Witness Name: Paul Cackette
Statement No.:1
Exhibits: PC
Dated: 06/11/2023

**UK COVID-19 INQUIRY**

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**WITNESS STATEMENT OF PAUL CACKETTE**

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

1. I am Paul Cackette, care of Scottish Government, St Andrew's House Edinburgh. I worked for the Scottish Government from November 1988 until I retired in January 2021 in a range of roles. Initially I worked as a lawyer in the Government Legal Service and was Interim Director of Legal Services from May 2018 to June 2019. Prior to Covid I was the Chief Planning Reporter for Scotland (the equivalent to the Planning Inspectorate) and was redeployed to Covid roles on 26 March 2020. I was (a) Deputy Director in Organisational Readiness from 26 March to 9 April (b) Director of PPE from 9 April to around 26 June and (c) Director of Outbreak Management from around 26 June until 18 November 2020 (ahead of my formal retirement in January 2021). I am no longer employed by the Scottish Government (SG) as a civil servant. I am though a part time, self-employed planning reporter. In my Covid related roles, I provided no legal advice (my role was purely a policy role) and gave no clinical advice (I hold no clinical qualifications).

2. As I have been retired since January 2021, I have not had access to any materials previously prepared or seen by me in relation to the roles set out above (prior to receiving the letter from the Inquiry dated 20 June 2023). All the records once held by me ceased to be accessible after I returned my SG laptop on retirement. Certain material has been provided to me so far as appears to me to be most relevant to assist my preparation of this statement (and to determine what materials should

be submitted to the Inquiry). I have received practical support from the Scottish Government Covid Inquiry Information Governance Division to enable the statement to be completed, but have not had general access to my previous papers. I have not discussed any aspect of this statement with any other potential witness.

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 or recall and are true to the best of my knowledge and belief.

4. References to exhibits in this statement are in the form PC 1 and PC 2 - numbers - INQ000000 and INQ000000. I refer below to a number of meetings of the SG Resilience Room (SGORR) in relation to local restriction decisions in particular affecting Gretna, Coupar Angus, Aberdeen and Glasgow (both imposing and lifting restrictions). I understand that my submissions to and in relation to SGORR, amongst other SGORR related materials, have separately been produced to the Inquiry.

5. My statement to the Inquiry relates only to the periods when I was deployed to Covid policy roles, prior to my retirement. In effect I ceased working in these areas on 18 November 2020, due to the outstanding balance of untaken leave ahead of my retirement date of 8 January 2021.

6. Prior to taking up a Deputy Director role in Organisational Readiness Division on 26 March 2020, I had no involvement with any aspect of SG Covid work. Between 23 August 2016 and 26 March 2020 I held the posts of Chief Planning Reporter (and as above, Interim Director of Legal Services). I cannot therefore answer questions set out in section B of Annex B of the Inquiries request relating to the period prior to 26 March 2020 nor, in light of paragraph 5 above, on the timeliness of the restrictions of January 2021.

7. I held three Covid related roles in the period 26 March to 18 November 2020.

8. My role as Deputy Director role in Organisational Readiness Division was initially envisaged as primarily providing co-ordination in support of the NHS in relation to

excess deaths, if that arose, where that might overwhelm public or other services in their ability to cope in consequence of the pandemic. In practice, my primary focus was the co-ordination of the final development and launch of a "Scotland Cares" volunteering campaign. That was designed to encourage volunteering to assist those with shielding needs or otherwise vulnerable or isolated members of the community to ensure that shopping and other needs could be met. This required policy co-ordination with existing support services and sectors such as Volunteer Scotland (to avoid duplication, overlap or confusion), publicity, establishing or modifying a website (Ready Scotland), considering arrangements to protect vulnerable people from opportunists exploiting them (such as accelerated approvals from Disclosure Scotland of suitable persons in respect of the Protection of Vulnerable Groups [DBS equivalent]) and seeking Ministerial authorisations for the campaign. This campaign included the encouragement of former NHS staff to return to help (with accelerated checks of suitability). It was successfully launched on 30 March 2020.

