areas including Greater Glasgow and Clyde, Lanarkshire and Lothian have been tracking rates in excess of 100 positive cases per 100,000 population over the last 7 days, with a rate of 146.1 in Greater Glasgow and Clyde over the last 7 days. Each of these Health Boards has been adding over 100 additional new cases to their count per day over the last week, and for Greater Glasgow the number of daily cases has been in excess of 200 cases per day (with 1,728 new positive cases in the week to 5th October). 6 10. These 3 Health Board areas now account for three quarters of all new positive cases in Scotland over the past 7 days and nearly two thirds of cumulative positive cases overall. However, we can also now see that neighbouring areas in Ayrshire and Arran and Forth Valley are also showing an increase in excess of 55 cases per 100,000, suggesting there may be a 'ripple' effect spreading from existing areas of high case numbers and growth."

340. The paper also set out the contribution of hospitality in suppressing the virus. Data collected showed that "the percentage of individuals who have tested positive for Covid-19 and who have reported hospitality exposure (pubs, restaurants, cafes etc.) has been consistently over 20% in September and up to 26% in the period from the end of July to the beginning of October. All ages are included but of the 26%, half were in the 20-39 age group". Close contact with an infected individual remained one of the biggest risks and the paper stated that:

"…any indoor setting where the public mixes freely with members of different households and people of different age groups carries a number of risks. Hospitality therefore presents one of the highest risks. Generally, this setting involves people of different ages with different individual risk profiles mixing with other households, or being seated in close proximity to other households, for more than 15 minutes." The paper also noted that the disinhibiting impact of alcohol would lessen concern about social distancing.'

341. The approach to communicating these decisions was the same as on previous occasions.

342. I am asked about the information/advice provided to the Cabinet about the emergence and nature of the Alpha/Kent variant and/or the Delta variant. As the minutes of the meeting show, Cabinet was advised on 15 December by the CMO as follows:

"It was as yet too soon to know whether a new variant of the SARS-CoV-2 virus which had recently been identified in south-east England made it more transmissible than hitherto, but there was no evidence at this point that the variant was likely to cause more serious illness. Thus far, some nine instances of the new variant had been found in patients in the Greater Glasgow and Clyde area. Public Health England was carrying out further analysis, and Cabinet would be informed as new information emerged."

343. At the cabinet meeting on 19 December 2020 the CMO advised as follows:

"Following a Four Nations call that morning, during which the UK Government's Chief Scientific Adviser had briefed the First Minister and others on the conclusions of a meeting of the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) late the previous day, it had become clear that immediate action would be required across the UK"

344. Cabinet was advised that this new variant was likely to be 60 to 70 per cent more transmissible, and that unless controlled it would likely lead to an increase in the R number and exponential growth in infection rates. This new variant, which became known as Alpha, was therefore considered a significant threat, and I will reflect in the next section how this impacted decision making in the period to follow.

345. Cabinet was provided with information on the Delta (B.1.617.2 / April-0.2) variant in May 2021, and advised that it was also likely to be a more transmissible strain. I will reflect more on the significance and impact of this in later sections.

346. Cabinet received weekly advice on the prevalence and impact of the virus in Scotland throughout September 2020, and on whether the measures in place were sufficient to control transmission. The decisions taken and set out earlier in this section of my statement, were considered appropriate at the time. In October 2020 further, more stringent measures were introduced. This was also considered to be a proportionate and justifiable step based on the evidence. While not referred to as a lockdown, in many areas the restrictions were similar to and just as stringent as those in place in England.

347. The Covid-19: strategic framework published on 23 October 2020 [NS4/056-INQ000249320] set out the protection levels framework. In discussion at the Cabinet on 21 October it was noted as follows:

"Since we now know more about the virus and how it is transmitted, we can set out Level 2 and 3 restrictions that focus on key areas of risk – broadly, indoor settings where household mixing takes place with less, or less well-observed, physical distancing and mitigations. These are sharper than the 'blunt instrument' of a full lockdown. They are still painful for sectors like hospitality, and they still restrict many aspects of normal life; but they leave much more economic and social activity possible, compared to March."

This approach also allowed levels to be set geographically, building on the local approach to managing outbreak that had been deployed over the summer.

348. The Inquiry has asked about the timing of the Four Harms Group being established in October 2020, and whether I agree with the description in the DG Health and Social Care statement dated 23 June 2023 [NS4/057 - INQ000315534] that: "to begin with, cross government co-operation within the Scottish Government was informal. Then the "Four Harms Group" was set up, in Autumn 2020". I think what is meant here by 'informal' is that for a period of time there was not a specific, named group in place. Rather the work was undertaken by relevant policy teams across government. Cross-government working is the norm in the Scottish Government, and it is common practice for multiple teams to work together to develop policy advice. This approach worked reasonably well over the summer. However, with the resurgence in Covid cases and the likely need for further restrictions, it was decided to formalize and streamline these arrangements. I understand the Inquiry was provided by DG SEA with a more detailed draft statement on 31 August 2023 explaining the four harms approach and the establishment of the group.

The 5-tier Covid management system

349. I have already touched on this in paragraph 347. As I set out in the Foreword to the document:

"This new Strategic Framework sets out how we will work to suppress the virus and presents an honest reflection of the decisions we will need to make, and the balance we will have to reach, and it does so rooted in tackling the four harms we know the virus causes."

The strategy set out the Protection Levels Framework - Level 0 to Level 4. Level 0 corresponded to Phase 3 of the initial Route Map. Phase 3 applied at that time. The Route Map had served us well – however, as we entered a new phase there was a need to develop it further. The new approach also supported risk-based variation between different parts of the country should that be required.

350. The strategy was discussed and agreed by Cabinet on 21 October 2020. The strategy was agreed in principle with delegation to me on the specific detail, which was informed by the most up to date information, ahead of publication on 23 October 2020. In my view the new strategy was reasonably effective in achieving what we set out to do. It supported the overarching approach of taking decisions in the context of the Four Harms approach but enabled us to target measures geographically when necessary. It also aided overall communication with the public.

351. Scottish Government officials were in regular contact with four nation counterparts throughout the pandemic. I don't recall being advised of any specific assessment of the restrictions in place during October 2020 in England and Wales, Ministers and officials paid attention to the different approaches being taken and the impact of them on Covid data.

352. The levels framework gave us the flexibility to put in place different measures in different parts of Scotland if local and regional data supported that. At that point in time there were so many uncertainties that I do not believe any strategy would have given absolute assurance that a second national lockdown would not be required. Decision making in this period took into account lessons which had been learned from the first lockdown.

353. Cabinet always carefully considered the extent to which the decisions we took were capable of being communicated in a way that the public could understand. The protection levels approach was complicated and while I think it was broadly understood, I am aware that any approach that was not uniform across the country would at times cause confusion – and I think that was true at times of the levels

approach. However, we were at a stage of the pandemic when both the broader harms and the law required us to be proportionate and targeted, I am not sure any approach could have completely avoided this. The daily media briefings continued to be an important mechanism to build as much public understanding as possible.

Conclusions and lessons learned

354. Ministers were legally required to review any NPIs in force at least once every 3 weeks. These reviews ensured that we considered the effectiveness of measures and reach a balanced judgement on whether to retain or ease them. These reviews were informed by an assessment of the data collected over the preceding weeks. In the period from 10 November to 22 December the Scottish Government also published a weekly review of the allocation of levels to local authorities, with a summary of indicators and trends. I'm not aware of any assessment of the likely outcomes had different or earlier decisions been taken in this period.

355. Throughout this period decisions continued to be taken in the context of the Four Harms approach. This included advice on economic, social, and non-Covid health related harms. Consideration was also given to the impact on vulnerable and at-risk groups. In December 2020, the Scottish Government also published the Equality and Fairer Scotland Impact Assessment: Evidence gathered for Scotland's Route Map through and out of the Crisis Phase 3 Measures [NS4/051 - INQ000182799]. It reviewed measures set out in Phase 3 of the Route map and in place prior to 10 October 2020. Ministers and officials also continued to engage with key stakeholder groups to gather feedback and lived experience. This helped inform our ongoing decision making. The Four Harms approach was built into all Scottish Government processes.

356. Engagement on a four-nation basis continued through this period to support alignment when possible and mutual understanding when not. I have commented in other statements and earlier section of this one on the effectiveness of four nation engagement.

357. Following the initial lockdown, and the sense of hope in the summer that a resumption of normal life may be on the horizon, the situation over the autumn was extremely challenging for everyone across Scotland. It involved some difficult and careful messaging, informed by the regular social attitudes polling being undertaken.

However, the more localised approach that we adopted through this period was more proportionate and helped avoid people being subjected to unnecessary restrictions, which was the risk with a nationwide approach. Undoubtedly this led to greater complexity and frustration on the part of those living under the most stringent restrictions – the sense that 'we were all in the same boat' was much harder to maintain during this period. However, it is not immediately obvious how complexity in this phase could have been avoided while still maintaining the necessary proportionality.

PART H – DECISIONS RELATING TO SECOND LOCKDOWN: JAN TO APRIL 2021

a) Background to the second lockdown

358. As I have set out in earlier in this statement, a range of restrictions remained in place during December 2020 to restrict the ability of different households to mix. It was agreed between the four UK governments that it would be desirable to have a degree of relaxation of these restrictions over the Christmas period to allow people to spend some time with family/friends. We were acutely aware that Christmas can be a lonely time for many people and that, after a very difficult year, there could be significant benefit to morale and mental health from restoring some normality over the festive period.

359. On 24 November 2020, the Cabinet was advised of a proposed approach to Christmas, which was further discussed at a COBR meeting that I attended later that day. The cabinet paper stated as follows:

"The essence of the UK Government's proposal is that, for a defined period (23-27 December), people from up to three households may meet, if they so choose, in their homes; and that restrictions on travel within the UK (but not from abroad) will be eased to make that possible."

A joint statement was published later that day, confirming that the four governments had agreed the following:

- Travel restrictions across the four administrations and between tiers would be lifted to provide a window for households to meet up between the 23rd and 27th of December.
- Up to three households would be permitted to form an exclusive 'bubble' to meet at home during this period. When a bubble had been formed it should be fixed, and not changed or extended further at any point.
- Each Christmas bubble could meet at home, at a place of worship or an outdoor public place, but existing, more restrictive rules on hospitality and meeting in other venues would be maintained throughout this period. [Four nations approach to Christmas – gov.scot (www.gov.scot)]

360. On 15 December 2020, we became aware of a new and possibly more infectious variant of the virus, which became known as Alpha. On 19 December I convened an emergency meeting of the Cabinet meeting to discuss the emerging understanding of this new variant and the possible impact on the easing of restrictions over the Christmas period. As recorded in the minutes of the meeting, I expressed the following opinion:

"…the single most important lesson since the initial outbreak in February 2020 had been that waiting for more data (and therefore delaying action) could have highly negative consequences. It was essential to act quickly, decisively, and preventatively".

It was therefore agreed that on the basis of the emerging evidence it was necessary to re-evaluate the UK-wide relaxation of restrictions that had been proposed for the period 23 to 27 December 2020.

361. Later that day I held a media briefing at which I set out what was known about the new variant, and the speed at which it appeared to be spreading across the UK. I also shared the advice provided by the UK Chief Scientific Adviser on four nations call that morning. This was to the effect that, while there was no evidence to suggest the new variant of the virus causes more severe illness, or affected the effectiveness of vaccines, there was strong evidence that it was spreading much more quickly than other variants. I reported that 17 cases of Alpha had already been identified in Scotland through genomic sequencing, but that we expected that to be an

understatement of prevalence. The situation in other parts of the UK seemed to be even more advanced with cases rising quickly and hospitals under severe and growing pressures. I made clear my view – arrived at reluctantly and with great regret – that it was therefore necessary to take decisive action in Scotland to stem transmission over the coming weeks.

362. Updated guidance was issued asking people not to visit other parts of the UK. Cross border travel for all but the most essential purposes was not permitted. People were asked to celebrate Christmas at home in their own household and to meet with others outdoors only. Legislation was updated to allow for an indoor mixing bubble on Christmas day only - however, the advice was not to meet indoors on Christmas day if it could possibly be avoided. Travelling within Scotland on Christmas Day was permitted. I acknowledged at the time the impact of this decision, particularly at the time of year when people want to be with family and friends. In a year of difficult decisions, this was one of the more difficult to make and communicate – and I know it was one of the more difficult for the public to bear.

363. On 22 December 2020, I made a statement to Parliament confirming that there would be a move to level 4 restrictions from 26 December for the whole country, except Orkney, Shetland, the Western Isles, and other relatively remote islands who would move instead to level 3. This decision had been agreed at Cabinet earlier that day and was based on the emerging scientific advice that the new variant could be 60 to 70 per cent more transmissible.

364. The detail of and rationale for these decisions was published on the Scottish Government website. A television advert fronted by the National Clinical Director was filmed and aired over the festive period, to underline the advice being given to the public. I understand the Inquiry has a copy of the transcript [NS4/058 – INQ000239843] and [NS4/058A – INQ000239842]

The second lockdown

365. In light of the serious threat posed by the Alpha variant and the need to take further action in response, I asked the Presiding Officer to recall the Scottish Parliament from its festive recess on 4 January 2021. I made a statement, updating Parliament on our current understanding of the Alpha variant and confirming that Cabinet had decided as follows: that from midnight, and for the duration of January 2021, a legal

requirement to stay at home except for essential purposes would be added to the existing level 3 and 4 restrictions in place from 26 December 2020. For those in the shielding category guidance was updated to advise that they should not go into work at all. For those unable to work from home, a letter issued by the CMO was to be treated as a Fit Note, thereby allowing them to remain at home.

366. The decisions Cabinet had reached on 4 January 2021 were informed by the latest advice on the Alpha variant. PHS data, SAGE, Spi-M and NERVTAG evidence, and research by Imperial College London led us to conclude as follows:

"…it is clear that the new variant strain is much more transmissible than the previous strain (although there is a range of estimates as to exactly how much more so); that it appears to infect young people more easily than the previous strain of the virus (although there is as yet no conclusive evidence that the health effects on young people are more serious); that it is well on the way to becoming the dominant strain in Scotland; and that there is good reason to believe that it may be responsible for the recent strong growth in the number of cases, which comes at a time when the NHS is already under great pressure and is approaching the point of peak seasonal demand"…and "On the basis of this picture, clinicians' view is that without further firm preventative action the NHS in Scotland is likely to be overwhelmed within the coming month, with more local emergencies appearing before then.

The conclusion of the Cabinet was that these steps were necessary and, in the situation, we faced, the only responsible course open to us. However, in recognition of the additional harm that further restrictions would cause, we also commissioned urgent work to speed up as far as possible the deployment of vaccines and prioritise particular groups for early vaccination.

367. As I have already indicated, I believe that one of the most important lessons of preceding months was the need to act quickly, decisively, and preventatively. On the basis of the evidence before us, this decision – and the timing of it – were essential.

368. I am asked what consideration was given by Scottish Government to the Great Barrington Declaration (October 2020). As I have set out earlier in this statement, all of our decisions were informed by a Four Harms approach. This ensured that we took into consideration the wider impact of the decisions being taken. Indeed, the decision to allow some easing of restrictions on Christmas Day was in itself a recognition of the toll that Covid restrictions were taking.

369. The scientific advice regarding the Alpha variant indicated that the new strain was more readily infecting younger people. In the light of this, advice was provided to Ministers by the C19AG Sub-group on Education and Children's Issues, the Education Recovery Group and education policy officials. It was agreed at the Cabinet meeting on 4 January 2021 that schools should move to a further period of remote learning for all children, except those who were deemed vulnerable and the children of key workers, for a further period. While this decision was considered essential to help stem transmission, it was not taken lightly given the significant negative impacts and risks it would have for young people and their families. It was agreed that the decision would be reviewed after two weeks to ensure schools did not remain closed for longer than was absolutely necessary.

370. A review of the measures announced on 4 January 2021 was undertaken by Cabinet on 19 January. Our conclusion at that time was that the measures should remain in place until the middle of February. Cabinet considered all of the most up to date information and data – which was showing a mixed picture - but remained extremely concerned about the impact on the NHS. There had been a rapid rise in the number of new Covid-19 hospitalisations over the preceding two weeks. At this point the number of Covid-19 patients in hospital – 1,959 - was the highest in the pandemic to date and represented 82 per cent of NHS Scotland's surge capacity. The majority of NHS boards were pausing treatment of Priority 3 and 4 elective patients given the demands that Covid-19, alongside more normal seasonal pressure, were placing on staff and services.

371. Overall, it was concluded that the restrictions in force from 26 December 2020, supplemented by the 'Stay at Home' regulations from 5 January 2021 were having a positive impact. However, a further week's data would be needed to understand the full impact.

372. The C19AG Sub-Group on Education and Children's Issues (Sub-group) conducted its first fortnightly review, on 12 January 2021, of the decision to close schools. This was guided by the following 3 factors:

- The impact on, and levels of, key indicators, including the rate of community transmission, levels of new infection, and the percentage of positive tests (with consequential implications for hospital / ICU capacity);

- Evidence regarding any change to risk for specific groups of children and young people as a result of the new variant, or evidence of a changed role in transmission as a result of it or other factors; and
- Evidence of the impact of loss of access to in person provision on educational and developmental outcomes.

