Witness Name: Dr David Caesar
Statement No.: 1
Exhibits: DCA
Dated: 02 October 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF DR DAVID CAESAR

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

1. I am Dr David Caesar, principally employed at the Emergency Department, Royal Infirmary of Edinburgh. During the specified period in question, I had been seconded on a part time basis to the Scottish Government Health & Social Care Department since February 2016. My initial role on commencement in Scottish Government was as National Clinical Advisor to the Chief Medical Officer (CMO) (Dr Catherine Calderwood) for Acute Services. My main areas of work were to implement the Scottish Trauma Network, engage and advocate for Realistic Medicine, and subsequently to lead the development of a Leadership and Talent Management Approach across Health & Social Care in Scotland. This latter role became my focus from 2018, when I moved to the Health Workforce Directorate to lead a division dedicated to Health and Social Care (HSC) Leadership and Talent Management. I was undertaking this role into 2020 and when the initial decisions regarding Covid were taking place.

2. In March 2020, this role was pivoted to ensure that the wellbeing of the HSC workforce was being adequately attended to during the pandemic, and I formed the team and led the work regarding the National Wellbeing Hub in Scotland, including measures to ensure staff safety and support, as part of the Health Workforce Directorate. In the summer of 2020, I was asked by the Interim CMO (Dr Gregor Smith) to support the CMO Directorate in its advisory work. I re-joined

the CMO Directorate as Interim Deputy Chief Medical Officer (DCMO) on October 1st 2020, fulfilling that commitment on a full-time basis until August 1st 2021. I had a particular focus on leading the healthcare approach to Clinical Prioritisation and service/workforce impacts of Covid, advising on elements of non -pharmaceutical interventions (NPI) implementation, contributing to discussions surrounding emerging Covid evidence and managing harms, and liaising with key stakeholders via the Workforce Senior Leadership Group, Local Authority meetings, Convention of Scottish Local Authorities (CoSLA)-convened Trade Union Representative meetings, Scottish Academy, Scottish Association of Medical Directors, and others. On August 1st 2021 I returned to Health Workforce until leaving Scottish Government service on 1st April 2022.

3. 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.

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 [DCA/number-INQ000000].

Advisory Groups

6. The principal advisory/decision-making groups that I participated in were:
    a. Workforce Senior Leadership Group (mostly March 2020-October 2020)
    b. UK CMO / DCMO forum (from October 2020-August 2021)
    c. Scottish Government Covid-19 Advisory Group, plus subgroups for Education & Children's Issues and Universities & Colleges (from October 2020-August 2021).
    d. Scottish Government Health & Social Care Management Board (from October 2020-August 2021)

e. SAGE subgroup on Equalities (from October 2020-August 2021).
f. National Clinical Prioritisation Group (Chair) (from October 2020-August 2021) [DCA/001-INQ000249258]
g. Management Reference Group (Multiprofessional Health Service liaison group) (from October 2020-August 2021)
h. Public facing advisory functions, eg on TV / Radio regarding State of the Pandemic and rationale for NPI / population health measures (from October 2020-August 2021).

7. From my appointment as Interim DCMO in October 2020, I contributed to the analysis and decision-making within the UK CMO / DCMO meeting structure, which occurred most weeks. This was principally regarding the clinical implications of emerging evidence and data, both directly related to Covid-19 and to the impact on HSC services. I supported many of the conversations regarding the Local Authority "Levels" during Wave 2 (Winter 2020-21) and was the principal clinical advisor to the CoSLA-convened meeting of Local Authority stakeholders and Trade Unions. This was largely to provide and explain the clinical rationale for the NPIs that were being proposed across Local Authority areas.