9. On 9 April 2020, I was appointed to the role of Scottish Government Director PPE. This was a newly created Directorate (with me as the only member on that day), designed to draw together co-ordination of clinical, policy and logistical advice, planning and delivery into one place. The new Directorate sat within the Health and Social Care Directorate-General area. I reported to the Chief Executive of the NHS and Director-General for Health and Social Care (initially Malcolm Wright and in May 2020 split between John Connaghan and Elinor Mitchell). My Ministerial lead was the Cabinet Secretary for Health and Social Care, though my role was designed to be cross-governmental.
10. In my period in that role, I developed a Directorate Plan ( PC/001 – INQ000224570) setting out the priorities of Directorate delivery. This version is dated 19 April 2020.
11. In practice, the purpose developed beyond that document adopted on that date. In short, the role, as it developed over time, was to provide SG co-ordination of a range of aspects of PPE delivery, including-
    - Supporting the supply of PPE by National Services Scotland (NSS) to all NHS staff in Scotland (by then extended to supply without charge to all care homes, whether local authority or private);
    - Co-ordination of arrangements and development of policy for ensuring that all public sectors workers outwith the NHS received te necessary PPE

required for their jobs in time (which included those carrying out public services even though not public officials, such as funeral directors). Many of these functions were already being delivered by local authorities and organisations such as Police Scotland and the Scottish Fire and Rescue Service;

- Supporting procurement arrangements for PPE (beyond NSS);
- Consideration of potential policy priorities in the event of PPE shortages;
- Supporting the administrative organisation of delivery of PPE by NSS to care homes, initially through established Health & Social Care hubs, but moving quickly as the pandemic spread to direct PPE delivery to care homes in Scotland (1100 homes in total);
- Co-ordinating with SG International Trade colleagues and their Minister (Ivan McKee) to ensure maximum potential for securing contracts for PPE supply from abroad (frequently China) and delivery (often by flights to Prestwick Airport) in time;
- Development of capacity in Scotland for PPE supply, less dependent on imports;
- Advising SG officials about the implications on policy decisions of matters relating to PPE. This included matters relating to the use of face coverings. Though not strictly PPE in themselves, decisions relating to use of face coverings in public transport, shops and offices required advice, including on public statements of policy (against the risk that demand for face coverings/PPE in these areas might cause shortages for NHS staff in greater need of PPE). This included internal advice affecting essential services provided by SG staff, where for example public facing;
- Co-ordinating offers of PPE supply from private bodies, to ensure they could be considered and taken up, where genuine (ie avoiding financial scam offers) and meeting identified shortages;
- Co-ordinating arrangements with NHS Boards in Scotland to ensure advance reporting of PPE supplies (and anticipated shortfalls) and ensuring joint working to share PPE where any Board was at risk of facing a shortfall;
- Carrying out of a review of a help-line established at the start of the outbreak where any NHS staff unable to secure the appropriate PPE could

email in to ensure supply – the system had been set up urgently and there were failures to respond adequately or quickly enough due to administrative systems failures which required an overhaul of the help-line;

- Co-ordinating and streamlining all aspects of advice to Ministers on all matters relating to PPE, primarily (a) designing and signing off daily reports to Ministers on the current state of PPE supplies in Scotland, to assist in the focus of supplying and planning supply and (b) providing briefing to the FM, Cabinet Secretary Health & Social Care and whichever of the Chief Medical Officers were in attendance at the daily lunchtime FM-led media briefings in relation to any likely issues or questions concerning PPE;
- Supporting the Cabinet Secretary Health & Social Care in briefings and meetings with the Secretary of State for Health & Social Care, on 4 Nation co-ordination;
- Working with UK DH&SC colleagues on information exchanges on PPE policies and supply (including on ways of working abroad to minimize the risks of different parts of the UK being in competition abroad in procuring PPE);
- Working with Army logistics experts to improve the workings of NSS in PPE co-ordination and supply;
- Establishing and chairing a future planning group looking at maintaining supply and future planning of PPE supply beyond the pandemic;
- Considering how return to normalisation might work on issues such as withdrawal of free PPE to private care homes at the appropriate time;
- Co-ordinating the Communications demands from the Press on PPE related matters, to ensure consistency of responses and public messaging and maximise efficiency of resource in answering Press requests relating to PPE;
- Supporting Ministers on their inter-actions with the Scottish Parliament and Opposition members in respect of PPE related issues.