373. The Sub-group concluded as follows:

"It was agreed that, at this time, it was too early to offer any further advice on the timescale or process for the return of face-to-face learning, given the need for a longer period of time to monitor the effects of current restrictions in reducing community transmission. There also needed to be further modelling undertaken to look at the impacts of pupils returning to school, and of the differential impact of reopening ELC settings, primary, and secondary schools. However, it remained essential to focus on what needs to be done to mitigate the worst impacts of school closures. The sub-group will provide further advice after its meeting on 26 January, when it will have had the chance to consider the latest data and evidence."

374. I communicated this decision to the Scottish Parliament on the afternoon of 19 January and relevant guidance on the Scottish Government website was updated.

The easing of the second lockdown

375. On 2 February 2021, following the next fortnightly review, Cabinet was provided with updated advice from the Sub-group using the factors set out above. This advice stated as follows:

"Younger children are less susceptible to acquiring infection than older teenagers. They also appear less likely to transmit the virus".

Alongside this, the latest Covid data was considered, which showed that while cases remained at a high level, there had been some improvement. The impact of the school closures on young people was discussed and in statement to Parliament that afternoon I set out the Cabinet's conclusions as follows, making clear that it was:

"…the government's determination to use every inch of headroom that we have to get children back to school – even if that means adults living with restrictions for longer. In short, the judgement the Cabinet arrived at this morning – and this is a judgement based on and taking account of the advice of our expert advisers – is that if we all do agree to abide with the lockdown restrictions for a bit longer so that our progress in suppressing the virus continues, then we can begin a phased, albeit gradual, return to school from 22 February, following the February mid-term break".

376. From 22 February, we intended that the following would happen:

"Firstly, a full time return of early learning and childcare for all children below school age; secondly, a full time return to school for pupils in primaries 1 - 3; and thirdly, a part-time return, albeit on a limited basis, for senior phase pupils to allow in-school practical work that is necessary for the completion of national qualification courses. Initially though, it is intended that there will be no more than around 5-8% of a secondary school roll physically present at any one time for these purposes. We also intend to allow small increases in existing provision for children and young people with significant additional support needs where there is a clear and demonstrable necessity. We will hopefully confirm these decisions in two weeks' time. At that stage, I also hope we can also set out the next phase of the gradual return to school and also at that time set out even an indicative timescale for the return of in-person learning in our colleges and universities."

377. On 16 February I confirmed to Parliament that, in line with the sub-group's latest advice, the first phase of re-opening of schools would go ahead as planned on Monday 22 February. This was recorded in the Cabinet minutes of 16 February as follows:

"The decision to proceed with the first phase of re-opening of the education system had been finely balanced; it had been based on the clinical and public health assessment of the available data, modelling, the existing evidence base, and the overall balance of risks. The decision had been informed by the COVID-19 Education Advisory Sub-Group, the National Incident Management Team, and discussions among senior clinicians, and it remained firmly predicated on very close monitoring and on the assumption that no other changes in restrictions should be made until a further review had been undertaken."

378. On 22 February, children in early learning and childcare settings and in primaries 1 to 3 returned to class, as did a limited numbers of young people in secondary years 4 to

6 who required to complete practical work to achieve an SQA certificate. This decision did not impact on pupils already in classrooms (primarily the children of key workers and those considered vulnerable).

379. On 15 March, children in primaries 4 to 7 returned to class, and secondary school children began spending time in school each week up to the Easter holidays. Following the Easter holidays all young people, with the exception of those on the shielding list, had returned to school.

380. The return of secondary school pupils required, just as it did August 2020, the removal of the 2-metre physical distancing protection. As a mitigation against the risk created by this, secondary school pupils were asked to wear face coverings.

381. On 23 February an updated version of the Strategic Framework was published, the previous version having been published in October 2020. [NS4/059- INQ000232694] As I noted in my foreword to the new document, there had been two significant developments in the intervening period: first, the more contagious Alpha variant resulting in the need for additional measures; and second, the rapid roll-out of vaccines, which it was hoped would reduce illness and deaths from Covid. The document explained our approach follows:

"This update to our Strategic Framework highlights our early priorities for gradually easing measures when the epidemiological conditions allow us to do so safely. We are deliberately setting conditions for easing, rather than giving fixed dates, to reflect the ongoing uncertainties with the epidemic. However, by outlining our early priorities and a suggested sequencing of easing, initially on a national basis and in due course with a return to geographically varied levels, we hope that people, businesses, and other organisations can better understand the likely path back to something much closer to normality."

The new framework had been discussed at cabinet over a number of weeks and was informed by the latest available data and by advice from scientific, clinical and policy teams from across government. It was also informed by WHO guidance. In addition to the usual means of communication, the framework was supported by a marketing strategy to aid public understanding.

382. On 2 April 2021 the 'Stay at Home' requirement came to an end and was replaced by a 'Stay Local' message. Cabinet considered that this interim step was sensible to help minimise spread across the country as we tried to restore greater normality. 'Stay Local' was considered a relatively easy to understand message. As with the 'Stay Safe" message from the previous year, it was intended as a reminder to people that the virus was still circulating and there was therefore a continuing need to be cautious.

d) Conclusions and lessons learned

383. As I have set out already, the measures implemented during this period (January 2021 to 2 April 2021) were considered a necessary response to the Alpha variant, and over time helped suppress its spread. The Cabinet closely monitored the impact and effectiveness of these measures.

384. All decisions in this period were taken in a Four Harms context and informed by advice from the Four Harms group. This included advice on economic, social and non-Covid health related harms and consideration of the impact on vulnerable and at risk groups. Ministers and officials also continued to engage with key stakeholder groups to gather feedback and lived experience, to help inform decision making. In June 2022 the Scottish Government published an evaluation of Business support schemes [NS4/060- INQ000182977]. The report sets out the impact of the pandemic on the Scottish economy and the indicative outcomes of the Covid-19 business support measures available in Scotland up until Summer 2021.

385. The DG Communities statement of 23 June 2023 [NS4/018 - INQ000215482] states:

"In March 2021 the regulations that closed places of worship were subject to judicial review. The opinion of Lord Braid on 24 March recognised that the decision to close places of worship in January 2021 was rational and pursued a legitimate aim. However, the Judge concluded that there was insufficient evidence presented that Ministers had given sufficient importance to Article 9 rights. This led to an informal review of how Scottish Government evidenced the consideration given to fundamental and human rights as part of the advice given to Ministers. Up to that point the advice to Ministers included a summary of the considerations in the form of an assurance of proportionality and legal considerations rather than a full record of any analysis that had been carried out. Following the informal review, future advice

on changes to protective measures included an annex which included more detailed consideration of how each measure may interfere with the rights of individuals or businesses as well as an assessment of proportionality. This change made considerations upfront, clear, and explicit in the advice to Ministers in order to provide greater assurance and transparency around the process".

The findings of this review enhanced the advice that Ministers would receive in future.

386. Engagement between the four UK governments continued over this period, January 2021 to 2 April 2021. The sharing of data in relation to the spread of the new variant was important in helping us understand the impact it was having in different parts of the UK.

387. I am not aware of any formal assessment of how outcomes might have changed had different or earlier decisions been made. However, I believe that, when necessary, we took decisive action – the need to do so had been one of the key lessons of the preceding 12 months. We had also learned more in the first lockdown about the impact of closing schools on young people, and throughout this period made it a priority to get young people back to school as quickly as possible. This learning was built into the advice provided by officials to Ministers.

388. This was period was extremely difficult as it felt, to some extent, like going back to square one. However, the fact that we were able to suppress the virus is testament to the people of Scotland who once again adhered to the guidance put in place.

PART I – DECISIONS RELATING TO PERIOD APRIL 2021 – APRIL 2022

General

389. In the months leading up to April 2021, significant progress was made in reducing transmission. The 7-day average of cases had gone from 2,027 to 237 by mid-April. The overall trend was therefore firmly on a downward trajectory. Based on the evidence of reduced transmission, and cognisant of the wider harms of restrictions, I considered it appropriate to begin a process of easing restrictions in April 2021.

390. Decisions in the subsequent 12 months continued to be informed by the latest Covid-19 data and advice from a range of sources including the CMO, NCD, SAGE, C19AG, the Four Harms Group and policy teams across Scottish Government. The Strategic Framework which guided our approach was updated a further 3 times over this period – in June 2021, November 2021 and February 2022. These updates reflected the state of the epidemic at those points in time. In June 2021 we were seeking to minimise the impact of the new variant known as the Delta; in November 2021 we were seeking to minimise as far as possible the impact Covid-19, in addition to more normal winter pressures, would have on the NHS; and in February 2022 was considering how as a society we would live with and manage the Covid-19 risk for the longer term. The objective of the decisions taken over this period was to minimise the overall impact of the virus on the people of Scotland [NS4/061- INQ000246800].

391. Case numbers fell week on week during April 2021 and this gave us the confidence to slightly accelerate the plans for easing restrictions. It is also worth noting again that we had an ongoing duty to ensure that any restrictions in place were lawful – that required us to judge them to be necessary and proportionate. As case numbers fell, this judgment became a much make finely balanced one, and tilted more towards lifting restrictions. Therefore, on 16 April 2021 the 'Stay Local' rule came to an end and the advice on meeting up with other people outdoors was relaxed to allow for a maximum of six adults from up to six households. These changes reflected the improving epidemiology and were intended to boost to mental health and wellbeing. Other restrictions remained in place at that time. As we had done throughout, we were still seeking to strike the best balance possible between easing restrictions and controlling the suppression of the virus. When these changes were confirmed on 13 April, I also indicated that – assuming an assessment of the data in the wake of these changes allowed it - further easing would take place on 26 April. The data continued to show a positive trajectory and so on 20 April, we confirmed that from 26 April, non-essential retail would re-open, as would outdoor hospitality.

392. I am asked about a comment from Michael Gove to the effect that the matter of an independence referendum distracted the Scottish Government from the Covid response. I disagree and consider that statement to be not just politically motivated but also utterly lacking in evidence. It is for others to judge, but I know that I gave the Covid-19 response my all – as did my colleagues in the Scottish Government. Indeed, at the outset of the pandemic I explicitly put planning for a referendum on hold to ensure that all of the Scottish Government's energy was directed at the

Covid-19 response. It is worth noting that the UK government of which Mr Gove was part did not do likewise on Brexit. Planning for the end of the transition period in December was a pre-occupation for the UK government throughout 2020.

393. The epidemiology continued to improve across Scotland as we entered May 2021. However, Glasgow and Moray were outliers. The decision was therefore taken – and announced on 14 May - that these two areas would remain at Level 3 for a further period while the rest of the country moved to Level 2 on 17 May. This decision was informed by the latest data and by advice from the CMO and NCD, the National Incident Management Team, and the Four Harms Group, as well as general scientific advice from SAGE. The judgment was that further suppression of the virus was needed in these areas to reduce the direct health harm (Harm 1 in the Four Harms approach) of the virus. However, it was a finely balanced decision, and it was agreed to undertake a further review in one week. The situation in Moray improved over the subsequent week, and it moved to Level 2 on 22 May 2021.

394. On 1 June, the Cabinet received advice to inform the timetable for reviewing levels and easing remaining restrictions. It was developed with input from the CMO and NCD, the National Incident Management Team, the Four Harms and from the Scottish Government Legal Directorate. This led to confirmation that from 5 June, Glasgow would move to Level 2, 13 council areas would remain at Level 2 and all others – with the exception of islands – would move to Level 1. Island communities moved to Level 0 on 5 June.

395. An assessment of the situation in Scotland had been undertaken against the WHO criteria. It was considered that the data – broken down to local authority level - did not support a nationwide move to Level 1 at that point. However, the minutes of the Cabinet meeting state as follows:

"In areas where the criteria were met for continuing to progress downward through the levels, it would therefore be difficult to justify not proceeding with these planned moves. In addition, the differences between the measures in place in Levels 2 and 1 would also be much less apparent, for most people, than between Levels 3 and 2 (although particular sectors –such as children's soft play areas –would be affected by a failure to move some areas to Level 1)."

It was therefore decided to take the differentiated approach set out in the preceding paragraph.

396. Information on public attitudes was also shared as follows:

"Recent changes in restrictions have generally been well received. The majority (76%) support different restrictions in different areas depending on the local situation, and this view has strengthened during 2021. Most people (65%) feel comfortable with recent changes and feel that the pace of change is "just right" (54%) but there has been an increase in the proportion (20%) who believe the speed of easing is too fast, compared to when this was last measured in March (11%), and 75% agree that even though restrictions are changing, they don't want to rush into things. Fieldwork for this research was 18-19 May."

397. As with all decisions we took in the course of the pandemic, we sought to support these decisions with clear public messaging. I made a statement to the Scottish Parliament and updated guidance was published on the Scottish Government website. I also covered the detail of the announcement at subsequent media briefings. We published a summary of indicators broken down by geographical area to share a public understand of the prevalence of the virus in different areas. Throughout the pandemic, the Scottish Government also undertook regular polling. Data captured at the end of June 2021 indicated that 67% of respondents were clear as to what was required of them in terms of the current restrictions and 51% thought the advice provided by Scottish Government was clear and helpful, though this represented a dip from the start of the month when figures had been 78% and 58% respectively [NS4/062 - **INQ000249230**].

The move to level zero

398. All of Scotland moved to a slightly modified level 0 on 19 July 2021. This decision was taken by Cabinet on the basis of updated advice from the CMO, NCD, the National Incident Management Team, Four Harms Group, and policy teams, and after consideration of the latest available data and an assessment that the six criteria advised by the WHO were being met. The evidence showed that case numbers, having risen over the preceding few weeks, were now in decline, although the impact of the more transmissible Delta variant was still being felt. Good progress had also

been made on vaccination. A high proportion of those over 50 and in other more vulnerable groups had been vaccinated, reducing their risk of becoming seriously ill as a result of the virus. As I have set out already, it is also important to remember that Ministers were legally required to review regulations every 3 weeks and be satisfied that any restrictions were lawful – which meant we had to consider whether, or not, they continued to be necessary, justified, and proportionate.

399. It was agreed that in order to maintain public understanding of the remaining measures, clear communication would be important. Although reduced, the threat of Covid remained and it was important that the risk continued to be understood. Clear guidance was issued on the Scottish Government website, and I used the media briefings to underline key messages.

400. Most of the remaining legally imposed restrictions in Scotland were lifted on 9 August. Cabinet made this decision on the basis of the data and in the context of the Four Harms approach. The data continued to show a downward trend in infections, although case numbers were still higher than had been anticipated. It was noted that it was still too early for the data to reflect the full impact of the decisions implemented on 19 July – although it was expected that any initial impact would be evident by this point. It was also considered that the six criteria advised by the WHO were being met. Cabinet agreed that a range of 'baseline measures' would remain in force, including the requirement for face coverings in indoor public places and on transport, the operation of Test & Protect, the roll-out of vaccines, the use of appropriate local outbreak control measures, advice to work at home when possible, and a gateway process for outdoor events >5000 and indoor events >2000.

401. I advised Parliament of this decision in a statement on 3 August 2021, and supporting guidance was published on the Scottish Government website.

402. On 9 September Scottish Government published a paper setting out proposals for mandatory vaccine certification, sometimes referred to as vaccine passports [NS4/063- INQ000147442]. Vaccine certification supported the Scottish Governments strategic intent to 'suppress the virus to a level consistent with alleviating its harms while we recover and rebuild for a better future'. We considered that vaccine passports would help to reduce the rate and impact of transmission while allowing more economic activity to open up, thereby alleviating economic harm.

403. When the proposal was first published Covid rates had been increasing sharply, and whilst there was a reduction in the weeks that followed, there remained a significant concern about the risk of infections rising again, and the impact that this would have on the NHS, particularly over the winter months. An evidence paper on vaccine certification was published on the Scottish Government website [NS4/064-**INQ000383489]** along with the impact assessments which had been undertaken.

404. Vaccine certification had the following 4 aims:

- To reduce the risk of transmission.
- To reduce the risk of serious illness and death and in doing so alleviate current and future pressure on NHS Scotland.
- To allow higher risk settings to continue to operate as an alternative to closure or more restrictive measures; and
- To increase vaccine uptake (which as mentioned in an earlier section was one of a number of baseline measures)

The proposal to introduce a vaccine certificate was debated in the Scottish Parliament and supported in a vote by a majority of MSPs.

405. Vaccine certification commenced at 5am on 1 October 2021. Its introduction coincided with the lifting of capacity limits at venues. The NHS Covid Status app had been available from the previous day. The scheme applied to certain higher risk settings:

- late night venues with music, alcohol, and dancing.
- indoor unseated live events with audiences of 500+
- outdoor unseated live events with audiences of 4,000+
- all live events with audiences of 10,000+

A number of other countries operated certification schemes similar to Scotland's at this time.