8. In the weeks prior to end-March 2020, I recall a briefing to describe the clinical background and evidence of the emerging threat of Covid-19 to SG Clinical Advisors. This was the first professional notification of a formal global threat that I was party to in Scottish Government. Following the escalation of this threat during March 2020, it was mandated that all non-Covid-19 work was paused and all resources were pointed towards supporting critical infrastructure and information flows as we approached the first national lockdown. The first 2-3 weeks of Covid-19 being recognized as a national emergency were very intense, with a somewhat frantic re-organisation of the entire Scottish Government organogram to support a system response and adequate information control. There was no doubt that the threat of Covid-19 was being taken extremely seriously and this was clearly messaged from the Permanent Secretary and through the entire organization. During this time, we were all struggling with untested working-from-home infrastructure, unsatisfactory web platforms,

unfamiliar communications and information etiquette, whilst trying to manage a (inter)national emergency. Fortunately, we were not subject to the same extent of critical cases as Northern Italy, and the organization managed to re-organise with relative agility.

Non-Pharmaceutical Interventions

9. I was not involved in any of the discussions or decision-making regarding the initial lockdown or use of NPIs in March 2020, including for the specific events of the Nike conference or the Six Nations rugby match on 8th March 2020. I was involved in subsequent discussions regarding "herd immunity" after I joined the SG Covid-19 Advisory Group in October 2020. This was specifically in the context of the emerging vaccines, and how likely the combination of natural exposure to Covid-19 and acquired immunity via vaccination could contribute to reaching the threshold for population level immunity. There was still much uncertainty regarding the likelihood of this being achieved, and it was not considered a realistic outcome given the paucity of data regarding vaccine effectiveness, circulating antibodies, and as it transpired, Covid-19 variant evolution.

10. From October 1st 2020, notably during the lead-up to and peak of the "2nd wave" through the winter of 2020-21, I was part of the clinical team analysing the emerging evidence on NPIs, advising on public health measures to other Scottish Government Directorates, policy groups and Ministers, and providing liaison with stakeholder groups, Local Authorities and the general public.

11. This included discussions and advice regarding the public health measures that were used to underpin the Covid Protection "Levels" as implemented by Scottish Government across Local Authority areas, the role of NPIs, testing and isolation in schools and education settings, and the use of travel restrictions.

12. In the main, our responsibility as clinicians was to ensure clear advice regarding harms and protections directly related to Covid-19 (Harm 1), with consideration of the risks associated with these related to wider health issues (Harm 2), for

example from a reduction in routine health service provision or screening mechanisms.

13. We ensured that we had a consensus opinion on issues that we could be consistent with publicly, though we often held a spectrum of views that were informed by a variety of evidence-bases and professional standpoints.

14. Managing this internal / external dichotomy was achieved by regular internal discussions and exchanges, sometimes via media such as WhatsApp. It could often be a source of tension for the clinical team.

15. All policy decision-making was ultimately done via the "4 Harms" process, where the 2 Harms stated above (Direct Covid and Indirect Covid) were analysed with Harm 3 (Social, including educational) and Harm 4 (Economic). I was not involved in the 4 Harms meetings, but the clinical consensus was captured through official means and included in this process.

16. There was undoubtedly a "5th Harm – Political" that was constantly part of this mix informally, in attempting to gauge the tolerance of the population to various measures and interventions. This was captured through regular polls and compliance questionnaires and fed into the "Compliance" group. I contributed to this given my previous role in Leadership Development, as did some external experts such as Prof Stephen Reicher. This group advised on the way NPI measures may be best introduced, why some things may cause unexpected consequences, or not be effective, and where else we may need to look at emerging evidence and different messaging (eg on the role of ventilation).

17. These 5 factors/"harms" were in constant evaluation, with emerging evidence, epidemiology, polling, and expertise all being distilled in through the various advisory groups and into the "4 harms" process into the First Minister and Cabinet. The pace of this process was very rapid through that Autumn 2020 and carried by a relatively small number of individuals in Scottish Government.

