Witness Name: Derek Grieve
Statement: 1
Exhibits: DG
Dated: 8 November 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF DEREK GRIEVE CBE

In relation to the issues raised by the Rule 9 request dated 19 June 2023 in connection with Module 2A, I, Derek Grieve, will say as follows: -

Background / Experience

1. I, Derek Grieve, am currently the Deputy Director for Social Care Response and Improvement within the Directorate for Social Care and the National Care Service within the Directorate General for Health and Social Care of the Scottish Government. I have a Batchelor of Arts in Administration Management and a Master of Business Administration. I started my civil servant career on September 1985, starting in the Ministry of Defence as an apprentice engineer at Rosyth Dockyard before being recruited as an engineer in Royal Naval Armaments Depot (RNAD) Crombie in 1989. I was then promoted to a Professional and Technology Officer based in the RNAD Coulport, before returning shortly to RNAD Crombie and then moving to Kentigern House in Glasgow on promotion to a Higher Professional and Technology Officer to lead the policy team on vocational skills and learning.

2. I then transferred to the Scottish Executive as a B2 policy officer (which was a level transfer) to initially work in the central finance team. Although I do not have access to this date, I believe it was around the summer of 2000. I then moved on promotion as a B3 in a policy team within skills and lifelong learning, where during this time I was promoted to a C1 to lead the youth training team. I was then promoted to a C2 to lead the sports team and then was promoted to become the head of Active Scotland as a C3 on 4 August 2017. I then became Head of Health Protection Division on temporary promotion to a Senior Civil Servant (SCS) on the 1 May 2019 in Health

and Social Care. I do not have the exact start and end dates of these of all of these posts, but can confirm the chronology and details of these are accurate.

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-19 Inquiry Information Governance team to enable the statement to be completed. References to exhibits in this statement are in the form [DG/xxx-INQ000000].

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. Immediately prior to January 2020, I was the Deputy Director (on temporary promotion) to the Health Protection Division, within the Directorate of Population Health. This was a policy division which had responsibility for a range of health protection activities such as vaccinations, screening, organ transplantation, burials and cremations and the Public Health (Scotland) Act 2008 including part 2, notifiable diseases, notifiable organisms and health risk states, which includes provisions for the protection of public health in Scotland. I was also the programme lead for the establishment of Public Health Scotland and the Vaccination Transformation Programme. During the timeframe requested by the inquiry, I became a substantive Deputy Director (being promoted from the temporary position I was fulfilling) in August 2021 through a Senior Civil Service recruitment exercise.

6. During January to June 2020, I had policy responsibility for the initial response to the emerging pandemic, reporting to the Director of Population Health and engaging with colleagues across the Scottish Government. My role was primarily to support and advise Ministers, and in doing so I acted at all times in line with the civil service code to enable Ministers to make decisions by providing advice and at times recommendations in the form of Ministerial submissions. In doing so I formed judgements (i.e. made decisions) about what was to be included in that advice, how it was developed, presented and framed, as well as what recommendations I provided based on the evidence and my assessment of it. I also provided supporting material and information to ensure Ministers and others were fully briefed and aware of the

situation as it evolved. I did this guided by the four values of the civil service code: integrity; honesty; objectivity; and impartiality.

7. As the inquiry will be aware, particularly during the early stages of the response, it was a highly dynamic, uncertain and evolving situation. However, well established mechanisms of engaging with colleagues (including Scottish Government policy leads, clinical experts and colleagues in other Government Departments such as the UK Government) and supporting Ministers were used as part of the early response. From a personal perspective, this was the most challenging and pressurised period of my career in both trying to operate within an environment with extraordinarily high levels of ambiguity, coupled with working very long hours whilst dealing with a health-related pandemic which had a direct impact on the wider population, including my friends and family.

8. This personal statement covers the two primary roles that I undertook during the timeframe requested. Firstly, my role as the immediate public health policy response function which evolved over time between January 2020 and June 2020 and secondly, my role leading the team preparing for the deployment of a Covid-19 vaccine, and its subsequent roll-out, from June 2020 to November 2022. It should be noted that in this latter role I transferred to a new vaccines Directorate from February 2021 until July 2022. I note that there is a future model on vaccines, but in the interest of candour I have sought to provide information on both roles in order to assist the inquiry.

9. I would wish to put on record both my appreciation and respect for colleagues both within and outwith the Scottish Government, the NHS and wider delivery partners who responded to mitigate the impacts of the pandemic. And I would also wish to acknowledge the impact Covid-19 has had on individuals, families and communities within Scotland and beyond. The impact of the policy response is not lost on me and was an issue that was front and centre in my considerations in developing advice and engaging with Ministers and delivery bodies at that time.

