Witness Name: Fiona Catherine McQueen
Statement No.: 1
Exhibits: FMQ
Dated: 15 November 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF FIONA MCQUEEN

In relation to the issues raised by the Rule 9 request dated 20 June 2023 in connection with Module 2A, I, Fiona C McQueen, will say as follows: -

1. I am Fiona C McQueen of C/O St Andrew's House, Regent Road, Edinburgh EH1 3DG. I was the Chief Nursing Officer (CNO) for the Scottish Government (SG) from November 2014 until demitting office at the end of February 2021. Prior to me taking up this role (interim from November 2014, then substantive from April 2015) I had been an executive Director of Nursing in various organisations within NHS Scotland. My qualifications are Masters in Business Administration (MBA), BA Nursing, Diploma in Management Studies (DMS), Registered Nurse (RN).

2. I have prepared this statement myself by reference to records and material provided to me by the Scottish Government. I have also received assistance from the Scottish Government Covid Inquiry Information Governance Division.

3. 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.

4. References to exhibits in this statement are in the form [FMQ/number-INQ000000]

5. As the CNO I was responsible at a national level for all matters that related to the professional leadership of nurses and midwives across Scotland. As a consequence of the impact of the professions on improving health and delivering world class safe and effective healthcare, my role supported the achievement of the best health and care outcomes for the people of Scotland. The role also had policy responsibility for Healthcare Associated Infection (HCAI) and Antimicrobial resistance (AMR); commissioning of undergraduate nursing and midwifery education; policy for the regulation of all healthcare professionals; oversight of inspection programmes for Healthcare Environment Inspections (HEI); inspection for care of older people in hospitals; and also supported the Chief Allied Health Professions Officer as well as the Chief Healthcare Science Officer. I was responsible for providing advice to Scottish Ministers within my remit and was a member of the Health and Social Care Management Board.

6. The Health and Social Care Management Board (HSCMB) is chaired by the Director General (DG) for Health and Social Care (HSC) and is responsible for overseeing HSC policy and delivery and supports the DG to exercise their overall accountability. As part of the membership of the HSCMB there are three senior clinicians, the Chief Nursing Officer (CNO) (my role), the Chief Medical Officer (CMO) and the National Clinical Director (NCD). During the period of managing the pandemic we tried as far as possible to work as a triumvirate ensuring we all had the opportunity to contribute to any clinical or health advice that was given to HSCMB, or to Scottish Ministers.

7. Given my portfolio and experience the advice I gave during the pandemic surrounded nursing and midwifery professional practice and workforce numbers; regulation; and in particular HCAI which included guidance on what Personal Protective Equipment (PPE) should be worn. There were wider issues upon which I would give advice given my role within the HSCMB and the requirements of the pandemic response which will be detailed below.

8. I exercised my responsibilities by providing unilateral advice and briefings, or more usually as developed throughout the pandemic, through attendance at meetings and giving professional advice. The following are the groups I attended/was associated with:
    - Health and Social Care Management Board (HSCMB) was essentially the main decision-making body for health and social care delivery during the pandemic
    - The Four Harms Group was developed as a means to enhance extant arrangements through the existing lines of accountability to provide advice for Scottish Ministers on the broader pandemic response
    - Care Home Professional Advisory Group (adhoc attendance, the group reported to the CMO, me as CNO and Director of Social Care) on providing enhanced assurance around healthcare delivery and protection for the Care Home sector [FMQ/001-INQ000323461] [FMQ/002-INQ000323438]
    - Adult Social Care Oversight Board (Chair) convened senior officials to take stock on arrangements that were in place to oversee care in Care Homes and social care
    - Four Country Clinical Group was a group that evolved from the four country senior doctors. Discussion would take place about new information on the pandemic or new evidence for treatment. We tried to seek consensus on the clinical view for approaches to pandemic response. At times each of the four countries clinicians may have taken a slightly different view on application of evidence and how they advised their countries' Ministers
    - Four country CNOs would meet to share knowledge and information as well as seek consensus on relevant matters (such as staffing levels for Intensive Care Nursing where existing protocols and norms would be breached) [FMQ/003-INQ000228362, INQ000228363 and INQ000228364]
    - Executive Nurse Directors (END) of Scotland meeting was a forum where I met with the ENDs and discussed professional matters and was a forum for them to feed into policy making
    - I was Chair of the Louisa Jordan Oversight Board which was the Board that oversaw the creation and ongoing use of the Scottish temporary medical facility. This was a contingency arrangement to provide additional beds to care for people who had COVID-19 should the NHS run out of capacity

[FMQ/004-INQ000228365, INQ000228366, INQ000228367, INQ000228368, INQ000228369, INQ000228370, INQ000228371 and INQ000228372].