12. I established a small Directorate comprising myself and one temporarily available Deputy Director and a range of policy staff, with responsibility for different aspects of these functions.

13. As what became known as the first wave began to pass and PPE systems became more streamlined, it no longer appeared to me that a separate PPE Directorate was necessary.
14. I was therefore, following a discussion with my Director-General, appointed as Director of Outbreak Management on 26 June 2020 (as I recall the date). This was also a newly created Directorate (again with me as the only member on that day), designed to draw together co-ordination of clinical and policy advice, planning and delivery of local lockdown policy into one place. The new Directorate retained strong links with the Health and Social Care Directorate-General area, but the intention was that the new Directorate was more cross-cutting across the SG in its role, drawing together clinical matters and wider practical policy consequences of local restrictions. I reported in practice both to the D-G for Health and Social Care (Elinor Mitchell) and, as technically my line manager, the D-G for Constitution and External Affairs (Ken Thomson). My Ministerial lead became the Deputy First Minister, though - as my role was designed to be cross-governmental – I remained within the "family" of Health and Social Care Directors. I believe that I was the only SG Director straddling these two roles because of the close read across of roles. I continued to attend the weekly portfolio meetings held by the Cabinet Secretary Health & Social Care.
15. The Directorate was structured in the period after being established based on support to me by two temporarily promoted Deputy Directors, broadly subdivided into responsibility for dealing with (a) the immediacy of local restrictions and the impacts on a range of policy areas and (b) longer term planning, as became planning for the anticipated second wave and matters such as restrictions over the period at Christmas and New Year 2020.
16. In my period in that role, I developed a Directorate Plan, based on and summarised in my submission to the First Minister dated 4 July 2020 (PC/002 – INQ000224571) setting out the priorities of Directorate delivery.
17. At Director level, there was a small number of non-clinical Directors working closely together under Ken Thomson on different aspects of senior level non-clinical advice, in often fluid cross-Directorate arrangements. We worked on the progressing over time of the decision making balances of the 4 harms tests (the direct health impacts of Covid; indirect impacts on health and social services; physical and mental health impacts, including learning and development and

justice; and harm to the economy) and the transition to different levels of restriction. Moving from a total restriction of movement across the entire country (which happens to be an island) into ranges of other restrictions which would work differently according to topic and local (at speed) was enormously challenging. Geographical limitations were especially difficult (in particular in conurbations where communities coalesce, but also where unique challenges are faced by islands communities in areas where there are significant numbers of populated Scottish islands). For example, closing pubs in Aberdeen may lead to undesirable behavioural displacement (for a range of reasons) to neighbouring towns outwith the City area. Over time local restrictions moved from being ad hoc responses and bespoke restrictions (eg closures of areas in Gretna due to an outbreak sourced in Carlisle or as a result of a poultry processing factory outbreak in Coupar Angus). This led to the move from location specific restrictions to categories of areas where "levels" of restriction were adopted and areas transitioned between levels, based on clinical and other advice. My Directorate was less involved in deciding levels (or triggering changes) than working through the policy and practical implications of restrictions.

18. In short the role, as it developed over time from the snapshot in my submission of 4 July 2020, was to provide SG co-ordination of a range of aspects under the general heading of outbreak management, including-

    - Supporting meetings of the SG Resilience Room (SGORR) chaired often by the FM, in making strategic decisions on the imposing (and lifting) of restrictions where an outbreak of national (ie Scotland-wide) significance. SGORR is the equivalent of COBRA;
    - Monitoring, attending and supporting national incident management planning led by Public Health Scotland, considering the clinical recommendations according to circumstance and place;
    - Attending and advising (so as to ensure consistency and report to senior officials and Ministers) in respect of local incident management teams convened in light of outbreaks not having national significance. It should be noted that attendance by a representative of my team was a "courtesy", though invariably extended to us, as decisions of the local incident management teams can be based on clinical matters only;