At-Risk Groups

18. Regarding the considerations to "at risk" individuals, I believe that the approach to people who were on the so-called "shielding list" after the very initial first infections was thorough and anticipated the adverse clinical outcomes from Covid specifically. I did not lead on this aspect of Covid-19 protections, but we did discuss the approach and impact of measures regularly in the clinical advisory team, and within the education and young peoples groups in which there were implications to be considered. It may have underappreciated (as, possibly, did the social impacts on children and young people through removal of educational provision) the psychosocial impact on this group which emerged through and after the shielding measures.

19. I do think that there was a universal underappreciation of the risks associated with ethnicity and SE status, notably that individuals within some minority groups and from poorer backgrounds were significantly more likely to contract Covid-19 and have poorer clinical outcomes. These are complex issues, and ultimately, we did make good progress in offering tailored solutions to some marginalized groups (eg Travellers / migrant workers) with vaccine provision and messaging.

20. I think that through the course of my experience as Interim DCMO, I noted several areas that worked well. Most notably:
    a. UK-wide clinical / public health community – sharing evidence, experience, resources, and analysis.
    b. Communication with the public.
    c. Liaison with stakeholder groups.
    d. Consistent process for decision-making and policy interventions.

Divergence from UK Government Approach

21. The over-riding principle during my term as Interim DCMO was that across the 4 nations of the UK, there was a genuine effort to be in lockstep regarding clinical advice and policy decisions. There were occasions when this diverged, namely due to different political philosophies, social contexts, and economic realities. In Scotland, of the 4 Harms, Harm 1 (Direct Harm from contracting Covid-19) was

given most weight, followed possibly by the political perspective. Clinical advice was therefore translated into greater degree of public health protections than may have been apparent in other home nations. I think less weight was given to social and economic harms in Scotland than in England.

22. However, there was also a pragmatism to this, to avoid further complications and encouraging greater risk taking by individuals, for example ensuring that International Travel restrictions were consistent across the UK, and that some of the rules around hospitality were not too divergent from those in England. We learnt that NPIs were most easily followed and complied with when they were consistent across the UK, so there was a further balance to strike – that of being tailored to local outbreaks and variations in epidemiological patterns, whilst also creating guidance and policies that were most likely to be communicated well, understood, and followed.

23. I do not think there is much evidence (yet) to support which of these approaches was "better or worse". The implications of these decisions have yet to fully manifest and will be nearly impossible to attribute to policy alone. For example, the social impacts of recurrent lockdowns and restrictions on young people, their mental health, educational attainment, and early-career opportunities and aspirations are still playing out and will have an impact on their long-term health and happiness. The macro-economic effects of Covid-19 on a National, UK, and International level are probably still being experienced and understood.

Medical and Scientific Data Modelling

24. Regarding my role in medical and scientific data and modelling, we had excellent access to national and international epidemiology, provided by SG analysts, Public Health Scotland, UKHSA, UK Government, and international agencies. I was not responsible for gathering this data, but was responsible, with the rest of the clinical team, for the clinical scrutiny and analysis, and for distilling and presenting the key findings to policy officials, Ministers, and the public. These data were discussed regularly within the clinical team in SG and across the UK, and within the Scottish Government Covid-19 Advisory Group and subgroups.

25. Where further questions were asked, we were able to commission or access additional evidence when it was available.. Most notably, data from Public Health Scotland and the UK Health Security Agency was readily available and discussed weekly within our clinical groups and the Covid-19 Adivsory Group.

26. I do not recall an inability to access information when it was available and required. We were privileged with as full a picture in terms of data and new epidemiology as any part of the UK, and probably internationally.

Public Health Communications

27. I believe the public messaging of information regarding Covid-19 and NPIs was a particular strength of Scottish Government during this time. I occasionally contributed to this alongside Scottish Government Ministers, on television, radio, or pre-prepared statements – giving the clinical rationale for NPIs and protective measures, as well as advice regarding how to stay healthy and safe during the pandemic.