406. On 4 October 2021, Scottish Government amended the traffic light system for international travel. In changes that were consistent with those made by the UK Government, the green and amber lists, used in the categorisation of countries, were merged. This meant that, from this point, there would be two categories of country

only – those on the red list and all others. Ahead of this change taking effect, the UK Government had also indicated that it would change the rules on Covid tests for returning travellers. In a statement to Parliament on 21 September, I said as follows: "Scotland - like Wales and Northern Ireland – has not yet taken a final decision on this, though we will do so within the next couple of days." On 24 September we confirmed that we would align with the UK testing regime. This was considered a necessary step as non-alignment would have created the risk of travellers opting to route through airports elsewhere in the UK – this would have disadvantaged Scottish businesses but delivered no public health benefit. However, despite the pragmatic decision to align, we continued to harbour concerns that the removal of the requirement for a pre-departure test for some travellers would reduce protection against the importation of new variants weaken. Public Health Scotland was asked to consider additional safeguards and surveillance of inward travel to help reduce this risk.

407. In preparation for the COP 26 summit in Glasgow, which took place from 31 October to 12 November 2021, the Scottish Government worked with the UK Government, United Nations, Public Health Scotland, Glasgow City Council and NHS Greater Glasgow and Clyde to develop the 'COP26 Covid-19 Adaptation Plan' [NS4/065-INQ000268003].

408. Details of the protections that were put in place [found within NS4/066-**INQ000292539**] are summarised as follows:

"We have put together a comprehensive set of COVID-19 mitigation measures which includes a bespoke travel regime for COP26 including mandatory Pre-Departure Test (PDT), strongly recommending that everyone coming to COP26 is fully vaccinated against COVID-19, a bespoke test, trace and isolate regime, physical/social distancing, face coverings (also referred to as 'masks') and enhanced hygiene measures. We have developed a range of mitigation measures to help protect participants, staff and the local community. Mitigations in the Blue Zone include, but are not limited to:

- *Mandatory face coverings unless medically exempt (see supporting Q&A for more details on when you do and do not need to wear face coverings);*
- *1 meter + physical distancing;*
- *Daily LFD testing (negative results shown at Blue Zone entry points);*

- *Enhanced ventilation within the venue;*
- *Hand sanitiser stations throughout the venue;*
- *Information desks and signage to assist all participants.*

  Enhanced cleaning measures have also been developed for the Blue Zone."

409. Throughout COP26, there was ongoing monitoring of Covid cases in Scotland. The following was reported to Cabinet on 16 November:

"Intense preparation for COVID-19 has proved successful to date. Within the conference, out of over 160,000 LFD tests, positivity rates were 0.09 per cent, and the number of COVID-19 cases within the NHS Greater Glasgow and Clyde region has remained stable since mid-October. This will need further assessment over coming days."

410. Cabinet was advised at its meeting the following week that COP26 appeared not to have resulted in any significant upward pressure on the R number.

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

411. The initial advice received by the Scottish Government - informed by data provided by the WHO and by emerging reports from South Africa. – was that Omicron may be more transmissible than the dominant Delta variant, that it was possibly sufficiently different to previous variants to increase the risk of reinfection in those who had been infected previously, and that it may be more able to evade current vaccines.

412. There was a clear view, based on the early advice, that it was important to identify and trace any identified Omicron cases. Following four nations officials call on 29 November 2021, the following was reported to Cabinet on 30 November 2021:

"Administrations reintroduced and then expanded a red list covering Southern African countries; introduced a temporary flight ban while managed quarantine is stood up; and reintroduced day 2 PCR testing for inbound travellers, to enable genomic sequencing to identify instances of Omicron."

413. Cabinet reviewed the current baseline measures on 7 December and concluded that it was proportionate to maintain these, and work to strengthen adherence to them. This decision was informed by the latest data and emerging scientific advice on Omicron and in the context of the Four Harms approach. At this time there were a number of baseline measures still in force in Scotland, including the use of face coverings on public transport and in public indoor spaces, the collection of customer contact details in hospitality and other venues, and the vaccine certification scheme.

414. Cabinet considered whether there was a need in introduce further measures but concluded that to do so would not be justified at this stage. There was still limited data and significant uncertainty about the characteristics of Omicron. It was agreed that public messaging would be strengthened to encourage people to get tested before going out, and to wear face coverings as recommended.

415. In the following this decision the number of Covid cases increased sharply. I considered it important to be blunt about the severity of the situation we appeared to be facing and, at the 10 December media briefing [NS4/067-INQ000292541], stated as follows:

"To be blunt, because of the much greater and faster transmissibility of this new [Omicron] variant, we may be facing - indeed we may be starting to experience - a potential tsunami of infections."

416. In an effort to limit the spread of Omicron, new advice was issued with effect from the following day: all household contacts of confirmed Covid cases should isolate for 10 days, regardless of vaccination status and even if an initial PCR test was negative; and non-household contacts should to isolate pending a PCR result - if it was negative they could leave isolation as long as they were double vaccinated.

417. This decision was based on emerging evidence of the transmissibility of Omicron and advice from the CMO, NCD and the National Incident Management Team. In addition to setting out the position at the media briefing, the Scottish Government updated guidance and published an evidence paper on its website. [NS4/068 - INQ000078506].

418. On 12 December I took part in four nations call about Omicron. We agreed that a top priority to reduce its impact was rapid acceleration of the booster vaccination programme as a means. However, both me and the Welsh Government noted that

we did not believe this action alone would be sufficient, and expressed the view that the UK Government should be taking further, more decisive steps to slow transmission.

419. On 17 December new guidance came into effect requiring businesses to take reasonable measures to minimise transmission of Covid-19. This guidance asked businesses to enable home working where possible, ensure the wearing of face coverings, and, in retail and hospitality, reduce crowding and manage queues through physical distancing and one-way systems. We also announced a £100m financial package to support eligible businesses, and £100m for self-isolation support grants.

420. These decisions were informed by the data and clinical advice and taken in the context of the Four Harms approach. The measures were intended to slow down transmission while minimising the additional burdens being placed on businesses.

421. Notwithstanding these measures, Omicron cases continued to rise, and modelling indicated that, without further intervention, this was likely to continue, and be followed by increases in admissions to hospital and ICU, and also in deaths. There was still significant uncertainty about the severity of Omicron, but it was considered that there was a need to reduce transmission to avoid the NHS being overwhelmed just by the sheer number of infections. On 21 December Cabinet considered the following 3 options:

    a. To maintain current levels of restrictions (and review these on 29 December).
    b. In addition to maintaining current restrictions, to pause large-scale events and strengthen protections in hospitality settings for 3 weeks from 27 December to 16 January (with review points on 5 and 11 January); and
    c. To introduce a time-limited 'circuit breaker' of stringent measures for four weeks from 27 December (with reviews on a weekly basis from 5 January).

422. Advice from clinical advisors – and informed by the Four Harms approach - was that a 'circuit breaker' would have the biggest impact on harms 1 and 2 (health and non-covid health harms), but would be disproportionate without financial and economic support, which was unavailable from the UK Government.

423. It was therefore decided that in addition to maintaining current levels, further restrictions as set out in the second option above should be put in place from 26 December with protections in hospitality settings coming into effect on 27 December. This was considered to be the most balanced option. I announced this decision on 21 December and supporting guidance was published on the Scottish Government website.

The lifting of restrictions in April 2022

424. On 30 March 2022 I advised Parliament of Cabinet's decision on the timescale for converting the legal requirement to wear face coverings in certain indoor settings into guidance. The matter had been discussed by Cabinet the day before and the following three options had been considered:

- To maintain the current requirement for a further period given the high prevalence of the virus.
- To remove the requirement for face coverings in all settings and replace it with guidance.
- To remove the requirement in some settings, such as places of worship, while retaining it in others, such as public transport, prisons and workplaces.

425. The decision the Cabinet reached was informed by data and clinical advice, and also by evidence indicating that people felt safer using public transport when there was a requirement to wear a face covering. It was considered that this would be an important factor in encouraging people to return to public transport. Given upcoming religious festivals over the following weeks, it was considered to be a case for lifting the face covering requirement in places of worship slightly earlier than in other settings as part of a phased approach.

426. I confirmed Cabinet's decision to parliament as follows:

"…subject as always to the state of the pandemic - that the legal requirement to wear face coverings will be replaced with guidance on the following phased basis. From next Monday 4 April, it will no longer be a legal requirement to wear a face covering in places of worship or while attending a marriage ceremony, a civil partnership registration, or a funeral service or commemorative event. And then the

wider legal requirement - applying to shops, certain other indoor settings, and public transport - will be converted to guidance two weeks later on 18 April."

427. Updated guidance was published on the Scottish Government website. The Scottish Government continues to maintain dedicated space on its website with the latest advice and guidance on Covid-19, and PHS continues to provide Covid-19 data on its website.

Conclusions and lessons learned

428. I am not aware of any assessment of what the outcomes might have been had different or earlier decisions been made. However, as I have already made clear, all decisions taken by Ministers were based on an assessment of the spread of the virus and the impact of restrictions and rooted in a Four Harms analysis. There was also significant learning in the first year of the pandemic and this helped inform decision making over this period. For example, the experience of dealing with the Alpha variant helped inform decisions about Delta and Omicron.

429. I am aware that academic research has been undertaken on public health measures more generally and that this has shown benefit from a number of the measures used in Scotland such as face coverings and self-isolation, in helping to reduce transmission of the virus.

430. All decision making over this period was informed by advice from the Four Harms group, which considered economic, social and non-Covid health related harms, as well as impacts on vulnerable and at-risk groups. Ministers and officials also engaged with key stakeholder groups to gather feedback and lived experience, which helped inform decision making.

431. Two new variants emerged in this period and the transmissibility of them necessitated action. We had learned from previous phases of the pandemic that swift and decisive action was necessary to stem transmission and reduce the direct health harm of Covid – we sought to apply these lessons in this period. However, we also know that the economic, social and indirect health harms were mounting and so the need to get the balance of decisions in this period right was even greater. I think it is always possible to argue, with hindsight, that more should have been done to

suppress the virus and the direct health harm caused by it – but this would have been at the cost of further increasing the wider harms. I think, on balance, that we made the right judgments in this period.

432. Four nation engagement continued throughout this period and the sharing of data, information and experience continued to be important, particularly as new variants emerged.

433. As I have set out earlier in this section, the Scottish Government had reservations about the changes to Covid testing for international travel, which were shared by the other Devolved Administrations. These concerns were raised by officials on four nation official calls, however, the UK Government decided to proceed, and in practice, this left the Scottish Government with little option but to align its decisions. To do otherwise would have disadvantaged Scottish airports without delivering any public health benefit – people would still have travelled to Scotland but would have been more likely to do so through airports elsewhere in the UK to take advantage of more relaxed testing requirements.

434. Given that decisions of the UK government on issues like this have practical implications for the discharge by the Devolved Administrations of our own responsibilities, I think there is a need in these situations for the UK government to take more account of our concerns than they tend to do.

435. Scottish Ministers established a Public Inquiry into the impact of Covid-19 in Scotland, and I believe the findings in due course from it, along with the findings of this Inquiry will be extremely important in helping assess decisions taken in this period and inform recommendations the response to future pandemics.

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

436. I have nothing to add the comments and observations already set out. However, I do want to stress my appreciation of and gratitude to the Scottish people for the manner in which they followed advice and complied with restrictions. The impact of this was significant and will be felt for many years to come – but there is no doubt that the sacrifices made, and the solidarity shown to each other during the most difficult time most of us had ever lived through, saved countless lives.

PART J – CARE HOMES AND SOCIAL CARE

437. On 16 March 2020 the Cabinet Secretary for Health and Sport advised the Scottish Parliament that the NHS would be placed on an emergency footing. This decision was deemed necessary at the time for the NHS to cope with the anticipated demands of the pandemic and manage the expected increase in the number of cases of Covid-19. Modelling at that time suggested that significant numbers of the population could be infected with Covid-19 and a percentage of them would require acute hospital care. International advice also indicated that in-hospital capacity would be crucial to the effectiveness of a country's response. Early indications from countries such as Italy were that hospitals were under severe pressure.

438. While Ministers are responsible for decisions that determined conditions within hospitals or care homes, decisions on the discharge of individuals are taken by clinicians responsible for their care. Whether, and when, a patient is ready for discharge is a clinical decision. A patient is assessed by a clinician as fit for discharge into the community, which for some will be transfer to a care home, when hospital treatment is no longer required. It is – and was during the pandemic - at this point that a patient would be discharged, either to a care home or to their own home. I understand that the matter of discharging people from hospital is addressed further in a draft DG Health and Social Care corporate statement submitted in September 2023 [NS4/017 – **INQ000346089**].

439. It is accepted best practice across the NHS and social care that people who have been assessed as ready for discharge should, primarily for their own wellbeing, but also to maximise hospital capacity for those who require inpatient hospital care, should be discharged safely and quickly. Reducing the number of delayed transfers from hospitals to the community for patients assessed as clinically fit for discharge has therefore been a priority across the NHS and social care for many years, including in the period before and at the outset of the pandemic.

440. Guidance at the time of the pandemic recognised the risk of transmission to vulnerable individuals in social care and other settings. The pre-pandemic guidance on infection prevention and control for adult social care settings was contained within the National Infection Prevention and Control Manual (NIPCM) [NS4/069-INQ000292542].

441. In March 2020 the Scottish Government issued guidance advising that before admission to a care home, whether from hospital or the community, individuals should be clinically screened; and that risk assessments should be undertaken to ensure that sufficient resources, including appropriate isolation facilities, were available within the care home to support social distancing and isolation. This guidance was set out in the following documents:

- *'COVID-19: Information and Guidance for Social or Community Care & Residential Settings*', published by Health Protection Scotland (HPS) on 12 March 2020. This was based on the NIPCM and included advice on how to prevent spread of all respiratory infections, including Covid-19, with setting-specific information and advice. [NS4/070 – INQ000292543]
- '*Clinical Guidance for Nursing Home and Residential Care Residents and COVID-19',* published by the Chief Medical Officer and the Chief Nursing officer on 13 March 2020. This guidance drew on that issued by HPS guidance but provided more targeted clinical advice for nursing and residential care home residents. [NS4/071 – INQ000147440]

442. On 13 March 2020, the Cabinet Secretary for Health and Sport wrote to Integration Joint Board (IJB) Chief Officers, Local Authority Chief Executives, IJB Chief Social Work Officers, Scottish Care, the Coalition of Care & Support Providers in Scotland, the Care Inspectorate, and the Scottish Social Services Council drawing attention to the guidance and highlighting its key aspects [NS4/072 - INQ000147441].

443. The structure of social care in Scotland is described in paragraphs 170 – 171 of the Module 2A corporate statement from DG Health and Social Care dated 23 June 2023 [NS4/057 - INQ000315534] and can be summarised as follows.

444. Adult social care in Scotland is delivered by a wide range of partners, including the public, independent and third sectors. The Scottish Government sets the overall strategic and legislative framework. However, the statutory responsibility to provide social care services lies with local authorities. Some care homes are operated by local authority or voluntary sector providers, but the majority are run by private entities. Local authorities and NHS boards work together through Integration Authorities to plan, commission, and deliver services. In most areas, this is achieved through an Integration Joint Board (IJB). IJBs are responsible for the planning of

adult social care services, as well as some health services and other functions. While the Scottish Government does not have direct responsibility for the delivery of social care it had a central role during the pandemic in supporting the care sector and providing national level advice and guidance across a range of issues.

445. It was understood that transmission of Covid-19 could occur in any setting where people gathered together. The general vulnerability of those in care homes was also recognised. For instance, the Health Secretary's letter of 13 March, referred to above, stated that: *"It is recognised that those who are in care homes are often frail with complex needs"*. It was to reduce the risk of the virus spreading within residential care settings that specific guidance on the isolation of residents for a period on their admission was issued. The Scottish Government also issued guidance to care home staff on the appropriate use of PPE and to steps to improve the supply of PPE to care homes.

446. Guidance on infection prevention and control measures was issued by the Scottish Government, Health Protection Scotland and Public Health Scotland to the health and social care sector.). It was expected that social care staff working for local authorities and in care homes would be supported and trained to implement these measures. As more was learned about the specific characteristics of Covid-19 further guidance was developed to help mitigate risks.

447. I am asked about the Cabinet Secretary for Health & Sport's statement on 21 April 2020 [NS4/073 - INQ000292544]. In recognition of how difficult and concerning the situation in care homes was – for staff, residents, and families – and to provide as much assurance as possible, the Cabinet Secretary announced a number of measures in relation to care homes. These were: asking Directors of Public Health to provide enhanced clinical leadership for care homes; establishing a new rapid action group; equipping the Care Inspectorate to deliver enhanced assurance; expanding testing to all symptomatic residents and all new admissions to care homes; supporting care homes to recruit additional staff; and increasing access to PPE.

448. I am asked if there was any advice from medical or scientific experts that was not followed in making these decisions. Clinical advice was provided to me and the Cabinet Secretary for Health & Sport by the CMO (with input from Public Health Scotland) on 20 April 2020 in a submission entitled 'Testing Policy and Application in

a Care Home Setting" [NS4/074 - INQ000249330]. The clinical advice note stated that:

"…robust infection prevention and control policies, together with the appropriate numbers of staff to support this, are the safest way to limit Covid-19 infection in care homes, including appropriate isolation periods…"

The covering submission stated as follows:

"The CMO has considered this issue and concluded that given the current PCR test may give false reassurance, and a positive test may well not impact upon how residents would be treated, blanket testing of all admissions to care homes prior to their admission is not advised at this stage".