9. I provided advice to Scottish Ministers directly but mainly through comprehensive and integrated advice being given by the three clinicians, HSCMB, or through the Four Harms Group. The advice was around nursing and midwifery practice across health and social care, broader NHS service delivery, HCAI and PPE, inspection programme for HEI and older people in acute hospitals, HCAI and workforce within Integrated Joint Board (IJBs), and vaccination practice.

10. From a local government perspective, I contributed to general advice on matters appropriate to local authorities (LAs) which shaped advice on the general approach to the pandemic rather than advice directly to LAs.

Initial Understanding and Readiness

11. I first became aware of the virus and possibility of an epidemic at the HSCMB meeting on 15 January 2020 where it was highlighted by the then Deputy CMO that there may be a problem with a virus that was circulating in Asia.

12. My contribution was in general to HSCMB discussions but in particular working with the regulators to support temporary registers being opened and the Nursing & Midwifery Council (NMC) and Higher Education Institutions (HEI) in Scotland to facilitate senior students to complete their programmes as part of the NHS workforce thereby enhancing available workforce as well as supporting the undergraduates to complete their programmes and graduate on time. I also had responsibility for ensuring PPE advice was contemporaneous and up to date.

13. I was not privy to Cabinet discussions or any discussions with the UK government, so it was not obvious to me whether or not the threat of a pandemic was being taken seriously enough. Within Scottish Government (SG) I saw evidence of action and planning. However, given the lack of preparedness for a pandemic, planning that should have taken place – such as evaluating scenarios of lockdown versus differing approaches – did not appear to take place. I am

uncertain whether or not this was due to lack of understanding as to how serious the pandemic was to become or because the thinking had been linear in its approach. At the meeting of HSCMB of 5 February 2020 it was noted that the data on the virus was incomplete and unreliable with regards to whether or not a pandemic would develop albeit it was recognised that the virus would be problematic for some months to come.

Initial Strategy and Decision Making

14. A number of large-scale events took place prior to lockdown, two of them being the NIKE conference and the Scotland/England rugby match. I was not involved in the discussion about the Nike event (or subsequent information on the infections that had been identified); I was party to informal discussion on the rugby match but was not part of the decision-making process. My understanding was that due to our belief about the virus (good hand hygiene and cough etiquette and being held outside limited risks to the population) it would be appropriate to allow the match to take place.

15. I was not involved in the original strategy for managing the pandemic, that tended to be the CMO along with the First Minister and the Cabinet Secretary for Health, albeit HSCMB members received briefings. My understanding is that consideration was given to what would be best for the people of Scotland and the UK wide meetings would facilitate agreement and discussion on matters. As a number of matters were reserved to the UK government (economy therefore supply of money and border control) there appeared to be little that the other three countries could do to influence this. I had observed a desire to take the same steps for pandemic management across the four countries where possible. At the start of the pandemic, I saw no evidence of thinking within the SG that alternative approaches were being considered to manage the pandemic, that were not in step with the other three countries. I was not aware of any intentional approach to develop 'herd immunity' at the expense of health and well being of the population. Over the course of the first lockdown within Scotland we did have discussions on eradication of the virus as far as possible which did not appear to be in step with the Westminster government.

16. In general, I had limited involvement in advising Scottish Ministers on how we should respond to the pandemic between January and March 2020. I was not involved in the decision to discharge as many people as possible into care homes, however I did, along with my CMO and Chief Social Work Advisor (CSWA) colleague issue guidance to social care, [FMQ/005 **INQ000376204** and in partnership with other colleagues advised HSMB that cancellation of routine NHS cases should take place in order to create capacity for people with COVID to be treated, in line with observing other countries, such as Italy and also England, who were ahead of us with regards to numbers of infections. As a consequence of my limited involvement between January and March 2020 I had no involvement in the advice on working from home, reducing person to person transmission with social distancing, self-isolation, or school closures. As the pandemic progressed, I had a greater involvement in such matters, including regional and local restrictions, as we created and developed a more inclusive approach to providing advice to Scottish Ministers on the management of the pandemic.

17. I think this period could have allowed the four countries to consider what approach we would want to take to manage what subsequently turned out to be an international pandemic. There could have been discussion and modelling on differing approaches other than the blunt instrument of a lockdown as the main way to curtail transmission; including how we would protect our most vulnerable citizens such as those who were shielding and care home residents. However, as I was not present at the UK meetings, I am unaware of whether or not due consideration was given to other methods of managing the pandemic and keeping the citizens of Scotland as safe as possible. I think there was also an opportunity to put in place effective governance arrangements to ensure the best possible advice was being fed into UK and four country discussions as I do not believe the decision-making structures were transparent and clear.