28. This was reflected in our relatively good behavioural compliance surveys and data, and the high levels of trust in Scottish Government recorded during the pandemic. I believe this was due to an extensive use of the media (daily St Andrew's House briefings, regular high-profile media opportunities targeting different demographic audiences – eg TalkSport and BBC Scotland Radio, "The Nine") and good use of consistent highly effective communicators – The First Minister, Prof Jason Leitch.

29. When high-profile breaches of rules occurred, it naturally undermined this messaging and trust. Some of the alleged breaches associated with the UK government may have perversely strengthened the resolve of Scots to behave "properly" and may have enhanced the compliance and trust in SG in some quarters.

30. Broadly though, our polling data would suggest that trust, compliance with NPIs, and public engagement, slowly and marginally decreased over the duration of the pandemic but was relatively stable.

Legislation and Regulation

31. One of the biggest difficulties with the legislation and implementation of NPIs as the pandemic evolved was the inconsistencies between different societal situations, in an attempt to balance the 4 Harms. For example, the difference in social distancing and mask wearing between supermarkets and pubs/restaurants. These inconsistencies were discussed in the clinical teams, and despite our role being to advise on Harms 1 and 2, with some influence in Harm 3 (Direct Covid-19 Harm, Indirect Covid-19 Harm, and Social Harm respectively), I did note that this could stray into offering policy advice that "shortcut" the 4 Harms process. Some of this inconsistency was introduced by specific legal challenges, for example the Judicial Review into NPIs within Places of Worship, that SG lost. So that one was left with different (less) protective measures in Church than in other public settings. This could undermine the compliance in the setting with the more stringent measures, or alternatively in the messaging as a whole.

32. There were also examples, especially early in the pandemic, where social constraints may have been overzealously policed, for example the arrest of people travelling to remote areas to exercise. I note that the messaging in these high-profile incidents was inherently powerful but eroded quickly if felt to be overreaching.

Lessons Learned

33. Following the first wave of Covid-19 (in the summer of 2020) I was involved in a "Lessons Learned" exercise, commissioned by the Director-General for Health & Social Care (H&SC) in Scottish Government, and undertaken by KPMG. I was primarily involved to offer insights regarding the H&SC workforce. This document is included in the evidence provided [DCA/002-INQ000147474].

34. Regarding the wider learning, it is clear that the resilience of the H&SC system has and continues to be severely tested by the Covid-19 pandemic. There simply wasn't the "headroom" in the system capacity to either train regularly or effectively for these types of scenarios (including other CBRN events), and I don't believe there is yet. The reliance on "discretionary effort" amongst clinical and non-clinical professionals within H&SC was revealed to be significant and exhaustible, which we are now seeing in the "quiet quitting" (a reduction in the core and discretionary work that employees are now prepared to undertake routinely) that is evident internationally amongst healthcare workers. There needs to be a mature cross-party debate and plan regarding the future model of the NHS in the UK, that is taken out of the directly political sphere, and establishes a clear definition of what the aim of healthcare is, what the funding model needs to be, and how the workforce is best supported, recruited and retained to provide services against current and future demand. This should use international benchmarking and include the capacity to train regularly for significant events. It should move away from a "just enough" model, which currently is "not enough".

Informal Communications and Documents

35. Regarding the use of messaging groups in Scottish Government during my time as Interim DCMO, I was part of several formal and informal WhatsApp groups. These were predominantly formed for the Scottish Government H&SC Directors, and for the H&SC Clinical Advisors (Chief Medical Officer and team, National Clinical Director and team, and Chief Nursing Officer and team). The formal versions of these were used daily, often 14-15 hours a day, 7 days a week, to enable rapid communication, policy discussions, confirm official support for ministers, and to reach consensus regarding advice. This was then translated into official advice that was captured in the formal document management systems in SG and played into decision making or advisory settings.

36. I do not have access to these messages now, as they were auto deleted, but their essence was captured in formal advisory notes or minutes.

Statement of Truth

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

Personal Data

Signed: _____

Dated: _____02 October 2023_____