The covering submission went on to note that *"offering testing in addition to the requirement to self-isolate individuals on admission could offer a degree of reassurance."*

It was therefore to provide this reassurance that the Cabinet Secretary announced on 21 April that all new admissions would be tested. However, mindful of the advice about the primary importance of infection prevention and control measures, including isolation, she also said this:

"I now expect other new admissions to care homes to be tested and isolated for 14 days in addition to the clear social distancing measures the guidance sets out. Testing is not an alternative to following the guidelines on social distancing, but it can and does provide assurance to family of those already in care homes, those being admitted to homes, as well as staff."

449. I am not otherwise aware of any advice from medical or scientific experts not being followed in making these decisions.

450. The management and mitigation of transmission risks in care homes and other social care settings was always a key factor in the Scottish Government's decision making. Our strategic aim was to minimise the overall harm of the pandemic. In April 2020, we published the Framework for Decision Making [NS4/003 - INQ000131025], which

set out our approach to managing the pandemic, particularly in relation to the use of NPIs.

451. The Framework recognised that care homes are first and foremost where residents live, and so it was important to find safe ways for them to reconnect with family and friends. However, it also highlighted the particularly high-risk nature of care homes with many people requiring personal care living in settings where social distancing can be challenging. The Module 2A DG Strategy and External Affairs corporate statement [NS4/001-INQ000215495], dated 22 June 2023, provides a detailed overview of the Framework document.

452. Throughout the pandemic, medical and scientific expertise, data, and modelling from a range of sources helped inform decisions about the management of care homes and the social care sector. As covered in section D of this statement scientific and clinical advice was provided on testing. This took account of the most up to date scientific opinion and included consideration of the WHO's infection prevention and control guidance for long-term care facilities in the context of COVID-19 published on 21 March 2020. The Scottish Government also considered WHO advice on testing of asymptomatic people transferring from hospital to care settings. Our approach at the time reflected, not just the limited testing capacity that was available, but also the fact that there was no reliable test for pre-symptomatic or asymptomatic patients. I understand further detail is provided in the DG Health and Social Care Statement submitted in September 2023 [NS4/017 - INQ000346089]. Scottish Government officials closely monitored the progression of Covid-19 in other nations, including the impact it was having in social care settings. Consideration was also given to research papers published over the period which focused on the impact of Covid-19 on care homes.

453. During the pandemic, Scottish Government engaged with those involved in the delivery and oversight of social care through stakeholder network meetings, and individual meetings with representatives of social care provider organisations, such as COSLA, Scottish Care, and the Coalition of Care and Support Providers Scotland (CCPS). The Health Secretary was in regular contact with Scottish Care throughout this period. Further information about social care advisory groups can be found in the Module 2A DG Health and Social Care corporate statement dated 23 June 2023 [NS4/057 - INQ000315534].

454. Engagement with Scottish Care was undertaken on behalf of the Scottish Government by the Cabinet Secretary for Health & Sport. I did not meet directly with them. The Cabinet Secretary would be able to provide more information on her engagement with them. I will come on to talk more about stakeholder engagement.

455. The issue of testing residents entering care homes from both the community and acute NHS settings was raised in Parliament in March/April 2020. However, as covered above, the advice at that time was that the limitations of PCR testing for asymptomatic and pre-symptomatic cases may result in false assurance and therefore the focus should be on infection prevention and control measures. In addition, there was limited availability of testing capacity in March 2020. WHO guidance at the time was clear that testing all hospital discharges was not the best use of available capacity while it was still being expanded. When capacity did allow for it – and for the reasons set out above - testing of all care home admissions commenced on 21 April. A detailed timeline of the development of diagnostic tests is set out in paragraphs 417 to 431 of the DG Health and Social Care statement dated 23 June 2023 [NS4/015 - INQ000215470].

456. Although there was not testing of all new admissions until 21 April, there was nevertheless guidance in place that took account of, and was designed to mitigate, the transmission risks in care homes. As set out earlier in this section, guidance was issued in March 2020 advising that there should be clinical screening of all admissions to care homes, alongside a risk assessment to ensure that sufficient resources, including appropriate isolation facilities, were available within the care home to support social distancing and isolation. In effect, therefore, individuals admitted to care homes were to be treated as if they were Covid-19 positive and barrier nursed for an initial isolation period.

457. I am asked about comments by John Swinney to the effect that in spring 2020, the Scottish Government was under cross-party pressure to discharge patients from hospitals. To be clear, political considerations did not influence the decisions we took on the discharge of patients from hospitals to care homes. Decisions were taken on the basis of the scientific and clinical advice, and the capacity available to us, at the time. However, it is a statement of fact – as the Official Report of the Scottish Parliament will show – that concerns were being raised about delayed discharge from hospitals. This was not surprising, and I would not criticise it. As set out earlier,

it had long been accepted as detrimental to the wellbeing of patients for them to be in hospital longer than medically necessary.

458. I am also asked if I agree with comments by Mr Swinney to the effect that decisions on discharge were for clinicians. While this is a statement of fact, it in no way seeks to abdicate the responsibility of the Scottish Government – we were responsible for the decisions taken on testing and wider infection prevention and control policies in care homes. However, decisions on whether and when a particular individual was fit for discharge were for clinicians, not ministers.

459. As set out previously, decisions on testing were informed by clinical and scientific advice. However, they also had to take account of – and prioritise use of - available testing capacity (further detail on testing is covered in section D of this statement). Rapidly expanding testing capacity in Scotland was one of our key priorities in the early phase of the pandemic and, as it increased, judgments had to be made about where it should be targeted. NHS staff were considered to be a particular priority as many of them were treating patients seriously ill with Covid-19. It was important to give reassurance to NHS staff to establish as much confidence as possible that those working in clinical settings were not infected. However, as testing capacity expanded further, regular testing was offered to other groups in the population, including care home workers whose vulnerability and priority was also recognised. The Inquiry has asked about comments made by Scottish Care in their statement. As I have not seen the entirety of the statement, I am not able to comment on it.

460. I am asked about the availability of PPE in care homes. Care homes operated by private enterprises were responsible for securing their own supplies of PPE. However, at the outset of the pandemic the Scottish Government (through National Services Scotland) held stockpiles of PPE for the NHS and social care in Scotland. We were acutely aware of the additional demands care homes faced for PPE because of the nature of the virus and the difficulties in securing supplies because of global pressure on stocks. We therefore took steps to strengthen the supply and distribution of PPE for care sector staff and ensure that staff had guidance about appropriate use. Measures to strengthen supplies to the care sector were announced to the Scottish Parliament by the Cabinet Secretary for Health and Sport on 21 April 2020. Further information about how social care providers could receive PPE support during the pandemic is set out in paragraphs 137-145 of the Module 2A DG Health and Social care statement, dated 23 June 2023 [NS4/057 - INQ000315534].

461. Advice was provided to the care sector on the use of PPE and infection prevention and control measures by a range of public health sources, including Health Protection Scotland, before and during the pandemic. On 13 March 2020 the Cabinet Secretary for Health and Sport wrote to IJB Chief Officers, Local Authority Chief Executives, IJB Chief Social Work Officers, Scottish Care, the Coalition of Care and Support Providers in Scotland, the Care Inspectorate and the Scottish Social Services Council highlighting advice from the CMO that appropriate PPE should be used for positive cases and that long term facilities should ensure that they had access to adequate stock and knew where to source additional supplies if needed. Health Protection Scotland (HPS) provided advice on what PPE to use, and on how to obtain equipment and dispose of it. On 13 March 2020, the Sottish Government published clinical guidance from the CMO and CNO entitled: 'Clinical Guidance for Nursing Home and Residential Care Residents and COVID-19' [NS4/071 – INQ000147440], which underlined that all staff must be made aware of the appropriate PPE guidance. It was aimed at providing both advice and reassurance to the sector and was subsequently updated to reflect HPS advice on Infection Prevention and Control. As I have set out in the previous paragraph there was a national stockpile made available to social care providers, to ensure their homes had sufficient PPE.

462. In the early stages of the pandemic, it was recognised that people who had already been assessed as ready for discharge from hospital should be discharged safely and quickly, both for their own wellbeing and to maximise hospital capacity for those likely to require inpatient care.

463. In the early stage of the pandemic, international advice, and experience, indicated that in-patient hospital capacity would be crucial to ensure that the NHS could cope with the demands of Covid-19. Therefore, moving fit for discharge patients out of settings that would inevitably be receiving Covid-19 infected patients was also crucial for patient safety, as well as for capacity.

464. It is widely accepted within health and social care that delays in transferring patients who have been judged clinically fit for discharge from hospital to community settings is not in their best interests. It can also impact on a hospital's capacity to treat patients who do have a medical need for inpatient care.

465. The 'Data Analysis' and 'Advisory Group' sections, at paragraphs 243 to 384, of the module 2A DG Health and Social Care corporate statement dated 23 June 2023 [NS4/057 - INQ000315534], details the data flows into and from the Scottish Government, how data was analysed in a four-nation context, and which expert advisory groups supported the decision-making process across different aspects of the pandemic response.

466. Enhanced professional clinical and care oversight of care homes was announced by the Cabinet Secretary for Health and Sport in her statement to Parliament on the 21 April 2020. The objective was to significantly strengthen oversight of Scotland's care homes, with clinical and care professionals within NHS boards and local authorities assuming a leadership role for care homes in their area. Directors of Public Health were asked to provide an initial assessment of the performance of each care home in their area against the following criteria: infection control, staffing, training, social distancing, and testing. They were also asked to report back on actions care homes were taking to address any deficiencies identified. This decision was taken on the basis of clinical advice at the time.

467. A detailed account of the National Care home Rapid Action Group (CHRAG) is provided at paragraphs 334 to 337 of the module 2A DG Health and Social Care corporate statement dated 23 June 2023 [NS4/057 - INQ000315534].

468. The Coronavirus (Scotland) (No.2) Act 2020 contained additional measures relating to the duties of the Care Inspectorate in respect of care home inspections during the pandemic. These 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 had inspected in the two-week period and the findings of those inspections.
- New duties for the Care Inspectorate on reporting of deaths in care homes services from or suspected to be attributable to Covid-19 or not.
- That care home service providers must provide certain information to the Care Inspectorate each day in relation to the numbers of deaths which had occurred in a care home service, whether caused by or suspected to be attributable to Covid-19 or not.
- That the Care Inspectorate must prepare a report at the end of each 7-day period on the information provided by care home service providers and share this with

Scottish Ministers; and that Scottish Ministers must subsequently lay reports prepared by the Care Inspectorate before Parliament no later than 7 days from receipt.

469. The rationale for the enhanced Care Inspectorate role, including greater powers to require reporting, was to ensure that care homes were following guidance, and applying good clinical and infection control practice, and that they were receiving support when necessary. We were aware that not all care homes were providing staff with adequate training or the necessary equipment. The intention therefore was to ensure that private care home providers were providing a robust level of care and protection to residents and could access the significant additional support on offer if they needed it.

470. I have set out the decisions we took on the expansion of testing, and the reasons for these, earlier in this section.

471. Scottish Care had significant opportunities to engage directly with the Scottish Government through regular meetings with the Cabinet Secretary and membership of CPAG, which developed visiting guidance for care homes through collaboration with national and local partners. I was not involved in these meetings.

472. Scottish Government officials also liaised with social care stakeholders to prioritise actions to support the sector during the pandemic and inform the development of guidance. Paragraphs 329 to 345 of the module 2A DG Health and Social Care corporate statement dated 23 June 2023 [NS4/015 - INQ000215470] provides a detailed account of the adult social care advisory groups which helped inform the Scottish Government's decision making.

473. While I am acutely aware of the difficulties faced, and deeply regret the loss that so many with loved ones in care homes suffered, I disagree with the statement that the Scottish Government did not respond quickly enough to the needs of care homes and social care in the community.

474. Residential social care is primarily delivered by private providers, some of which are large UK wide corporate entities. Significant support was offered to these businesses to ensure that they were able to provide good care and protection to residents. The

regulatory role of the Care Inspectorate was enhanced during the pandemic in part to increase government scrutiny and oversight of the residential care sector.

475. As noted above, local authorities have statutory responsibility for providing social care support in Scotland and the Scottish Government played an important role in supporting the sector to respond to the challenges of Covid-19. As soon as the Scottish Government became aware of problems or the need for additional support we sought to act quickly and appropriately. The social care sector is complex as it is comprised of a range of providers. Given this complexity, I think there were some issues with understanding aspects of the sector – for example, the mix of large and smaller homes and the differing challenges they presented.

476. Guidance published by the Scottish Government from the early stages required local multi-disciplinary oversight teams - comprising clinical leads, Directors of Public Health (DPH), Nurse Directors, Chief Social Work Officers and Chief Officers - to provide oversight and support to adult care homes. These arrangements aimed to significantly strengthen oversight, with clinical and care professionals from NHS boards and local authorities having a lead role in the oversight of care homes in their area.

477. In addition, the Scottish Government was guided by WHO advice, which at the time stipulated that individual entering a care home setting, whether from hospital or the community, should have an initial isolation period. Enhanced infection control guidance was published and made available to the sector. Access to testing for health and social care staff was implemented as soon as there was sufficient testing capacity. These measures were intended to ensure a preventative approach was adopted from the outset of the pandemic.

478. I am asked about the role of the Scottish Government in local outbreaks at care homes in West Lothian, Larbert, and Aberdeen. The Scottish Government had no direct role in managing local outbreaks. Outbreak monitoring and intervention was the responsibility of the local Incident Management Teams (IMT) and would trigger an Incident Management response by HPS. this involved contact tracing and liaison with relevant agencies such as the local Health and Social Care Partnership. Daily SitReps, however, enabled the Scottish Government to monitor the situation at any care home with a Covid-19 outbreak.

479. I do not agree that there was a reluctance by decision-makers to take account of the expertise or experience of those operating in the social care sector. Indeed, I believe the contrary to be the case.

480. The Cabinet Secretary for Health and Sport met regularly with Scottish Care and discussed a wide range of issues. Two stakeholder groups were also established:

- The Clinical and Professional Advisory Group for Adult Social Care (CPAG); and
- The Care Home Rapid Action Group, which was subsequently replaced by the Pandemic Response Adult Social Care Group (PRASCG).

481. These groups brought together a wide range of stakeholders with relevant expertise, to help inform policy and guidance. The members of these groups were also able to bring issues to them, in order that appropriate solutions could be considered. There were also policy-specific advisory groups that provided advice and support to the Scottish Government on a range of issues. As already indicated further detail can be found in paragraphs 329 – 345 of the module 2A DG Health and Social Care corporate statement dated 23 June 2023 [NS4/015 - INQ000215470] provides a detailed account of the adult social care advisory groups that helped inform the Scottish Government's decision making. Given the range of providers within the sector Scottish Government would not have known every detail of its differing needs. That is why we considered it important to have strong stakeholder input.

482. Scottish Care had significant opportunities to engage directly with the Scottish Government through regular meetings with the Cabinet Secretary and membership of CPAG, PRASCG and policy-specific advisory groups. If it felt that engagement with the Scottish Government was tokenistic, I regret that. However, I do not believe that it was or that evidence supports such a suggestion. The contribution it made to the development of policy and guidance through these groups was hugely welcome.

483. While I cannot comment directly on the relationship between Public Health Scotland (PHS) and Scottish Care, I can say that PHS played an important role in providing advice to Ministers and guidance to NHS Boards and social care providers throughout the pandemic.

484. While the challenges were significant and difficult, I consider that the NHS, NSS and PHS worked effectively with the care sector. Problems were identified when they arose and addressed where possible through shared decisions.

485. The Scottish Government Health and Social Care Analysis (HSCA) Division was a key provider of data, analysis, and evidence throughout the pandemic. It worked in close collaboration with Public Health Scotland (PHS) and analysts across government. In terms of advice received by the Scottish Government, the 'Data Analysis' and 'Advisory Group' sections, at paragraphs 243 to 384, of the module 2A DG Health and Social Care corporate statement dated 23 June 2023 [NS4/015 - INQ000215470], details the data flows into and from Scottish Government, how data was analysed in a four-nation context, and which expert advisory groups supported the decision making process across all aspects of the pandemic response.

486. As noted above, there was substantial consultation and discussion with a range of adult social care stakeholders throughout the pandemic. Lessons learned were considered and shared through the key stakeholder groups outlined in paragraphs 329 – 345 of the module 2A DG Health and Social Care corporate statement dated 23 June 2023 [NS4/015 - INQ000215470].

487. On 12th of October 2020 the Cabinet Secretary for Health and Sport, commissioned an independent review into the occurrence and transmission of COVID-19 infection within four care homes in Scotland: 'Coronavirus (COVID-19) - Care Home Outbreaks: Root Cause Analysis' [NS4/075 - **INQ000280639**

488. On 6 August 2021 the Scottish Government published Coronavirus (COVID-19) initial health and social care response: lessons identified re March to September 2020 [NS4/052 - INQ000147474].