- Inter-acting with other Covid Directors to ensuring consistency and avoidance of duplication of resource application in policy development. This extended to co-ordination with Directors of Public Health in Health Boards and senior officials in COSLA, representing local authorities;
- Support to the Cabinet Secretary for Health and Social Care in Committee appearances in the Parliament (before the Coronavirus Committee) as necessary, including where a motion to annul the Aberdeen restrictions had been tabled;
- Development of local restriction policies across all areas of activity (without taking lead policy responsibility for different SG policy areas) in support of smooth continuation of public services;
- Consideration of consistency and comprehensibility of restrictions to make them as workable as possible, to maintain public confidence in them. Ad hoc development of restrictions in a non co-ordinated way might lead to loss of confidence ("If we can do X, how come we can't do Y"?). How focused should the local areas of restriction be? Local authority boundaries are generally understood, but could the areas of restriction be STD telephone code areas, Health Board areas, postcodes (as done at Gretna) or local council wards (not generally understood)?;
- Encouraging forward planning in ranges of areas less immediately directly involved in Covid planning such as liaising with SG policy leads for universities (and the universities themselves) in planning for the return of students for the academic year 2020/21;
- Encouraging forward thinking of where existing subject specific policy changes are needed in light of Covid or where potential inhibitors of essential changes would need forward planning to avoid. Some were direct in fighting the pandemic and some indirect. Examples of direct problems are looking at powers (and numbers) of local authority enforcement officers and looking at conditions of a pub licence where restrictions may need to be enforced by persons other than the Police. Less directly, were legislative changes needed to permit non face-to-face meetings in say planning appeals? What were the implications for the Franchise on the then upcoming Scottish Parliamentary Elections (May 2021) if, on polling day, there were restrictions in Glasgow but not Dundee?;

- Consideration of where restrictions are appropriate in law by means of legal regulation and where matters are appropriate to be contained in guidance. These considerations are important in light of the consequence of the former (ie criminality or at least a Fixed Penalty Notice) and so need careful drafting precision. Use of guidance allows greater individual autonomy and can be more flexible but more easily circumvented;
- Responsibility for producing accurate, up to date and clear guidance on all aspects of Covid restrictions on the SG website (including in relation to travel to the rest of the UK or abroad);
- Co-ordination of restrictions in other parts of the UK and ensuring consistency, subject to localised circumstances and decision making and keeping other administrations informed in a timely way of changes to restrictions. For example, when considering restrictions in Aberdeen City in consequence of an outbreak in a pub, we (a) contacted the UK Government to liaise to ensure minimal impact on workers in the North Sea oil and gas sector (as a reserved matter) travelling off-shore and (b) contacted the Royal Household as the late Queen was in residence at Balmoral (in Aberdeenshire) when restrictions were imposed (where she would normally return to London via Aberdeen City).

19. Finally in relation to section A of Annex B of the letter from the Inquiry, I refer to groups set up and joint decision making with UKG and other devolved administrations.
20. In both of my Director roles there were a vast number of ad hoc and regular meeting groups established and which ran for greater or lesser periods of time, where I was involved as chair, co-ordinator or contributor/attendee. My role in each was to provide policy inputs in my respective roles described above.
21. The most significant were (a) the frequent but irregular meetings of SGORR, chaired normally by the FM (b) the regular strategic decision making forum developed in Autumn 2020, chaired by the FM, with lead officials being Ken Thomson, the Chief Medical Officer and Jim McMenamin of Public Health Scotland (c) the strategic PPE group referenced above (chaired by me, meeting around every second week) (d) the weekly strategic national incident management team, set up by me but led by Jim McMenamin (e) the SG Directors meeting held each Thursday morning, chaired by the SG Permanent Secretary (f) regular meetings

by zoom between the Cabinet Secretary for Health and Social Care and the Secretary of State for Health and Social Care (g) phone meetings between the Chancellor of the Duchy of Lancaster and the other First Minsters (h) daily phone meetings of Covid non-clinical Directors (i) daily phone meetings of Health Board Directors of Public Health (j) weekly meetings of the NHS Chief Executive and chief executives of all NHS boards (my attendance was to brief on PPE) (k) weekly portfolio meetings of the Cabinet Secretary for Health and Social Care with all H&SC Directors (including me even after moving posts) (l) daily meetings with the Minister for Trade, Innovation and Public Finance on PPE supply (attended by a member of my PPE team) (m) daily 10am zoom meetings (7 days a week) of Health and Social Care Covid Directors and (n) twice weekly meetings chaired by the Deputy First Minister on wider governmental issues in Scotland which included PPE supply outwith NHS settings.