<u>Context to experience pre-pandemic</u>

10. In order to assist the inquiry, I have set out my role prior to January 2020 to provide additional context, as this role had a bearing on my roles in relation to working on the Covid-19 response. From May 2019, I was appointed as the interim Head of the

Health Protection Division and worked closely with Scottish Government clinical personnel including Senior Medical Officers (SMOs), the Deputy Chief Medical Officer (DCMO), the Chief Medical Officer (CMO) and the National Clinical Advisor (NCD). I and the team of officials within the Division that I led, routinely engaged with clinical and policy colleagues across the organisation on both developing policy propositions (for activities such as redesigning how vaccines would be delivered) and the policy response (for things such as a health outbreak or a public health incident). This often involved seeking contributions from others across the Scottish Government to develop advice to Ministers, and also ensure clinical and policy views were clearly and accurately represented and used to inform any recommendation that was provided.

11. Furthermore, the Division I led had, prior to the pandemic, (in my opinion) effective links and relationships with key external personnel including, for example, colleagues in Health Protection Scotland (HPS) which subsequently became Public Health Scotland (PHS) once this organisation was established on 1 April 2020. These relationships and direct lines of communication proved to be a useful blueprint for how policy propositions and advice were developed over the course of the early response.

12. Prior to the pandemic, there was usually an opportunity to develop policy advice over a period of weeks or even months incorporating iterative or evolving clinical advice and enabling engagement with stakeholders and delivery partners to test any assumptions and evidence. This enabled an assessment of risk and deliverables on the deliverability or implementation of any policy proposals and was then reflected within the drafting process to ensure the final product (often a detailed submission to Ministers containing a clear recommendation) was fully tested. Due to the pace and highly dynamic nature of the early part of the response to the pandemic, there was limited opportunity to develop advice in this way. At times Ministers were provided with clinical advice directly either orally - in private or in meetings - from both Scottish Government clinical leads and bodies such as SAGE etc. and advice when provided was often delivered in hours rather than weeks.

<u>Early notification and engagement on emerging position</u>

13. The Health Protection Division (and specifically the health protection unit within this division) were the first point of policy contact in the Scottish Government on health

protection related issues. This unit operated on a 24 hour 'on call' system in order to receive any notifications or alerts from the health protection network which included Directors of Public Health (DPHs) or their on call Public Health Consultants within NHS Health Boards. The health protection unit received a notification by email and I believe a phone call on 8 January 2020, following a HPS NHS National Services Scotland (NSS) alert regarding a cluster of pneumonia of unknown aetiology in Wuhan City, China. I was then contacted by the 'on call' official within the health protection unit shortly after by phone and email in the evening of 8 January 2020.

14. From this point, this unit became the lead Scottish Government policy point for the engagement with HPS (who led the health protection network) and updating and advising Ministers accordingly. This unit and I were in regular contact with colleagues in the Department of Health and Social Care (DHSC) and from Monday 20 January 2020 this level of contact increased to daily via four nation phone calls between officials from the UK, Welsh, NI and Scottish Governments or administrations, given the evolving position in Wuhan. These meetings provided an opportunity to share information and included discussions on the early plans for repatriation of UK citizens. However, decisions on the latter were for the UK Government, given this was a reserved matter.

15. To support the effective flow of information, the health protection unit established daily phone calls with HPS from 22 January 2020, which (along with the other engagements such as the four nations calls) were used to develop briefing for the Cabinet Secretary for Health and Sport to attend the subsequent Cabinet Office Briefing Room (COBR) meeting on 24 January 2020 that was chaired by the Secretary of State for Health and Social Care. However, I recall officials and Ministers received the relevant papers immediately before the meeting (around 20 minutes before the call started), so there was limited opportunity to provide detailed briefing or an assessment of the content of these, which became a feature of the COBR meetings. I provided official support, which entailed attending the meeting, offering the Cabinet Secretary advice or clarification if asked and I took a note of the meeting. I was accompanied by the CMO (Catherine Calderwood) and the Director General of Health and Social Care (Malcolm Wright) and following this COBR meeting, I provided a written update to the First Minister. A copy of this is attached at [DG/001-INQ000249491]. This led to the Scottish Government Resilience arrangements being set up with SGoR(O) and SGoR(M) meetings being put in place by Scottish Government Resilience colleagues.

16. From 28 January 2020, I used the existing Deputy Director (DD) Plus Network for Health and Social Care which is a forum (often taking the form of a meeting) of the Deputy Directors and Heads of Divisions within the Health and Social Care DG family to discuss and share policy and organisational priorities. I used this to engage with all members to provide them with an update on the position in Wuhan as we understood it and encourage them to initiate the appropriate preparatory work for their respective policy areas. At that stage, information was still highly dynamic, but nonetheless colleagues were encouraged to use the pandemic flu plan as the basis to prepare. Given these meetings were monthly and attendance limited I set up a series of one-to-one meetings with a select number of Deputy Directors within the DG Health and Social Care. These included Deputy Directors who had responsibility for health finance, health workforce, social care etc. The purpose of these meetings was to explore preparations, but also discuss the potential for wider implications than those contained within the pandemic flu plan and help me understand potential interdependences with other policy areas. A screen shot of a meeting diary request is attached at [DG/002-INQ000222970].