489. In 2020 the Scottish Government also commissioned the Independent Review of Adult Social Care in Scotland, which was chaired by Derek Feeley.

490. Other organisations, such as the Care Inspectorate and the Office for Statistics Regulation (OSR), have also carried out lessons learned exercises. All of these have informed the pandemic response in Scotland.

PART K – BORDERS

Internal UK borders

491. I am asked if I agree with comments at paragraph 153 of the DG Strategy & External Affairs corporate statement [NS4/001-INQ000215495] dated 22 June 2023 that it would never have been practicable to impose a complete ban on travel to and from Scotland from other parts of Great Britain. I do agree. The volume of essential travel – of food and medical supplies, for example - between Scotland and England, and the rest of the UK, would have rendered this impractical. That meant a different approach to that followed at times for international travel was required. As the initial travel restrictions associated with lockdown began to ease, the Scottish Government's Strategic Framework set out the broad approach to travel within Scotland, elsewhere in the UK or the Common Travel Area ("CTA") in each of the protection levels, as follows:

"We also need to minimise the opportunities for the spread of the virus from areas of high prevalence, whether in Scotland, elsewhere in the UK, or the wider CTA. That means that we have to limit non-essential travel to and from such areas. We will therefore advise people to avoid unnecessary travel either to or from Level 3 or Level 4 areas in Scotland. Similarly, people – whether they live in Scotland or elsewhere – should not travel between Scotland and areas of high prevalence elsewhere in the UK or in the wider CTA unless they really need to do so."

492. I am also asked about consideration given by the Scottish Government to closing borders between Scotland and the other UK nations. As set out above, the nature of cross border travel for essential purposes, meant that it would not have been possible to completely close the land border with England. However, when in November 2020, there was evidence to suggest that the virus may be coming into Scotland as a result of non-essential travel to other parts of the UK, I asked people at the daily briefing on 9 November to avoid non-essential travel outside of Scotland. This was considered at that time to be a necessary step to reduce transmission between different areas.

493. I received advice on 16 November about the regulatory approach to restricting travel to and from level 3 and 4 areas in Scotland, and to and from high prevalence areas in

other parts of the UK. This was discussed at Cabinet on 17 November [NS4/076 – INQ000214796].

494. Scottish Government Covid-19 guidance was extensive, covering travel within Scotland, to and from other parts of the UK and internationally. It was updated as changes were confirmed. There was also guidance to help explain the differences in advice/restrictions in different parts of the UK In addition, a web page was prepared by the four administrations to indicate clearly what guidance was applicable in each area. The rationale reflected the requirements of relevant regulations, and regular and useful liaison by policy, legal and operational leads to support a clear understanding amongst the public of what was being asked of them. There was also a requirement for transport operators to provide passenger information and check passenger compliance. In Scotland, this included ensuring that passengers arriving in Scotland were aware of the measures in place.

495. Throughout the pandemic public polling was used to track the public's understanding of the measures in place, including on travel, and attitudes towards these. This information was used to help inform decision making.

International borders

496. I am asked about the role of the Office of the Secretary of State for Scotland in decision-making about UK borders. I cannot comment on the Secretary of State's role in decision-making within the UK government. However, in terms of decision-making in which the Scottish Government was involved, I would refer to the following extract from my Module 2 statement [NS4/005 - INQ000235213]:

"I am not aware of them playing any significant co-ordinating role, although Scottish Government and OSSE officials were in contact through the pandemic. The Secretary of State regularly attended four nations meetings, but in the majority of these, he made no contribution. As far as I am aware, the Secretary of State had no significant executive responsibilities in relation to the pandemic – however, I cannot speak to what, if any, role he played in UK Government decision making as part of the UK Cabinet."

497. Although migration and management of international borders are matters reserved to the UK government under the Scotland Act 1998, operationalisation of border

measures was coordinated between the four governments. Also, the implementation of public health measures at borders is within devolved competence. It was primarily in the exercise of these devolved powers, that the Scottish Government participated in decisions on international travel. These decisions were informed by data and discussions between officials and ministers of the four governments. In the early months of the pandemic, I participated in COBR meetings at which consideration was given to measures that might restrict the virus entering the UK.

498. Given the mix of reserved and devolved powers in scope, a four nations approach was essential for the effective operation of international travel restrictions. Scottish Government officials worked with counterparts from the other administrations throughout the pandemic. There was a reliance on the Home Office to send Passenger Locator Forms to PHS, so that it could do follow up checks on travellers. UK Government decisions on, for example, aligning penalties for offences linked to the information requirements to its domestic enforcement regime required the Scottish Government to introduce equivalent measures in Scotland.

499. In the early months of the pandemic scientific advice came primarily from SAGE and this was considered at COBR (M) meetings. This would have included information emerging from other countries, which fed into decision making around border controls. There was also information available to Scottish Government scientific and clinical advisors from SAGE subgroups as well as groups such as the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG).

500. I am asked if the positions of the Scottish Government, UK government and the Office of the Secretary of State for Scotland on border closures remained consistent throughout the pandemic. The position of the UK Government and the OSSS are matters for them and I cannot comment. However, the Scottish Government took decisions in the context of our Framework for Decision Making [NS4/003 - INQ000131025] and the supporting evidence available at the time. Our positions therefore evolved throughout the pandemic to reflect the challenges faced as the situation changed.

501. I am asked if, on reflection, I think that a decision should have been taken to close UK borders in January – March 2020. I believe that knowing what we know now about the pandemic, and given the lessons learned about the importance of acting quickly and decisively, there may well have been benefit in closing UK borders in the

period of January to March 2020. However, it is a measure that could not have been taken for an indefinite or lengthy period. Nor could it have been done unilaterally by the Scottish Government.

502. I am asked what consideration was given to stopping flights between Scotland and Wuhan/China following the early cases, and/or screening of arrivals. I am also asked about the consideration given to Chinese New Year on 25 January 2020. Whilst public health measures on passengers coming into Scotland engage devolved competences, border control and immigration is a matter for the UK government. Given the limited knowledge about the virus in the very early phase, the issue of flights between the UK and China was kept under review. Measures on screening passengers arriving in Scotland at this time were consistent with those in place in other parts of the UK, which were based on the limited scientific evidence at the time. We were aware of the likely increase in travel between Scotland and China for Chinese New Year and, in anticipation of this, PHS developed a dedicated webpage to share updates and advice.

503. As I have already indicated advice in the early phase of the pandemic came primarily from SAGE and steps to prepare for and subsequently manage the virus were discussed at COBR meetings. The biggest challenges at the time were the limited information about the characteristics of the virus and the need, therefore, to communicate difficult messages to the public that recognised the uncertainties while being clear about the behaviour changes being asked of them.

504. There was limited availability of testing capacity in the early months of the pandemic. It was clear that we needed to delay the spread of Covid-19 spread through 'non-pharmaceutical interventions' (NPIs), including quarantine and self-isolation. Initial advice came primarily from SAGE and the four CMOs.

505. On the 12 March the response of all four UK nations moved from 'contain' to 'delay', in line with the UK Coronavirus Action Plan. This followed discussion at a COBR (M) meeting. On 13 March the UK Government lifted all special guidance for international arrivals from specific countries/areas. This meant there was no quarantine or self-isolation requirements for asymptomatic travellers and no screening or testing at the border. The UK Government would be able to advise on the extent of the involvement of the Office of the Secretary of State for Scotland. As the Coronavirus legislation was not in force at that time, the guidance was advisory. The Health

Protection (Coronavirus)(International Travel)(Scotland) Regulations 2020 from June 2020 [NS4/077 - INQ000292545] include a legal requirement to self-isolate.

506. The Foreign and Commonwealth Office decision to advise against all but essential travel from 17 March 2020 was made as part of their system for consular support and advice to UK nationals travelling overseas. There is no equivalent mechanism in Scotland as consular support is a reserved matter. In addition, these were decisions that were being taken at this time on a four nations basis.

507. I am asked about a publication which estimated that 77% of Covid-19 infections in the UK arriving via inbound travel in the first half of 2020 originated in Italy, Spain, and France. Scottish Government officials were monitoring Covid-19 rates in other parts of the world at this time, including Europe. However, precise detail such as this was not available until later.

508. I am asked about a comment made as part of an interview on Politics Scotland on 5 July 2020 by the Cabinet Secretary for Health and Sport. She stated that quarantine checks had not been carried out on passengers arriving in Scotland from overseas because Public Health Scotland officials had not been granted security clearance to access the passenger details required to carry out these checks, and that this was due to a delay at the Home Office. We were aware that PHS would require access to Home Office systems that was not dissimilar to the level of security clearance some PHS officials in certain roles already had, and anticipated that this would not cause any problem given that the UK Government had committed to working collaboratively. Unfortunately, this turned out not to be as straightforward as we had hoped. The Cabinet Secretary for Health and Sport spoke with her counterpart in an attempt to expedite a solution, however it took around four weeks for the necessary clearance to be granted. Responsibility for granting clearance rested solely with the Home Office, and I believe that the Scottish Government did everything possible to resolve the issue.

509. During July 2020 consideration was given to expanding the exemptions list for quarantine. However, localised outbreaks and high prevalence in countries/parts of countries under consideration complicated this. Our approach, therefore, was to consistently discourage people resident in Scotland from non-essential international travel. This communication meant that the public were aware that international travel came with a risk of a self-isolation requirement. Border health measures were

constantly reviewed, informed by the Joint Biosecurity Centre (JBC) weekly assessment of watchlist countries. Travel restrictions were agreed at Cabinet and imposed when considered necessary for reasons of public health protection. The rationale for this was clearly set out in Scotland's Strategic Framework and supporting guidance. Decisions relating to travel were also taken in the context of the Four Harms approach. assessment conducted for travel assessment. We were also required to consider the necessity and proportionality of limiting non-essential travel in terms of Article 8 of the EHCR.

510. On travel restrictions, as with other aspects of the pandemic response, we aligned with the other UK nations when we considered it appropriate to do so. However, the data and advice available to us, led us to take decisions were taken which diverged from the UK Government approach. All decisions were taken in accordance with the Strategic Framework. These were considered and agreed by Cabinet, using the latest Covid data relating to Scotland, and informed by clinical and scientific advice and a Four Harms assessment.

511. I am asked, in relation to decision making about borders, what did/did not work well. I refer to the following extract from my Module 2 statement [NS4/005-INQ000235213]:

"Communications between officials on the drafting of the regulations relating to international travel restrictions was generally good, as was liaison with UK Border Force on operational issues. In general, the Joint Biosecurity Centre (JBC) shared its country analysis, and the data on which that was based, with the devolved governments on a timely basis, though there were cases where it was withheld or delayed. The selection of countries for JBC to assess appeared largely to reflect the priorities of the UK Government. Although decisions were generally taken on a four nations basis, the UK Government was consistently keener to relax travel restrictions, either by introducing more sectoral exemptions or by arguing for earlier additions of countries to the country exemption list, or by delaying adding countries to the red list (the last is particularly relevant in the case of India in April 2021). The UK Government rejected the Scottish Government's request to regulate to require travellers arriving in England from Orange list countries and travelling on to Scotland to enter a quarantine hotel on their arrival in England when it was only requiring travellers arriving from red list countries to isolate in quarantine hotels."

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

512. I have set out my views on the decision making between the four UK nations at some length in my Module 2 statement [NS4/005-INQ000235213] and earlier in this statement, and so to avoid duplication, I intend to only add here anything not already covered already.

513. Paragraph 5 of my Module 2 statement [NS4/005 - INQ000235213] summarises my involvement in intergovernmental meetings:

"I took part in intergovernmental meetings with the UK Government on Covid-19 throughout the period covered by the Inquiry, in order to understand and, where possible, influence relevant UK Government decision-making and to share relevant information about the pandemic in Scotland and the Scottish Government's assessments, decisions and actions in response. These included meetings convened by the Cabinet Office through the Cabinet Office Briefing Room (COBR), sometimes at short notice. I did not take part in UK Government Cabinet or other internal meetings. A list of decision-making committees, groups and forums dealing with the UK Government's response to Covid-19 that I attended between January 2020 and February 2022 – including a detailed timeline – is included in the supporting evidence for this statement. [NS/0001 - INQ000130883]."

514. Throughout the pandemic, officials from the Scottish Government were also involved in ongoing dialogue with counterparts in the UK Government and other devolved administrations.

515. In my view, the effectiveness of inter-governmental working was mixed, and I have expanded on this in previous comments.

516. Paragraphs 51 to 67 in the Module 2/2A DG Strategy and External Affairs statement dated 23 June 2023 [NS4/001-INQ000215495] provide further detail on the different mechanisms for four nation engagement.

517. Between January 2020 and June 2021, I participated in a number of meetings calls the UK Government and other devolved administrations, principally COBR (M) meetings and four nation calls chaired by the Chancellor of the Duchy of Lancaster.

518. COBR meetings are facilitated by the UK Government and the attendees invited is a matter for it. The Scottish Government attended if and when invited and did so as a full participant.

519. I set out more detail on the Scottish Government involvement in COBR meetings in paragraphs 18 to 20 of my Module 2 statement [NS4/005 - INQ000235213] as follows:

"The attendance of my Health Secretary at the first five COBR meetings was considered appropriate as these meetings were chaired by her counterpart, the UK Health Secretary and attended by relevant Health Ministers of the other devolved governments. This was entirely in line with past practice. It is normal for heads of administration to delegate participation in inter-governmental meetings to lead portfolio Ministers. In my judgment, this has no impact on the effectiveness of governments' response to risks and threats. Specifically, in relation to early Covid planning, it is my firm view that the attendance at COBR of health ministers in January and February, rather than of me (or indeed the then Prime Minister) had no impact on decisions taken. It is part of the role of lead portfolio Ministers to report to heads of administration so that we may judge when our direct involvement is necessary, proportionate and justified. Indeed, to illustrate the point about past practice, as the Scottish Health Secretary during the 2009 Swine Flu pandemic, it was me – not the then First Minister – who attended COBR meetings, as these were chaired by the then UK Health Secretary rather than the then Prime Minister.
"As with other representatives from the Devolved Administrations, the Cabinet Secretary for Health was able to provide an update from the Scottish viewpoint, raise issues of concern and provide views on proposals. This included putting forward the views such as that communications about the state of the pandemic in Scotland should be led by the Scottish Government given our devolved responsibilities, and seeking answers to specific issues, such as whether all flights from China to the UK, not just those from Wuhan, should be subject to restrictions.
"I first participated in a COBR meeting on Covid-19 on 2 March 2020. I did so in light of the identification of the first case in Scotland the day before. I attended COBR meetings frequently from that point onwards, attending another seven in March 2020 alone. My contributions were of a broadly similar nature to those of the Cabinet Secretary for Health in earlier meetings. I was able to provide brief updates from a Scottish perspective and offer views on the nature and timing of non-pharmaceutical interventions that we should be implementing. While these views

were listened to, it was not my impression that they changed the mind of the UK government. It often seemed to me that the UK government's position on key issues had been decided in advance of COBR meetings. If the views that I was expressing were in line with that position, all good and well. If not, the UK government would listen but proceed in its preferred manner anyway."

520. I also spoke bilaterally with the First Minister of Wales on a number of occasions in 2020 – according to my diary, I did so on 9 March, 1 April, 5 & 17 June, 6 July, 7 and 21 September, 19 October, 21 and 23 November and 16 December.

521. There were also three trilateral Scotland/Wales/Northern Ireland discussions in 2020 – these were on 23 March, 20 and 27 July.

522. I am asked about a letter sent jointly to the UK government on 4 April 2020 by me, the First Minister of Wales, and the First Minister and deputy First Minister of Northern Ireland to suggest a COBR(M) meeting be scheduled for the following week. The terms of the letter are self- explanatory. It stated as follows:

"*Whereas hurriedly convened COBR(M) meetings earlier in the pandemic were understandable, given the rapid evolution of the scientific advice, there is no reason not to ensure an orderly process is established ahead of this predictable milestone. Nor do our Ministers' participation in the Ministerial Implementation Groups substitute for close engagement and joint working at head of government level on these most important issues. In addition to a proper process, we would also urge a transparent and collaborative approach to sharing and producing analysis, options appraisal, and papers for any COBR meeting next week. These proposals seem to us the minimum commensurate with an approach founded on partnership across our four nations. They should be the principles on which all COBR(M) meetings are founded for the duration of the current crisis, and indeed all such meetings in the future.*"

It seemed to us eminently sensible that there should be a planned approach to the first review of lockdown measures that we were all obliged to undertake and that a COBR meeting at which we could share data, experiences and views should be an essential part of that. I can't speak for the other signatories to the letter, but it reflected, on my part, a frustration that COBR (M) meetings were not being scheduled on a regular, planned and agreed basis. Other forums for collaboration, for example the MIGs, were useful but not a substitute for heads of government

engagement. I do not think that the situation in this respect improved in any sustainable way after the writing of the letter. Indeed, following the then prime Minister's period of illness, COBR (M) meetings became the exception rather the norm.