18. I was not aware of exact timings of when the decision to implement the first lockdown took place, but my understanding was the decision was taken over a few days prior to the announcement. At the time I was surprised that as we had

determined to go into lockdown as a control measure, we had not locked down sooner to limit the spread of the virus. When I queried why we were not doing so, nor limiting the amount of flights that were entering the country from other countries who were at a more advanced stage of the pandemic, I was advised that the advice was people would not tolerate a lockdown for long, so we had to wait until circumstances demonstrated the need for lockdown. On reflection I believe that we should have locked down earlier and also restricted our borders in order to limit transmission of the virus. This would have given us more time to think through the (negative) impact that lockdown would have on various groups of society (mental health and wellbeing, young people and education) and also plan to protect our most vulnerable such as care home residents. By the time we reached January 2021 we had more of an understanding of the fact that the population were compliant with restrictions but also the negative impact that lockdowns were having on wellbeing, education and the economy. Therefore, although the numbers of infections were rising, it was thought to be important to allow elements of normal life to go on for the holiday period, and I was supportive of that. I think an earlier lockdown in the autumn of 2020 may have limited the spread of the virus which could have prevented a longer lockdown at the beginning of 2021, however given we were not locking down until January 2021, I believe it was correct to wait until after the traditional holiday as this took cogniscance of the emotional and social wellbeing of the population.

Role in Relations to NPIs

19. As we moved through the pandemic, I was part of the clinical triumvirate who provided clinical and health advice on most aspects of the pandemic. By April/May 2020, SG very quickly realised that it was important to take a more holistic approach to managing the pandemic and explicitly recognising the 'four harms'; harm directly from being infected with the virus; wider healthcare harms from the health and social care services being focused on the management of COVID; other areas of society such as education; the economy. At all times decisions were made taking the four harms into account. However, it was not necessarily clear to me how SG took into account the vulnerability of people who had protected characteristics in creating the response.

Divergence

20. Within Scotland, the approach to four harms gained a rhythm that I believe enhanced decision making, although harm one, the impact from the virus did tend to dominate as the number of deaths grew in the country. At a ministerial level across the UK, I was not party to these discussions so cannot comment on what worked well; the wider clinical team of CNO/CMO and other senior clinicians struggled I think to have a coherent and reliable system of working across the UK.

21. There is perhaps an argument to say that Westminster diverged from the other three countries in its approach rather than Scotland diverged from the UK, for example Westminster often eased restrictions earlier or were later to add additional protective actions (such as use of face coverings). In a way the UK government had the upper hand as a number of powers were reserved to Westminster and therefore the devolved administrations had little room for manouvre, however where they did, as a result of being closer to their communities it was easier for the SG to make more localised decisions that suited the population of Scotland. This was seen across the devolved administrations and where possible could have benefited the people of Scotland had SG taken decisions based on Scotland rather than fitting in with the UK government; recognising that for most approaches' money was needed and SG needed the consequentials from the UK government, for example for furlough or for border control. That being said it is easy to say that with hindsight. We were in an alarming situation for many people so there is an argument to say the citizens across the UK would take comfort from a four country approach. From the summer of 2020 there were times that advice was given by clinicians within Scotland that was out of step with the UK government as we thought a more prudent approach would have been appropriate (such as longer use of restrictions). I am not aware of any time that a different approach across each of the four countries was taken when a UK wide approach would have worked better other than perhaps closure of borders or earlier lockdown. Each country has a unique identity and had a unique communications strategy so for the bulk

of the citizens it was straightforward enough to understand what arrangements were in place in which country when there was a difference.

Access to Expert Advice

22. In terms of expert advice being made available to decision makers, as I had a lead policy role in HCAI, I and my team facilitated advice from experts on the use of PPE. I also ensured there was data in relation to HCAI made available to ensure appropriate steps were being taken to reduce HCAI as far as possible [FMQ/006-INQ000228373] [FMQ/007-INQ000228374 and INQ000228375]. I do however believe there were missed opportunities for us not to model approaches other than lockdown to prevent spread of the virus. We were perhaps too focused on what we called harm one when more modelling could have been done on the other harms so we could better understand the longer-term implications of the approach we were taking. However, I have no reason at all to believe that Scotland was in any way hampered from receiving the best scientific advice and information.