22. In my roles, I played no part in cross-administration joint decision making. However, as set out above, I was regularly involved in cross-administration working to share experiences and alert colleagues (mainly in UK rather than Wales and Northen Ireland) about upcoming decisions with wider implications. Over the period of the pandemic, there were ad hoc issues which required consideration and co-ordination. Examples were a Press suggestion that English firms had been instructed not to supply PPE to Scotland, requests for sharing of PPE, limitations imposed on UK Embassies abroad from helping SG officials locally from securing PPE contracts.
23. In relation to section C of Annex B, once more my involvement being limited to the period after 26 March 2020 means I can offer no direct evidence. However, within the period working on Covid policy, my responsibilities included local and regional restrictions, closing of school and education settings and use of face coverings.
24. Despite the absence of a role in initial lockdown decisions, I would wish to make two observations.
25. Firstly, I do not recall in decision making an overt consideration of protected characteristics, in terms of equalities. These were strongly present though in two key respects – firstly a recognition that the biggest single contributory factor towards the most serious consequences of Covid, by a long way, was age and secondly that vulnerability was higher where a person with Covid had an underlying health condition (hence recognising disability as a key factor). As I

recall, a Director was appointed with specific responsibility for persons who were shielding. Understanding of the higher prevalence of Covid affecting persons from BME backgrounds as emerged quickly into the pandemic had not, as far as I am aware, been anticipated, either in Scotland or elsewhere. Others with clinical expertise can speak more about how this trend was identified and addressed and whether better equality impact assessments might have identified that trend earlier.

26. Secondly, after I retired I saw (I think on the BBC) an exploration about the disastrous impacts on victims of domestic abuse in consequence of becoming "prisoners" of the perpetrator in consequence of lockdown. Although national lockdown decisions pre-dated my involvement, I simply did not know about that consequence and was shocked and upset by the programme. That lack of knowledge contrasted with the high levels of knowledge and awareness of the needs of vulnerable children, in particular regarding policy decision making in the context of schools remaining open, so far as was possible. I would hope that, in future planning, addressing circumstances such as those will be part of advance planning.
27. In relation to section D (Divergence), from my experience I would reject any suggestion that there was a divergence of policy decisions "for its own sake". I cannot comment on political aspects of decision making by professional politicians, though I would recognise that the character and personality (and behaviours) of political leaders has potential to impact on public confidence in the willingness of the public to comply. Though it has gone under the radar, the absence of "Partygate" type issues in or around St Andrews House is an example of behavioural divergence.
28. My observations on divergence do not relate to clinical assessments (which appeared consistent, but others can speak to) nor specifically to other aspects of pandemic decision making.
29. Instead, I think the differences of policy approach can be explained under reference to wider factors such as (a) the different political make up of Scotland, represented in different ways in representation in the Scottish Parliament (b) the high level of existing institutional independence already in existence in Scotland (through a different NHS, different justice and legal systems, different central government structures in the SG etc) (c) specifically different structural and cultural

approaches and arrangements in Health Boards compared to Health Trusts (d) a smaller population base, making co-ordination of decision making on a national (ie Scottish) basis easier (e) the higher degree to which senior public officials are more likely to know each other (though recognising that that can have disadvantages) (f) differences in geography (recognised above in having fewer conurbations but more extensive populated islands communities) leading to different policy outcomes.