523. COBR (M) meetings are scheduled and facilitated by the UK Government, and the list of those invited is a matter for the UK Government. Scottish Ministers attended the COBR meetings to which we were invited and did so as full participants. I cannot say why the Devolved Administrations were not initially invited to participate regularly and routinely in the MIGs and Covid-O and Covid-S. This is a question that can only be answered by the UK government.

524. There was discussion and correspondence with the other administrations on how to best organise 4 nation engagement. Regular meetings included: CDL/Heads of Devolved Governments calls (from September 2020, these were sometimes chaired by Steve Barclay MP or Michael Ellis MP); Cab Sec (O) and Perm Sec (O); the UK-wide C-19 coordination forum.

525. It was important to have a rhythm of meetings in place which could be supplemented with additional interactions as required. Regular engagement was important to help each of the 4 governments understand the decisions the others were taking and the reasons for these.

526. In my view, intergovernmental engagement would have been more effective had the structures used been jointly owned by all four governments.

527. In my view, one of the lessons of the pandemic is the need for the UK government to understand that the Devolved Administrations are not accountable to it but to our own Parliaments and populations, just as the UK government is accountable to the House of Commons, and that collaboration on devolved matters in particular must therefore reflect the equal status of the governments.

528. I have expressed the view in my Module 2 statement [NS4/005 - INQ000235213] that COBR (M) would be the best forum to facilitate intergovernmental relations in a future pandemic, but only if changes were made to its 'ownership' and lines of accountability.

529. There was often an assumption on the part of the UK government that the Devolved Administrations would follow its decisions on NPIs and a sense of irritation and lack of understanding when that was not the case. However, I do not recall them particularly trying to persuade us to do so.

530. As I set out in paragraphs 7 to 11 of my Module 2 statement [NS4/005 - INQ000235213], there were a number of occasions on which I and other Scottish Government ministers sought to influence UK Government decision making. We did this through various channels, including COBR(M) and four nation meetings, written correspondence, and statements in the Scottish Parliament. I refer to the following extract from Module 2 statement:

> *"We did so even on certain matters that were largely devolved such as the nature and timing of non-pharmaceutical interventions (NPIs) where UK Government decisions often had an impact on, for example, media messaging and potentially, therefore, on the effective implementation of our own decisions.*
> *However, such representations were particularly important on reserved matters. This included making requests for additional budget flexibilities, but these were not granted.*
> *Devolved governments collectively secured the funding guarantee from HM Treasury in July 2020 which reduced a key element of funding uncertainty, but this was a temporary arrangement and was not extended beyond 2020-21, despite Scottish Governments requests for this.*
> *Scottish Government had no influence over UK Government policies such as the job retention scheme, or 'furlough' scheme, which was announced with little prior notice. While I made the case for the scheme to be extended further, this was not accepted by the UK Government. In late 2021, the Scottish Government was successful in securing additional upfront funding from the UK Government to support further Scottish public health measures, however it was not successful in influencing the UK Government to replicate the furlough scheme."*

531. There were regular discussions at four nation level about the different decisions on restrictions and NPIs being taken by the different governments, and that this would necessitate careful public messaging. As I have set out previously, a coordinated approach did not necessarily mean a uniform approach, and there were instances where difference decisions were taken by the Scottish Government based on the evidence available to us. As I have also set out previously, the UK government was

not always as careful as I thought it should be to make clear that its decisions on NPIs were for England only.

532. I am asked why the regular meetings between the First Ministers of Scotland and Wales and the First and deputy First Ministers of Northern Ireland throughout the pandemic were chaired by the Chancellor of the Duchy of Lancaster rather than by the Prime Minister; and who from the Scottish Government and/or the Office of the Secretary of State for Scotland attended these meetings. These meetings were usually attended by me or, on occasion, by the Deputy First Minister. Occasionally other Ministers, such as the Health Secretary, Jeane Freeman or the Constitution Secretary, Michael Russell would attend. I believe that the Secretary of State for Scotland was often on these calls, though he rarely contributed. However, his attendance would need to be confirmed by his office. I addressed the point about the chairing of the meetings in my Module 2 statement [NS4/005 - INQ000235213] as follows:

"I am asked about regular meetings between the Chancellor of the Duchy of Lancaster, Michael Gove MP and the First Ministers of Scotland and Wales and the First Minister and deputy First Minister of Northern Ireland. Regular meetings with a focus on the pandemic took place from May 2020 to February 2022. Following an early phase when four nations ministerial engagement was focussed on COBR and Ministerial Implementation Groups ("MIGs"), additional ministerial and official liaison mechanisms were put in place in April and May 2020. This includes calls convened by Michael Gove MP. There was a concern in the devolved governments about standing down the MIGs at the end of May 2021 and the resulting potential reduction in the bandwidth of ministerial action. Putting the calls convened by the Chancellor of the Duchy of Lancaster on a more regular basis was, I believe, proposed by the UK Government to address that concern. In my view, another reason for the CDL meetings being proposed by the UK Government was to reduce the requirement for the Prime Minister to engage directly with the devolved governments. However, notwithstanding the reasons for proposing these meetings, they were in the main helpful and constructive interactions that allowed issues to be aired and where possible resolved."

533. I did not use informal or private communications such as WhatsApp, Telegram, Signal, Viber or Slack to facilitate 4 nations decision-making with the Prime Minister, Cabinet Secretaries, Ministers, or the CMO in the UK Government. I

had occasional text message exchanges with the First Minister of Wales and the then deputy First Minister of Northern Ireland, but these did not result in decisions being taken. I no longer have these messages, with the exception of one exchange with the then dFM of Northern Ireland which I have provided to the Inquiry.

534. There were 11 SAGE meetings from 27 January and 22 February 2020 at which a Scottish clinician attended on behalf of the CMO, this was Dr Jim McMenamin of Public Health Scotland (previously Health Protection Scotland). The then Deputy Chief Medical Officer Professor Sir Gregor Smith attended on 3 March 2020, and Dr McMenamin attended the meetings which took place between 5 March 2020 and 26 March 2020. A Scottish Government clinician attended all of the meetings from 29 March 2020 onwards. It is not uncommon for the CMO to delegate attendance at meetings to other senior clinicians, due to availability or the nature of the issues being discussed. Dr McMenamin became the Strategic Director for Covid-19 and chair of the Covid-19 National Incident Management Team and was considered best placed to attend and report to the CMO.

535. Questions about the operation of SAGE, including decisions about attendees, are for the UK Government, as the SAGE Secretariat sits within the Government Office for Science. There were internal discussions within the Scottish Government about the most appropriate attendees for SAGE meetings. Scottish Government attendees at the meetings included the CMO or DCMO, the Chair of the Covid-19 Advisory Group and the Chief Scientific Advisor.

536. I am asked about engagement between the Scottish Government and the three UK 'Tsars' appointed by the UK government in April 2020 on vaccines, PPE, and track & trace. Dido Harding (Track & Trace) attended a call I had with the Secretary of State for Health, Matt Hancock, on 14 September 2020 to discuss a significant testing backlog in Scotland. The Cabinet Secretary for Health & Sport, the CMO, and Scottish Government officials had regular correspondence with Kate Bingham (vaccines). I am not aware of having had any direct engagement with Paul Deighton (PPE). I do not think that there was anything in the nature or frequency of these engagements that would be described as hindering Scotland's pandemic response, and aspects of it will have been helpful in a practical sense.

537. I am asked about the impact of the decisions taken by the four governments on inequalities. I cannot speak for the other three governments, but the Scottish

Government considered the equalities impacts of our decisions in the context of our Four Harms approach and through impact assessments.

538. Four nation meetings regularly considered the impact of living and working across internal UK Borders although, as I have already set out, there was a need on occasion for the approaches taken in the different nations to diverge.

539. Although there were discussions between the four nations on arrangements for the festive period in 2020 – I have set these out in detail earlier in this statement - the final decision on the situation in Scotland was taken by my Cabinet. Again, the detail is set out earlier in this statement.

540. Consideration was given throughout the pandemic, as appropriate, to the experiences and approaches of other countries.

541. I have addressed the question of how effective intergovernmental working was in my Module 2 statement [NS4/005 - INQ000235213]. I refer to paragraphs 27-31 in particular:

"Among my aims in participating in early inter-governmental discussions about our Covid-19 response was to ensure that the development and deployment of responses in Scotland and the UK was well co-ordinated where that would secure greater benefit for citizens within both Scotland and the wider UK, for example in relation to procurement and deployment of personal protective equipment (PPE) and later of vaccines, and through clarity and co-ordination of public messaging across the UK. With regard to vaccines, the provision of vaccines via UK contracts is a practice that has been in place for decades and leverages the UK's purchasing power and engagement with the pharmaceutical industry on research and development for all four nations. Also, as the UK population moves freely among the home nations, it makes sense to have the same vaccines in use across the home nations. In this early period, and throughout the pandemic, I sought and engaged in inter-governmental co-operation where I judged it had the potential to provide the most effective way for me and my government to exercise our statutory responsibilities and powers in relation to public health and the wider impacts of Covid-19, on the basis of the facts and evidence available to us about the situation in Scotland. Where a distinctive approach in Scotland – or for different areas within Scotland – appeared necessary, justified, and proportionate in all the circumstances, I took that approach, even if it differed from that

of the UK Government. I expected the UK Government to do the same in relation to its responsibilities and the facts and circumstances it faced in the areas for which it was responsible. To be clear, my view was that co-ordination of response was always desirable where possible. However, in circumstances where co-ordination would have meant responding in a way that the Scottish Government judged inappropriate for Scotland, I considered it our duty – where we had the power to do so – to follow the course that we considered more appropriate, even if that was different to the course taken by the UK Government.

I comment further below on how the arrangements for intergovernmental co-operation, co-ordination and communication operated in the run-up to and beyond the first 'national lockdown.' It is not for me, however, to explain the assessments, decisions, and actions of the UK Government, for which I am not accountable. However, there are two general comments that I think it important to make about the impact of UK Government decision making on the discharge by me and the Scottish Government of our responsibilities.

Firstly, it is certainly the case that on occasion there was a lack of understanding on the part of the UK Government – and/or a lack of willingness to explain to the population - that the public health decisions it was taking applied to England only. On the occasions when the Scottish Government had reached a different decision (in our view for good reason) – for example, lifting restrictions on a different timescale - this made our communication task more difficult. It took some time to persuade the UK Government – and UK-wide media – to be sensitive to this.

Second, while the Scottish Government had responsibility to take decisions, we considered appropriate to protect public health in Scotland – just as the UK Government, the Welsh Government and the Northern Ireland Executive did for England, Wales and Northern Ireland respectively – it was only the UK Government, when making such decisions for England that had the power and access to resources to provide financial compensation for individuals or businesses affected. While this was not a significant issue in the first lockdown, it became so during later stages of the pandemic when there was a greater divergence of views either about the need to impose NPIs or the appropriate pace at which to lift them."

PART M - Interrelation between the Scottish Government and local government

542. Overall, I thought the communications and partnership working between the Scottish Government and local government was effective. Local government was represented

through COSLA at meetings of the Scottish Government Resilience Room (SGORR) and the Four Harms Group. In these forums, information was shared on all aspects of the pandemic response. There was also regular engagement with local authorities on Scotland's Strategic Framework and, from Autumn 2020, on the allocation of Covid-19 levels. Individual authorities were on occasion invited to attend SGORR meetings when local outbreaks that affected them were being discussed. For example, Aberdeen Council attended SGORR on 13 August 2020.

543. Local authorities were also key partners in the development and implementation of strategies to recover from the pandemic. The Deputy First Minister and COSLA President co-chaired the Covid Recovery Strategy Programme Board, which oversaw the development and delivery of the Covid Recovery Strategy from 2021. There were also many bilateral discussions between Ministers and different local authorities.

544. In the operation of the levels system, which was agreed and published on 23 October 2020, consultation with Local Authorities was built into the process. The initial allocation of levels was based on advice from the National Incident Management Team (NIMT), led by PHS and comprising the Directors of Public Health of all NHS Health Boards with involvement by the CMO and a local authority representative. That advice was then subject to an analysis of the Four Harms group before a recommendation was made to Ministers. Ahead of the formal decision, there was further engagement with local authorities, led by the then Deputy First Minister and Cabinet Secretary for Communities, on the proposed allocations before decisions were made. Subsequent reviews on a weekly basis again were based around the review and advice of the NIMT and a Four Harms analysis, along with ongoing dialogue with any local authorities where a change in level might be recommended.

545. Further information on the process of decision-making is set out in the Module 2A DG Strategy and External Affairs corporate statement provided 23 June 2023 [NS4/001 - INQ000215495]. And paragraphs 4-7 of the DG Communities corporate statement [NS4/018 - INQ000215482] provided 23 June 2023.

546. In general, and once the levels system for more localised restrictions was put in place from October 2020, there was close collaboration with Local Authorities, both bilaterally and through organisations such as COSLA and SOLACE.

547. There was also close collaboration with local authorities from the early stages of the pandemic on the implementation of the regulations and guidance that supported NPIs. This was particularly important in relation to the local authority role in enforcement through Environmental Health Officers. Local authorities also had a key role in managing and reporting on local outbreaks, particularly where local authority facilities such as care homes or schools were involved.

548. The Scottish Government considered the impact of all decisions taken to impose local restrictions on different sectors of the populations and on vulnerable groups. We did so in the context of the Four Harms approach and based on the data and advice available to us on the prevalence of the virus across Scotland. There was extensive dialogue with local authorities, which were vital to the delivery of support to vulnerable people. COSLA was also represented on the Four Harms group which specifically considered the impacts on parts of society, including at risk and vulnerable groups.

549. Local authorities had access to a range of clinical and scientific advice and data from the Scottish Government. As noted above, representatives of COSLA attended meetings of SGORR at which clinical and scientific information was discussed. There was also a close partnership between local government, Public Health Scotland and the Improvement Service which used a range of data sources, including National Performance Framework indicators, to better understand and evaluate progress towards our shared outcomes. The Chief Medical Officer and the National Clinical Director also engaged with local government regularly to advise them of the latest scientific and clinical data.

550. While I think that the relationship between the Scottish Government and local authorities generally worked well during the pandemic, there were tensions when restrictions varied between different areas. We tried to manage these as much as possible, but it was inevitable that we wouldn't always succeed when the Scottish Government was taking decisions that we considered necessary but that local authorities sometimes felt impacted unfairly on them.

551. There was ongoing dialogue with local authorities around implementation of the levels system. Changes to the levels were considered by Cabinet, based on a standardized set of data from across Scotland and informed by the advice of key clinicians. These decisions and the reasoning behind them were routinely discussed

with the local authorities affected, and their views were always considered, even if we were not always able to agree.

552. I have been asked about an open joint letter to me from council leaders in North and South Lanarkshire. I believe this was sent in response to the leaking of a letter from DG SEA to COSLA which formed part of our routine communication and dialogue on the levels system, which was at that point in its early stages.

553. COSLA was a key partner of the Scottish Government throughout the pandemic. As noted above, COSLA was represented at, and played a key role in, meetings of the SGORR, the Four Harms group, the Covid-19 Education Recovery group, and other groups advising on the implementation of NPIs in areas of local government responsibility. The COSLA President also co-chaired the Covid Recovery Strategy Programme Board with the Deputy First Minister.

554. Ministers, and the Deputy First Minister in particular, were in regular contact with COSLA and, when appropriate, individual local authorities, throughout the pandemic. There were also multiple channels of communication between officials from across the Scottish Government and their COSLA counterparts on a wide range of issues.

555. There was a significant amount of interaction and collaboration already in place between the Scottish Government and COSLA by the outset of the pandemic. I have noted above the regular attendance of COSLA at SGORR meetings. At official level, there were also routine discussions with SOLACE, the association of Chief Executives of Local Authorities, as well as joint working in many key policy areas.

556. The underpinning systems of close working between the Scottish Government, COSLA and local authorities were the foundation of our joint working during the pandemic and served us well. As noted above, when new groups or advisory bodies were created as part of the pandemic response, and these engaged the responsibilities of local government, COSLA representatives were included as partners. Local authorities played a vital role in implementing many aspects of the pandemic response, including the distribution of financial support, over the course of the pandemic.

557. Overall, I consider that co-ordination and communication between the Scottish Government and (a) local authorities and (b) COSLA, while not perfect in what was

an exceptionally challenging set of circumstances, nevertheless was strong and worked well.

PART N – COVID-19 PUBLIC HEALTH COMMUNICATIONS

Public health communications strategy of the Scottish Government during the pandemic

558. The Scottish Government's priority throughout the pandemic was to communicate in a clear, open, accurate, and frank way with the Scottish public about what was being asked of them and why. We considered it important to be upfront about the severity of the situation and the action necessary to mitigate it; to be clear about what we knew and honest about what we didn't; and not to shy away – as politicians in more normal circumstances sometimes do – from nuance and uncertainty. We wanted to reach the maximum number of people as regularly as necessary and as effectively as possible with accessible information and rational explanations of the decisions we were taking. As the pandemic developed, it was also necessary to explain both the fact of and reasons for any differences in approach between the Scottish and UK governments. I felt instinctively at the outset of the pandemic that trust in government would be essential to ensuring maximum compliance with the actions people were being asked to take and the sacrifices they would make as a result; and that good communication was essential to building that trust. I therefore made this a priority and decided that I would lead from the front in our communications, while ensuring that clinical expertise was also to the fore.