Public Health Communications

23. As CNO I was involved in delivering the public communication plan through media and being part of the daily briefings with the First Minister (FM), although the overall plan was developed under the leadership of the NCD. The communications appeared to be well received and the consistency across the public sector strengthened this. My involvement was in partnership with the CMO and NCD where we rotated our involvement on the daily briefings (albeit at times if one of us had the particular expertise then they would be involved on that day). On the day of the briefings this involved providing any last minute or up to date advice to the FM prior to the briefing, in partnership with the communications team. There were a series of public information campaigns that tended to be delivered by the NCD, with others brought in on an ad hoc basis.

24. The impact of 'rule breaking' by Ministers, officials or political advisors has clearly had a devastating impact on people who have lost loved ones. Whilst there was

very little intentional rule breaking in Scotland by Ministers, officials or political advisors I do not believe this contributed to individuals not following guidance; there is no doubt that the intentional socialising that has taken place and been reported around Whitehall has deeply disturbed people who could not be with their loved ones at the end of their lives, or even keeping people who lived in care homes comforted and cared for whilst there were quite aggressive visiting restrictions.

Public Health and Coronavirus Legislation and Regulations

25. Whilst I did not have a strong role in advising on the coronavirus legislation, I believe on balance it worked well, including the fact that there was a requirement for review. Of course, other powers of Ministers were also exercised – such as Ministerial Intervention Direction towards the NHS that was also effective (such as requiring the Executive Nurse Directors to take oversight of staffing and HCAI across IJBs including Care Homes), [FMQ/008-INQ000228376], (National Health Service Reform (Scotland) Act 2004) or placing the NHS on an emergency footing National Health Service (Scotland) Act 1978.

Key Challenges and Lessons Learned

26. Due to the fact that I demitted office in February 2021 I did not have an opportunity to contribute to lessons learned – other than what we managed on an ongoing basis.

27. On balance much of what happened when responding to the pandemic was predicated on a plan for flu without due consideration being given to other options that may have altered the course of the pandemic. There was an opportunity from January to March 2020 to take actions that were different rather than put actions in place that assumed we were going to be overwhelmed with the virus. We did not properly consider the aftermath of reducing most NHS services, including treatment of drug and alcohol use, or mental health, which could have taken place remotely or been categorised as essential and taken place with NPIs in place. The decisions we seemed to be taking were linear in

their nature around how to create capacity in the NHS to save lives and provide access to clinical care rather than how to prevent the virus from circulating by the use of border control, earlier lockdown, testing and tracing. Current SG policy on social care is to have a mixed model of provision (public, third sector, private, charitable). The disjointed nature of the social care provision was a barrier in providing a comprehensive response to social care and starting off the pandemic with a health and social care workforce that was struggling with resilience in places was not ideal. By disjointed nature of social care, I found this to be so as care was being provided by a number of different organisations who were not necessarily connected. This meant that specialist and expert advice, or access to purchasing PPE was a challenge until other arrangements were put in place, which did happen as soon as it was recognised as being problematic. Whilst we recognised the impact the virus had on the more vulnerable in our society, I wonder if we could have done more during the pandemic to support such groups. For the future, improved preparedness, including public debate about what actions will be taken (with consequences – so trading wellbeing and education of our young people with increased transmission of the virus. This could be tolerated with a firmer grip of protecting care home residents and those who shielded – it just needs to be thought through). There is no doubt that additional funding is needed to invest in preparedness and emergency planning – the question of course is where that money comes from – along with additional investment in our health and social care workforce.

28. Messaging platforms such as texts and WhatsApp, in my experience were not used to make decisions or have a work-based decision-making discussion. In Scotland the only people who worked in St Andrews House (the headquarters of the Civil Service) were the First Minister and some of her direct support team; duty SG comms and officials who were supporting the FM at the daily briefing. There were very few others in the office and none of my director colleagues or team were routinely in the office. Therefore WhatsApp/Texts in my mind took the place of informal discussion when staff are in the office – in particular when we were working extensive hours. For example, if a paper was circulated at 7.30pm then a WhatsApp message would be sent to say look at your inbox, or do we need a meeting? Any decision making would take place by e-mail or in meetings

that were recorded. The use of WhatsApp certainly increased during the pandemic, but I attributed this to the fact that we were all working from home. As we did before the pandemic all messages were routinely cleared every few days at the longest. For the future there should be specific policies on how such messages should be used and if they are used then how they should be stored. My relationship with SG Ministers was such that I would not text or WhatsApp – I would go through their offices if I needed to message them. I have one set of text messages between myself and the DG that has been attached (which I for some reason did not delete) [FMQ/009-INQ000228377]. Not all messages relate to this inquiry.

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: 15/11/2023