30. A worked example of (f) above is that, while an outbreak of Covid in a fire station in London could be managed by resources in neighbouring areas, if a fire station in Ullapool is unusable due to an outbreak of Covid, a vast area of the country would be without emergency fire services. Another example might be the Coastguard station in the Shetlands, leaving a huge area of sea unprotected. These issues of remoteness are not unique to Scotland but arise more frequently. I recall that issues arose at the border of Wales and England due to the high level of daily (especially employment related) cross-border journeys. Though there is considerable inter-change across the Scotland/England border generally, local numbers of employment related cross-border journeys were less significant (in relative terms) as an issue. There are relatively few larger settlements at the Scotland/England border.
31. To these issues must be added the problem – common to all administrations in the UK – of bandwidth. Arguably this is a bigger problem for Whitehall Departments (having to understand and deal with or accommodate Scottish devolution, Welsh devolution, Northern Irish devolution (with its current extra complexity), London issues, issues in areas where there are metropolitan mayors and issues in areas where there are not metropolitan mayors).
32. Even in times of peace, civil servants in all administrations inevitably focus on the immediate which means their own Ministers, their own Parliaments and their own areas. That is what they can influence. That is what they are accountable for. The remit of civil servants, even though impartial, is constrained by the authority given to them by their Ministers. Effective inter-governmental relations in the common good is extremely hard to achieve.
33. Lastly in this regard, effective inter-governmental and 4 Nation co-operation cannot ignore the asymmetric nature of governance in the UK and of the imbalance of population and area. England is much bigger than Scotland and much bigger than

Wales and Northern Ireland. Whitehall departments are the governance bodies both of the UK and, in the absence of devolution to English Assemblies, England. This makes co-operation as equal partners more difficult. These matters impact on pandemic planning but play into much wider constitutional issues (evidenced in other areas) in the post-Brexit environment and in, for example, the changes to the devolution settlements under the Internal Market Act 2020. These are relevant in looking at improvements of inter-governmental relations and inter-governmental working in and across the UK.

34. I had no direct role in relation to communications or behavioural science except as set out above. I was not involved in facilitating or enabling access to medical, scientific advice or data and modelling. I cannot comment on whether there were limitations placed on scientific data sharing.
35. In relation to section G of Annex B, I reference at paragraph 18 above (bullet 10) the policy considerations relevant to deciding whether regulation or guidance is better. I am aware of academic writing on this issue and can provide these to the Inquiry, if they have not already been alerted to it.
36. In expansion of these policy considerations, the need for clear differentiation in regulations (and so as a matter of law) created at times artificiality in distinctions. These run the risk of discrediting restrictions and under-mining confidence and compliance. A worked example of that which I recall was English legislation which led to critical social media questioning of "When is a Scotch Egg a substantial meal?" Guidance could have avoided such problems.
37. Guidance has its drawbacks (as I note above) but in Scotland, when considering pub closures, it struck me as adequately obvious to a sensible observer what the difference was between a café and a pub (even if a café was licensed). The SG wanted to keep cafes open during the day (as a social meeting point often used by older people, subject to good covid security precautions). Placing that distinction into law as regulations would demand legal precision in defining terms that might give rise to the Scotch Egg problem.
38. In addition, I would wish to draw to the attention of the Inquiry that Police Scotland expressed concerns to the Scottish Government that policing by consent was at risk of being adversely affected if due care was not taken in making decisions criminalising certain conduct, where the police become front line enforcers. This is hinted at in my submission of 4 July 2020.

39. I provided no direct written advice or oral advice in my roles to the Scottish or UK parliaments. I provided a range of advice in support of attendance at parliament of the Cabinet Secretary for Health and Social Care and attended one Parliamentary Committee meeting with her. I supported her on a call with opposition health spokespersons. I recall one brainstorm session in the Autumn of 2020 involving senior officials (primarily non-clinical Directors) led by Ken Thomson on our ways of working by that group but cannot recall seeing the outcome, which may have followed my departure.
40. The challenges identified by me during the pandemic which appear to me from my areas of responsibility and from my experience to be relevant (as were in my mind at the time and were addressed so far as was possible at the time), fall into six headings. Some, though not all, have wider relevance in general to administrative systems but are most acute at times of a national emergency. They arise from my experience in the SG but may apply more widely to other administrations. I simply narrate these and do not place them in order of importance.
41. Firstly, in a national crisis arising urgently and with limited notice, administrative systems often cannot cope or are modified immediately but imperfectly. Once that imperfect operation is identified, systems face three simultaneous problems – (a) ongoing operation imperfectly (b) implementing interim and immediate modifications to remove the worst failings of the ongoing operation until a long term solution can be found and (c) designing and implementing an effective long term replacement. In Covid, all three challenges occurred with unprecedented complexity and urgency. The risk is that the replacement long term arrangements (if adopted too quickly) repeat the mistakes of the changes that were made immediately but imperfectly.
42. Secondly, though public administration (which was my job) is significantly less important than front line care, the applying of experienced and skilled resource to that form of administration is vital. My experience was one of endlessly fire-fighting the same issues several times – when raised by colleagues, but after was resolved, being raised by Ministers, but after that was resolved, being raised by Special Advisors (SpAds) but after that was resolved, being raised by the Press or Comms. The duplication of resource so spent is wasteful and demoralising.
43. Thirdly, without questioning anyone's commitment or professionalism (and recognising, as produced to the Inquiry, vast numbers of Covid related decisions,