559. Between March 2020 and the end of 2021, I led over 250 media briefings, all of which were broadcast live and available to watch on the internet and supported by contemporaneous British Sign Language (BSL) interpretation to ensure maximum accessibility. The 'daily briefings' as they were widely referred to came to be our principal means of communication. They were supplemented by ministerial and clinician interviews, online publication of key documents, decisions and guidance, and statements to Parliament. However, it became clear in the early period of lockdown, from emails I received and other anecdotal evidence, and later from polling, that the briefings were a daily focal point for many people during the 'Stay at Home' period, as well as a principal source of information and reassurance. To this day, I am regularly told by people that the daily briefings 'kept them going' – that they

were important to their understanding of what was being asked of them, to their mental health, and to their overall ability to cope with the situation we were in.

560. I was always accompanied at the daily briefings by a clinician. During her period as CMO in the pandemic, this was Dr Catherine Calderwood. After her departure, it would be one of the CMO, DCMO, CNO or NCD. I was usually accompanied by the Cabinet Secretary for Health and Sport but, on occasion by another portfolio minister – for example, the Economy Secretary when we were discussing support for business. My focus was on providing consistent, clear, and credible messaging. The briefings were also an opportunity for journalists to ask questions, and so were also important for the purposes of scrutiny.

561. In my view, the briefings were an effective means of communication – a view supported by evidence. For example, at the start of 2021, polling showed that 67 percent of adults in Scotland (aged 18 and over) trusted the Scottish Government to deliver information on Covid-19. This contrasted with 26 percent expressing trust in the UK Government to do so.

562. The briefings were initially daily, though on occasion they would take the form of statements to Parliament. As the pandemic developed, the frequency changed. The focus of messaging also adapted as the situation evolved – from urging adherence to the lockdown 'Stay at Home' message to more nuanced advice as the scope of restrictions changed in line with the virus.

563. Alongside the briefings, the Scottish Government developed marketing and communication campaigns – often fronted by one of our clinical advisers - to ensure that key messages were being broadcast on television and radio and reaching as wide an audience as possible. This was supported by communication on social media channels and guidance on the Scottish Government website. The content of the campaigns reflected the key messages at any given time.

564. The 'Four Harms' approach, which I have set out earlier in this statement, and which has been outlined in detail in several of the Scottish Government corporate statements, informed our communications strategy, as it did all aspects of our pandemic response, and helped ensure that it messages were being appropriately targeted at particular groups.

565. I am asked about the individuals involved in devising and implementing the communications strategy. The Scottish Government communications team led on the development of internal and external communications, working closely with communication leads in the other UK governments, executive agencies, statutory responders, and resilience partners.

566. The overarching approach was agreed at Cabinet level. Detailed plans were approved by me, or by Cabinet Secretaries in their own portfolio interests.

567. As set out above, I took the lead in the communication of key messages. I led over 250 media briefings and was supported in doing so by the Chief Medical Officer, National Clinical Director and other ministers and advisers as appropriate.

568. Our public messaging was always informed by what we knew about the virus at the time. We were also candid about the uncertainties we faced in what was a rapidly evolving situation. At all times, we sought to be clear, informative, and accurate in the messages and advice we were communicating and the rationale for the decisions we were taking and considered this essential to the maintenance of public trust.

569. I am asked if there were any restrictions placed on the publication of medical data and studies carried out by individuals or bodies providing advice to key decision makers in the Scottish Government. I am not aware of any such restrictions.

570. I am asked if any key public health communications went against expert medical or scientific advice. I am not aware of this being the case and do not believe that it was.

571. I am asked if and how the approach to public health messaging changed during the pandemic. The methods and means of communication were broadly consistent during the pandemic, but obviously the content and substance of the messaging changed in line with the evolution of the virus and the situation we faced as a result.

572. From the point of vaccines being available, promoting uptake was a key priority of our communications strategy. Messages about the clinical benefits and importance of vaccination in helping us all get back to normal were key features of the media briefings, and wider communications activity. We also took care to promote the safety of vaccines and address any issues causing vaccine hesitancy.

573. A marketing campaign 'Roll your sleeves up' launched in January 2021 [NS4/078 - INQ000292546] and was targeted at the groups eligible for vaccination. This included healthcare and social care workers, those in the 80+ age group and older adult residents in a care home, people over 65, and adults deemed to be clinically extremely vulnerable. The aim campaign promoted the importance and safety of vaccinations and encourage people to take up the opportunity get the vaccine when offered it.

574. Effort was also made to target and overcome perceived barriers to vaccination within some key groups. I understand that information about bespoke vaccine communications for minority groups has been provided in the Module 2A DG Corporate statement dated August 2023 [NS4/017 - **INQ000346089**

575. I am asked about the extent to which the Scottish Government promoted the assertion that it was 'following' the science. As I have set out earlier in this statement, I am sure language like this was used on occasion. However, I do not think it was used by the Scottish Government in such a way as to give the impression that Ministers had no choice, or agency, in the decisions arrived at. I always took care to explain that, while we were informed and guided by scientific and clinical advice, the decisions were for Ministers to make, explain and be accountable for. For example, during the media briefing on 23 April [NS4/079 - INQ000292547] when we published the Framework for Decision Making [NS4/003 - INQ000131025], I said the following:

"I am seeking today really, to start a grown-up conversation with you, the public. The decisions that lie ahead of us, of all of us, are really complex. We will - as we have done all along - seek to inform those decisions with the best scientific advice possible. But the science will never be exact, so we will also require to make very careful judgments."

576. I am asked about our efforts to ensure that our communications were accessible to vulnerable and minority groups, and to non-English speakers. A number of measures were taken to ensure that public health communications, including the media briefings, were accessible for vulnerable and minority groups. This included the provision of BSL interpreters for all of the briefings. Information and guidance were also made available in multiple languages and accessible formats, such as BSL, easy read and audio versions.

577. More information on the steps taken out to communicate accessibly with different groups is included in paragraph 52 of the Module 2A DG Corporate statement dated 23 June [NS4/007 - INQ000215474]. It states as follows:

"The Scottish Government works closely with stakeholders to amplify campaign messages and communicate effectively to the whole of Scotland, encompassing all geographies and minority communities. The team 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 (17 languages) and accessible formats via the NHS Inform website. The Strategy and Insight and Partnerships teams co-created materials specific to Minority Ethnic communities. For example, the Communications team worked with the Scottish Public Health Network (ScotPHN) to create a bespoke, printed Easy Read Version of the Test and Protect information specifically for the Gypsy/Traveller community. This was distributed by the Convention of Scottish Local Authorities (COSLA) to Gypsy/Traveller sites."

578. Qualitative research was carried out on Scottish Government communications by an independent research company, and this was used to inform the communications approach. The research targeted a range of different audiences, including those from minority and vulnerable groups. I understand that the DG Corporate statement submitted in August 2023 [NS4/017 - **INQ000346089**] provides more detail of this approach.

579. I am asked if the Scottish Government communications were sufficiently clear about the territorial extent of our decisions, if I was concerned about confusion in this regard, and about different campaigns used by the Scottish and UK governments. I refer to the following extracts from paragraphs 73 to 81 of my Module 2 statement [NS4/005 - INQ000235213]. I do not think there is anything I can usefully add to this.

"As I have noted above, I was concerned from the outset to ensure the clearest possible communication with the public about the response to Covid-19, and in particular what governments were asking members of the public to do as part of that response, especially when different conditions meant that the messages differed across the UK, within news media that has overlap across the four nations.
At the start of the pandemic the approach of UK Government assets being rebranded for use in Scotland, with the correct website links such as NHSInform, was the

preferred approach based on historical flu pandemic planning. However, the UK Government declined to do this in the early stages of the pandemic and at times did not inform the Scottish Government about what campaigns were being created and deployed until immediately before they were launched. Why the UK Government decided to do this is a question only the UK Government can answer.

Given the relatively higher trust of the Scottish Government brand in Scotland compared to the UK Government brand, it was important that people in Scotland were exposed to Scottish Government materials with the relevant websites to ensure they engaged with the communication and had access to the relevant information. Because the situation was changing rapidly, and where a communications need was identified that was not already filled by the UK Government (to the Scottish Government's knowledge at the time), the Scottish Government elected to develop its own advertising materials to increase reach and responsiveness. Communication and information sharing between the UK Government and Scottish Government in regard to what advertising activity was being planned and on what media channels enabled both governments in the main to plan their activity and ensure that the risk of conflicting messaging was avoided or minimised.

As the public health advice and response to the pandemic between England and Scotland started to differ, advertising activity needed to diverge. From a communications perspective a standard, consistent message across the UK may have had a stronger impact with the general public (though in my view this is arguable) but would have required a more consistent policy position across the four nations. In my view, it was important for messaging to flow from a policy approach we had confidence in, rather than to adopt a policy approach we had less confidence in just to make messaging easier.

In most cases, the UK Government developed public campaigns internally with limited input from devolved administrations. Although campaigns were shared in advance of launch in most cases, this would be at a relatively late stage in the process when scripts had been approved by UK Government Ministers and production was underway. This delayed our ability to develop relevant Scotland-specific marketing activity. There were occasions when the UK Government developed communication assets without allowing an appropriate opportunity for the Scottish Government to contribute. For example, the Scottish Government was not given an opportunity to discuss the change from "Stay at Home" to "Stay Alert" prior to launch. There was also very limited time available to input into the national door drop mailing campaign undertaken by the UK Government in 2020. It was also a source of frustration when the UK government failed to explain that its decisions

applied to England only. Scottish Government Marketing officials made regular requests during meetings with the Cabinet Office to share information on public health messaging earlier, I understand these requests were sometimes accepted and at other times rejected.

As the governments developed and implemented responses to the conditions each faced, research suggests that different behavioural asks caused some confusion among the general public in Scotland. This was particularly pronounced during 2020 as restrictions in the different nations were changed at different times and people living in England found themselves subject to different restrictions (geographical and social) than those living in Scotland. There were a number of indications in the research undertaken by the Scottish Government that the different behavioural asks between Scotland and England caused confusion.

For example, in July 2020, opinion polling showed over two fifths (42 per cent) of the general public in Scotland agreed that they are getting more confused about what's allowed and what's not allowed. At this point in time, restrictions in Scotland were different to restrictions in England. Outdoor hospitality had just started to open that week in Scotland, but two households were allowed to meet indoors in hospitality in England. In my view, it was not inevitable that the changing and differing nature of restrictions in England and Scotland would fuel confusion about what was allowed and what was not allowed. Instead, this was a result of the UK Government not always being careful enough in explaining that its decisions applied only in England – and this on occasion feeding through into unclear messages in the media. This is an issue that I and other ministers raised regularly with our UK counterparts.

As is set out in depth in the Module 2/2A DG Corporate statement already provided to the Inquiry, the Scottish Government made considerable communications and marketing efforts to separate regulations that applied in Scotland from those elsewhere in the UK."

580. I am asked about behavioural science advice. As set out as follows in in paragraph 53 of the Module 2A DG Corporate statement dated 23 June 2023 [NS4/007 - INQ000215474], all Scottish Government communications were informed by high quality behavioural science:

"All communications activity created in response to the threat to posed by Covid-19 was informed by behavioural science. Vital sources included stakeholder groups, papers published by groups such as the Scientific Pandemic Insights Group on Behaviours (SPIB) and on occasion, in consultation with leading experts including

Stephen Reicher and Linda Bauld. The DG Corporate Strategy and Insight team attended a weekly four nations call of behavioural scientists to share latest thinking and best practice around encouraging adoption of protective behaviours in response to Covid-19."

I believe this approach worked extremely well.

581. I am asked about a comment from Public Health Scotland about the use of different language to express policy intent. I have not seen this statement – or the context in which it was made – so I am unable to comment on it. However, I do not recall any concerns of this nature being raised with me at the time by PHS. I agree that there was a lot of different terminology which could be challenging in a communications sense. However, I believe the evidence shows that the Scottish Government's communications were effective overall and that key messages were understood fairly well by the public.

582. I am asked about the extent to which I think public health messaging was consistent and clear. It is important to note that the situation was inherently complex and uncertain and so it would have been impossible to communicate in a perfectly clear and accessible manner. However, I believe (and the polling evidence supports this) that the Scottish Government's public health messaging was – overall - clear, consistent, and accessible. That is not to say, however, that it could not have been better on occasion – I am sure it could have been.

Effectiveness of messaging

583. I am asked to expand on the following comments in my Module 2 statement [NS4/005 - INQ000235213]:

"*It is certainly the case that on occasion there was a lack of understanding on the part of the UK government – and/or a lack of willingness to explain to the population - that the public health decisions it was taking applied to England only. On the occasions when the Scottish Government had reached a different decision (in our view for good reason) – for example, lifting restrictions on a different timescale - this made our communication task more difficult. It took some time to persuade the UK government – and UK wide media – to be sensitive to this.*"

"*…at times did not inform the Scottish Government about what campaigns were being created and deployed until immediately before they were launched.*"
"*In most cases, the UK Government developed public campaigns internally with limited input from devolved administrations. Although campaigns were shared in advance of launch in most cases, this would be at a relatively late stage in the process where scripts had been approved by UK Government Ministers and production was underway. There were occasions when the UK Government developed communication assets without allowing an appropriate opportunity for the Scottish Government to contribute…It was also a source of frustration when the UK government failed to explain that its decisions applied to England only.*"

With respect, I consider these statements to be self-explanatory and there is nothing I feel I can usefully add.

584. Opinion polling was carried out on a weekly basis from March 2020 through to June 2021, fortnightly from June 2021 and monthly basis April 2022. The details of this are covered in more detail at paragraph 46 of the Module 2/2A DG Health and Social Care corporate statement dated 23 June [NS4/057 - INQ000315534], which states as follows:

"*The regular opinion polling via YouGov described above was used to monitor attitudes and reported behaviour from April 2020 onwards. It monitored key metrics over time, including:*

- *Trust in the Scottish Government to work in Scotland's best interests in relation to the coronavirus pandemic.*
- *Agreement/disagreement that 'I believe that the best thing to do in the current situation is to follow the Government's advice'.*
- *Agreement / disagreement that I trust the advice and guidance from the Scottish Government to…. Stay at home, protect the NHS and save lives / Stay safe, protect others and save lives.*
- *Agreement / disagreement that I think the advice from the Scottish Government is clear and helpful.*
- *Agreement /disagreement that I feel clear about what is required of people who live in Scotland as the restrictions change.*
- *Importance of protective behaviours / how well doing protective behaviours."*

The results from the polling were used to inform and adapt the communications approach as the pandemic developed.

585. I understand that further information detailing the public polling and effectiveness of public health campaigns is detailed in the Module 2A DG Corporate statement submitted in August 2023 [NS4/017 - **INQ000346089**]. I have nothing I can usefully add to that.

Maintenance of public confidence

586. I am asked if the messages the Scottish Government communicated promoted public confidence. Yes, I believe this to be the case. As set out earlier in this statement, regular opinion polling was carried out throughout the pandemic. This polling pointed to high degree of trust and confidence in the Scottish Government, both in absolute terms and relative to the UK government. Paragraph 40 of the Module 2/2A DG Corporate statement dated 23 June 2023 states as follows:

"The opinion polling showed a significant difference in perceptions of the Scottish Government's response and that of the UK Government. For example, the proportion of adults (age 18 and above) across Scotland who said that they completely or mostly trusted the Scottish Government to provide information on coronavirus stood at 72% at the end of July 2020 (fieldwork 28-30 July 2020) compared to 28% for the UK Government. This difference was evident throughout the pandemic."

I believe this demonstrates that our public health messaging was effective in promoting public confidence.

587. I am asked about the transparency and timeliness of data publication. Data was published on a daily basis from March 2020 until April 2022. It included the number of tests carried out, the number of test positive cases, the numbers with Covid newly admitted to/in hospital/ICU, the number of deaths after a positive test result, and numbers vaccinated. I also conveyed this information at media briefings. Internal analysis, advice and modelling was also provided to Ministers on a weekly basis used to inform decisions. Much of this was published on the Scottish Government website to help people understand the decisions being taken.

588. Covid-19 was the first pandemic to strike in the social media age and so we were always aware of the risk of dis/misinformation. One of the many advantages of the

daily briefings was the ability this gave us to take this head on, by debunking myths and conveying credible, accurate information instead. Paragraphs 41-42 of the Module 2/2A DG Corporate statement dated 23 June 2023 [NS4/007 - INQ000215474] offer this further detail:

"Mis- and disinformation was identified through weekly calls with the UK Government Cabinet Office and communication leads at Health Boards. Direct steps were not taken to refute disinformation to avoid increasing exposure. Instead, the Scottish Government used paid-for-advertising to clearly communicate the correct information. Learnings from mis- or disinformation were applied to campaign development. For example, Covid-19 vaccine explainer content was designed to address common areas of disinformation about the vaccine without repeating that incorrect information per se. An illustration of this is the video 'Covid-19 Vaccine: The Facts' which was placed on the Scottish Government YouTube channel.
"The insight gathered from interactions on Scottish Government-owned social channels also helped inform digital content. Instead of repeating false information, content provided the facts and directed users to current, reliable information on gov.scot and NHS Inform. 12 The web guidance was continually developed and improved to help users find the most relevant and accurate information quickly.
"While degrees of understanding of official information varied throughout the pandemic, there was no disinformation identified in mainstream media news reporting. Any inaccuracies in news reporting relating to the Scottish Government would be corrected in the normal way."