evidence and documents), I had a recurring sense of Ministerial frustration with the strategic planning thinking of the support teams in the SG. The decision to hold a SGORR meeting in relation to the pub outbreak in Aberdeen ought to have followed from advice from officials (of which I was one). It was though the FM who foresaw the need first and called it. Matters improved over the Summer through the leadership of Directors-General but too often her thinking was ahead of ours as officials. One consequence of that was that Ministers (such as the FM and the Cabinet Secretary Health & Social Care) felt the need to interrogate submissions to them almost *too* deeply. Too often they came back with questions that (a) had no answers (b) did have answers that ought to have been given first time round or (c) were not errors but where the issues were badly expressed.

44. Fourthly, my sense throughout was that the field of public health has been undervalued in the NHS and the importance of Directors of Public Health in Health Boards and their roles undervalued. It had the sense to me of being a Cinderella service within NHS structures.

45. Fifthly, despite the best efforts of the SG Perm Sec and HR professionals, the SG was less successful than it could have been in tilting resource and resource allocation into Covid roles. I personally spent considerable amounts of precious time discussing the recruiting of staff and creating management structures to serve the needs of the pandemic response.

46. Sixthly, a frustration at the time (Summer 2020) and very much in my view a lesson for the future is addressing the difficulty in ascertaining or identifying to any degree of accuracy the non-clinical impacts of certain interventions. Earlier in the pandemic, this was understandable but by the Summer/late Summer, given the economic implications of our decisions, it was sub-optimal that we had little by way of a tested and validated evidential base for making certain decisions. We had by then acquired a better (though still imperfect) understanding in clinical terms of the implications of interventions, but less so in other – especially economic - terms. This is not to diminish the care that went into decision making (including for example in considering unforeseen or unplanned consequences such as that closing pubs at 8pm will probably result in people not going home but going to an unregulated house party). But the more refined decisions became (close everything → close everywhere with a drinks licence → close everywhere with a

drinks licence in the evening → differentiate between standing areas and seating only), the more difficult the causal link is to be confident of.

47. In relation to section I of Annex B, I was a part of Whats App groups and used Zoom, Skype and Teams. In terms of my personal use of such media, this was never done for the purposes of recording SG decisions or any other material which had "corporate value". In the SG, our systems of electronic documents and records management (eRDM) required all material with corporate value to be recorded on eRDM. This was done through SG systems on my behalf by my PA.
48. The kinds of use by me were for example (a) being alerted about an issue that needed to be looked at in my area or (b) in parallel to Zoom calls so that SG staff could, off-line, agree who would answer what question. On (b) I recall a bespoke Whats App group being set up where I was supporting the Minister for Public Health in a zoom call. I was not part of any Whats app group with the FM or Cabinet Secretary for Health & Social Care.
49. My use of these tools ended when I retired and left the Whats App groups concerned. I no longer retain any such messages on my phone.
50. On being alerted that the inquiry request extended to text messages, I checked those and have found a series of text messages with my Director-General that I had not deleted. The text messages in that chain dated from 24 April to 18 November 2020 (other than three dated 3 November 2020 which relate to a different matter and comprise part of legally privileged material) are separately produced.
51. For completeness, in relation to Annex C of the letter of 20 June 2023, with the assistance of the SG support team, relevant documents can be produced, in liaison with them. I hold nothing falling within the category of diary or other notes (not otherwise held through the SG) nor, as above, Whats App messages.

**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:** ___ PD _____

**Dated:** _____06/11/2023_____