589. I am asked about the impact on public confidence of the following rule breaches:
   (i) Dr Catherine Calderwood (5 April 2020): while this had the potential to undermine public confidence, Dr Calderwood's swift resignation prevented it doing so. As I set out earlier, while she was a significant loss to the Scottish Government, it is to her credit that she put the integrity of the public health message ahead of her own interests.
   (ii) Margaret Ferrier (September 2020): while there was significant, and justified, public anger about Ms Ferrier's actions, I do not believe they undermined public confidence in the sense that other people were less likely to follow the advice as a result. Instead, there was universal condemnation of her behaviour, including on the part of the Scottish Government.

(iii) My removal of a face-covering at a wake (December 2020): obviously I was very concerned that this would undermine confidence given my leadership role in devising and communicating the advice. However, I believe that there was widespread understanding and acceptance that it had been a genuinely accidental and fleeting error, and that it did not therefore have the effect I was concerned about.

590. I am not aware of any specific assessment being carried out on the extent to which breaches of regulations undermined public confidence. Any impact would have been captured by the regular opinion polling carried out.

591. I am asked if I agree with the view of the Independent Advisory Group on Police Use of Temporary Powers related to the Coronavirus Crisis that compliance appears to have been highest during the first lockdown. I don't have access to the data that this statement is based upon, so cannot comment in detail. However, I think it stands to reason that a blunt 'Stay at Home' message is easier for people to understand and comply with than the more nuanced messages that, by necessity, followed. I comment at paragraph 540 on specific examples of high-profile breaches – I do not consider that these were a factor affecting overall compliance in Scotland. Compliance overall was high and that is to the great credit of the Scottish people.

Conclusions and lessons learned.

592. Throughout the pandemic Ministers and Scottish Government sought to provide the people of Scotland with clear, accurate, and accessible public health messages. I think in the main the approach taken worked well and that this is demonstrated in polling from that period. However, the overall effectiveness of our approach rested on the willingness of the Scottish public to comply with what was being asked of them – for that, I will always be deeply grateful.

PART O – PUBLIC HEALTH & CORONAVIRUS LEGISLATION & REGULATIONS

Legislation

593. Legislation and regulations were discussed as necessary at meetings of the Cabinet, SGORR, COBR and at 'Gold' sessions. I understand that the Inquiry has been provided with the dates and papers of relevant meetings.

594. All Coronavirus legislation was considered and passed by the Scottish Parliament, through debate, committee scrutiny and votes. Further detail is available in the DG SEA corporate statement on legislation [NS4/080 - INQ000216655].

595. I cannot comment – as the Inquiry has asked me to do - on the involvement of the Office of the Secretary of State for Scotland in the drafting or passage of the Coronavirus Bill 2020 and associated regulations, as I am not aware of this detail. The UK Department for Health and Social care led on the Bill and Scottish Government officials worked closely with counterparts in the UK Government and the other devolved administrations in its development. There was also discussion at ministerial level, including at COBR (M) meetings. The Scottish Government led on the instructing of provisions within the legislative competence of the Scottish Parliament, and officials worked closely with UK Government counterparts on other provisions applicable to Scotland. As First Minister, I was involved in overseeing this aspect of the Scottish Government's pandemic response, as I was with other strands.

596. The Scottish Parliament gave legislative consent to what became known as the Coronavirus Act 2020 on 24 March 2020 [NS4/081 - INQ000182814]. The Cabinet Secretary for Constitution, Europe and External Affairs led on the passage of the legislation, though I was fully sighted on the detail of the Bill and the legislative consent memorandum.

597. The DG SEA corporate statement on legislation [NS4/080 - INQ000216655] dated 23 June 2023 provided detail on the development of the Coronavirus Bill and I agree with the content of it.

598. The Scottish Parliament unanimously agreed that the Coronavirus (Scotland) Bill and the Coronavirus (Scotland) (No2) Bill should be treated as Emergency Bills. It also agreed by majority (92 votes to 27) that the Coronavirus (Extension and Expiry) (Scotland Bill) be treated as an Emergency Bill. An Emergency Bill is a Government Bill that requires to be enacted more quickly than the normal provisions of the Parliament's Standing Orders allow. It allows Stages 1 to 3 of the bill to be considered on the same day, subject to there being no objections. This is an established process, and it was effective in meeting the need to have the legislation in place within a short period of time.

599. Only the Coronavirus (Scotland) Bill was considered by the Scottish Parliament in a single day, which was 1 April 2020. Stage 2 scrutiny of the Coronavirus (Scotland) (No2) Bill was undertaken by the Covid-19 Committee, and the Coronavirus (Extension and Expiry) (Scotland) Bill was debated in the full chamber.

600. Of the 75 Covid-19 Health Protection Regulation SSIs, 74 were enacted through the 'made affirmative' procedure. 4 were revoked before proceeding to a parliamentary vote and all of the remaining 70 that were subject to a parliamentary vote were approved by Parliament.

601. Advice and updates on the use and development of legislation was provided to Ministers by Scottish Government officials. The development and parliamentary consideration of legislation was led by the appropriate Cabinet Secretary, who would keep Cabinet updated. As I have already indicated, there are established processes for the use of the Emergency Bill procedure.

602. I don't recall any significant discussion at Cabinet about the 'made affirmative' of emergency procedures, but advice on different aspects of legislation would have been contained in Cabinet papers and/or updates from Cabinet Secretaries. For instance, a paper discussed at Cabinet on 23 November 2021 [NS4/082 - INQ000078497] provided advice on the strengthening of the Covid Certification system and included a section on the use of the 'made affirmative' procedure. The Inquiry has already been provided with Cabinet papers.

603. Motions for use of an Emergency Bill were debated in the Scottish Parliament in line with the established procedure.

604. The Scottish Parliament Delegated Powers and Law Reform Committee (DPLRC) conducted an inquiry in the period December 2021 to January 2022 into the use of the made affirmative procedure during the pandemic. The report published by the Committee at the conclusion of its Inquiry [NS4/083 - INQ000292548] was debated in Parliament on 22 February 2022.

605. I am aware the DPLRC wrote to Ministers in late 2021 about the use of 'made affirmative' and that this was prompted by the regulations implementing the Covid Certification scheme. The Convenor of the Covid-19 Recovery Committee also

wrote to Ministers regarding this. I understand that the DGSEA is providing a statement with further information on the detail of this correspondence with Scottish Government.

606. The report from the DPLRC published in February 2022 [NS4/083 - INQ000292548] noted that the 'made affirmative' procedure had been a vital tool in the handling of the pandemic, and it should remain available. However, it also made several recommendations to the Scottish Government on checks and balance procedures, and the need to regularly consolidate, publish and disseminate details of made affirmative regulations. The DFM provided an interim response to the report on 21 February 2022 [NS4/084 - INQ000292549], and a final response was issued on 7 March 2022 [NS4/085 - INQ000285943 and NS4/086 - INQ000285944].

607. During the debate on the Coronavirus (Scotland) (No.2) Bill on 13 May 2020 it was noted by Adam Tomkins MSP that the shortened timescales would impact on the ability of MSPs to consider and consult on the bill. During the debate on 22 June 2021 on the motion to treat the Coronavirus (Extension and Expiry) (Scotland) Bill as an Emergency Bill, Stephen Kerr MSP raised questions about the urgency of the Bill and called for the summer recess to be used to consult more widely. Alex Cole Hamilton MSP also raised concern about the timetable for the Bill. The Scottish Government did not agree with these concerns.

608. The Coronavirus (Extension and Expiry) (Scotland) Bill was introduced to the Scottish Parliament in June 2021 as the temporary measures brought in under the Coronavirus (Scotland) Act 2020 and the Coronavirus (Scotland) (No. 2) Act 2020 were due to expire on 30 September 2021. As I have set out earlier in this statement, these measures were considered essential to the pandemic response and so it was necessary to take steps to ensure that they continued beyond that date. The purpose of the Bill was to temporarily extend existing measures. It did not introduce any new measures, nor did it modify or amend any of the existing measures.

609. On 17 August 2021 a full, 12 week public consultation was launched by the Scottish Government to seek views on the following:

- Proposals to strengthen public health resilience and protect Scotland against future public health threats.

- Proposals for public service reforms, to ensure that the benefits of modernisations put in place during the pandemic were maintained; and
- Proposals for reforms to the justice system to help tackle backlogs.

A Covid Recovery Strategy was in the process of being developed and we were seeking to build on lessons from the pandemic. Part of this was reviewing the impact of Covid-19 on the Scottish statute book. The Scottish Government considered that the proposals had the potential to support Covid recovery.

610. Consultation responses informed the development of the Coronavirus (Recovery and Reform) (Scotland) Bill which was introduced 25 January 2022 and passed by Parliament on 28 June 2022.

611. The devolution settlement allowed the Scottish Government to use public health powers to respond to the pandemic more effectively than would otherwise have been the case.

612. The Coronavirus Act 2020 (the Act) was an Act of the UK Parliament. It contained some provisions that were applicable that throughout the UK and others that applied only in Scotland. As it contained provisions in areas of devolved competence/executive competence of Scottish Ministers, the legislative consent of the Scottish Parliament was required. The Parliament gave its consent to the provisions in the Bill (as far as they related to devolved matters and the powers of Scottish Ministers) on 24 March 2020. The Legislative Consent Motion was lodged on 20 March 2020, scrutinised by Committee on the morning of the 24 March and debated and approved by Parliament later that day.

613. As provided for in schedule 19 of the Act, Scottish Ministers used our powers to make health protection regulations. There were four principal sets of regulations made under this power. The regulations required Scottish Ministers to conduct a review of them at least once every 21 days. The provisions also put a legal duty on Ministers to terminate a restriction/requirement as soon as it was considered no longer necessary to prevent, protect against, control, or provide a public health response to the incidence or spread of the virus. I have set out earlier in my statement the advice and evidence provided to Cabinet to inform these reviews.

Much of this evidence was also published on the Scottish Government website. In my view the process was effective.

614. Over the course of the pandemic the Scottish Government produced fifteen reports on Coronavirus legislation. These were provided to the Scottish Parliament every two months. An additional report specifically on the Coronavirus (Extension and Expiry) (Scotland) Act 2021 was also produced. Reporting was a requirement set out in the Coronavirus (Scotland) Act 2020 and section 12 of the Coronavirus (Scotland) (No 2) Act 2020. Whilst the Coronavirus Act 2020 did not include a requirement for the Devolved Administrations to report, the Scottish Government chose to report on the provisions the Scottish Parliament had given legislative consent to. These reports were initially the subject of a Ministerial statement followed by debate. Later in the pandemic, they were subject to scrutiny by parliamentary committee instead. This change would have been agreed by the Scottish Parliament. I cannot recall any discussion in Cabinet regarding it. There are various mechanisms in the Scottish Parliament by which MSPs can ask questions of Ministers.

615. The decision that public health legislation, rather than the Civil Contingencies Act 2004, should be used as the legal framework governing the UK Government's response to Covid-19 was made by the UK Government in accordance with the Memorandum of Understanding on Devolution and supplementary concordats. I have set out earlier in this statement details of the Scottish Government's involvement in the Coronavirus Bill.

616. Throughout the pandemic the Scottish Government sought to carefully consider the impact of decisions made. As legislation was developed, equality impact assessments were undertaken. This also considered the impact of proposals for enforcement and sanctions. In addition to equality impact assessments (EQIA), the Scottish Government undertook Fairer Scotland Duty assessments, child rights and wellbeing impact assessments, and business and regulatory impact assessments. All of these are published on the Scottish Government website.

617. The Scottish Government Equalities Impact and Human Rights Directorate ensured that concerns raised on behalf of at risk groups were fed into advice and decision making. The Coronavirus (Scotland) (No 2) Act 2020 included a requirement for Scottish 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 when reviewing the operation of the provisions in the Scottish and UK Acts.

618. All draft Coronavirus legislation, from the outset of the pandemic in March 2020 onwards, was considered for Equality and Human Rights impacts. This was important in ensuring that the effects of the legislation were fully compatible with ECHR rights and that particular groups were not disproportionately impacted. Consideration of exemptions or reasonable excuses formed part of the regulatory drafting process. This also involved carrying out an EQIA.

Enforcement

619. Throughout the pandemic the Scottish Government strived to provide clear advice to the public on what they were being asked to do. This included being clear about which requirements were legally enforceable. At key points during the pandemic, I was joined at media briefings by the Chief Constable of Police Scotland.

620. Police Scotland adopted what was known as the 4E approach (Engage, Explain, Encourage – and Enforce only as a last resort). This approach worked well and meant that enforcement action constituted a very small part of the overall response. I am not aware of any significant or serious concerns being raised about clarity, proportionality, enforcement, or compliance.

621. Covid legislation and regulations were put in place as required and were subject to review at least every 3 weeks. This process was supported by clear guidance setting out any changes. Scottish Government officials had close and ongoing dialogue with Police Scotland throughout the pandemic.

622. NPIs were used by Scottish Government as a means to regulate and guide public behaviours. They were an effective means of helping reduce transmission of the virus. Regulations were used only when it was considered proportionate to do so, based on the assessment of risk. Criminal sanctions were included for use as a last resort to support overall compliance.

623. Throughout the pandemic a mix of guidance and regulation was used. This was supported by public health messaging, further details of which are set out earlier in this statement.

624. Police Scotland, Crown Office and Procurator Fiscal Service (COPFS) and Scottish Courts and Tribunal Service (SCTS) were consulted during the development of the initial Covid-19 Health Protection regulations. The feedback provided informed the design and operability of the enforcement regime in the Regulations. This engagement continued throughout the period when legal requirements and restrictions were in force. Feedback resulted, for example, in a specific offence of attending a party in a private dwelling being added to the regulations to address the specific risks posed by large gatherings (regulation 6ZA of the Health Protection (Coronavirus) (Restrictions) (Scotland) Regulations 2020). Police Scotland and COFPS also provided advice on Fixed Penalty Notices.

625. As I have set out earlier in this statement when regulations were developed, which included in consideration of whether to adopt sanctions, an EQIA was undertaken, along with other assessments. This included considering any potential impact of sanctions on at-risk groups, vulnerable people, or people with protected characteristics.

626. The fine rates for fixed penalty notices (FPN) differed in Scotland from the rest of the UK. For instance, in Scotland a first offence started at £60, which was the same as Wales but in England it started at £100. The Scottish regulations initially allowed FPNs to be issued to people aged 16 or over, whereas in the rest of the UK the lower age limit was 18. The lower age limit in Scotland was also raised to 18 on 27 May 2020.

627. Additional time-limited amendments to legislation were made to support Police Scotland's preparations for COP 26. These amendments brought Scotland into line with England and Wales on a temporary basis.

628. Police Scotland were consulted on the decision to include the option of criminal sanctions. The use of criminal sanctions was in accordance with the four E's strategy which was based on guidance issued by the NPCC and College of Policing during the first lockdown.

629. Police Scotland and COPFS were asked to provide advice on the potential effect of any increase to the penalty level of FPNs. The Compliance Advisory Group (CAG) and the IAG on Police Scotland's exercise of Covid-19 powers chaired by John Scott QC also offered views. While reviewing FPN levels, analysis showed there was no strong evidence to support increasing the level of FPNs. It was considered that the higher fine levels would risk undermining policing by consent and the 4Es approach. Police Scotland report that only 6% of total police activity involved the use of fixed penalty notices and in the majority of cases (94%), education and explanation by Police Scotland was sufficient to achieve compliance.

630. Analysis was also undertaken on the social and economic impact of increasing FPNs. This showed that an increase in the level of FPNs then could disproportionately affect deprived communities.

631. As set out in the Framework for Decision making a 'Four Harms' approach was used to inform and assess the actions taken in responding to the pandemic. The regulations were reviewed at least every 3 weeks, with advice provided to Ministers on the effectiveness and continued justification of them. The Acts were time limited, and where Ministers proposed extension of any provisions, a formal Statement of Reasons required to be laid before the Parliament. The maximum length of any extension was 6 months.

Lessons learned

632. Overall, I believe the use of legislation and regulations was effective, appropriate, and proportionate. It enabled us to respond quickly and flexible, with appropriate Parliamentary scrutiny. I consider that the use of public health legislation, rather than the Civil Contingencies Act 2004, was also appropriate and allowed the Scottish Government to take, and be accountable for, the decisions we considered necessary.

PART P – KEY CHALLENGES AND LESSONS LEARNED

633. The Inquiry has asked for details of appearances at Scottish Parliament committees. Four reports from appearances on 04 November 2020, 10 March 2021, 02 March 2022 and 28 September 2022 have been disclosed. I have not contributed any oral or written evidence to the UK Parliament Select Committees.

Statement of Truth

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

Signed: Personal Data

Dated: 6 November 2023