17. I, or my Director Richard Foggo also attended the regular meeting of Scottish Government Directors on a Thursday each week to brief the wider leadership group within the organisation often accompanied by a senior clinical colleague such as the DCMO. The first record I have of attending these meetings was on 27 February 2020.

Informing and updating Scottish Ministers

18. The health protection unit provided daily briefings in the form of a situational report (SITREP) to Scottish Ministers from 27 January 2020, although there were occasions when the frequency of these increased to twice a day. An example of these from 3 February 2020 is attached at [DG/003-INQ000222971]. The rationale for providing these reports was based on my assessment that the pace and volume of information being received by my unit from a variety of sources (such as HPS, DHSC, clinical colleagues etc.) were such that Ministers and senior officials required a consistent and clear mechanism to receive information. These also formed part of the official record (held within the Scottish Government electronic filing system, eRDM), but these were used to share information rather than be used to seek decisions from Ministers or others. Although developed by my team, I usually cleared them before

they were circulated as I did with other key documents which others drafted such as parliamentary statements, submissions to Ministers etc. Copies of these can be provided, although I suspect the inquiry has access to all of these already through other sources.

19. I also oversaw the production of the relevant Scottish Cabinet Analysis of News and Current Events (SCANCE) notes relating to Covid-19 which were drafted by the health protection unit and issued to Ministers copied to senior officials. The first note was provided on 25 January 2020 and subsequent notes were then issued in advance of Cabinet meetings. My team also provided First Minister Question (FMQ) briefing notes which were also copied to senior officials and I led on the drafting of the first substantial Cabinet paper on this issue on behalf of the Cabinet Secretary for Health and Sport which was tabled on 10 March 2020. I attended this Cabinet meeting to support the Cabinet Secretary along with the CMO where this paper and the recommendations were agreed. I understand that the inquiry is likely to have access to this paper so I have not provided it as part of my statement.

20. From January to mid-March 2020, the health protection unit also provided drafts to Ministers and on occasions for the CMO for materials such as letters to the Scottish Parliament Information Centre (SPICE), briefings to committees and MSPs etc. For the avoidance of doubt, these were drafted or cleared by myself before being issued to Ministers (or if relevant the CMO) for final sign off. The unit also provided Ministers with supporting material for responses to parliamentary questions, debates, briefings with MSPs and committee appearances.

21. As part of the response, I commissioned the establishment of a dedicated Scottish Government electronic mailbox in January 2020 and a system to generate and circulate notes of meetings and desk instructions for the various functions being undertaken by the health protection unit, given new personnel were being drafted in from other areas of the Scottish Government to support this work. Up until early March 2020, I was the lead Deputy Director but supported by a range of colleagues across the Scottish Government and reporting to the Director of Population Health, Richard Foggo.

22. The flow of information set out above was designed to provide Ministers and others with the material and information they would need to understand the highly dynamic and evolving situation and be fully abreast of developments as well as providing a

formal record of the information flow. This approach was designed and implemented taking due regard of the need for it to be fit for purpose if the position were to deteriorate. The flow of information would prove to be important, given that this provided the context in which future advice was developed for Ministers to aid their decisions.

Preparatory activity between first COBR, and 1st Positive case

23. Following the first COBR meeting on 24 January 2020, the virus was being treated as a High Consequence Infectious Disease (HCID) and therefore advice to Ministers and the response was heavily guided by clinical input from HPS and the CMO drawing heavily on their existing guidance and protocols. My unit supported Ministers' engagement with parliament given there were a series of meetings, briefings, statements and parliamentary questions (PQs).

24. In parallel, my unit was often involved in (and at times led on) the commissioning and coordinating of actions resulting from meetings with Ministers, including from SGoR. This included, for example, increasing NHS capacity such as ICU and testing, the changing role of the Scottish Ambulance Service special operations response teams (SORT), developing protocols for the first death etc. Copies of the action logs can be provided if that would be helpful to the inquiry. My unit also led on the coordination of briefing on the reporting of Covid-19 deaths which included providing advice to Ministers in relation to enable reporting over the weekend of 5 and 6 April 2020 and a copy of this is attached at [DG/004-INQ000249493] by way of illustration.

Meeting with Secretary of State

25. On 12 March 2020, I supported the Cabinet Secretary for Health and Sport at a meeting with the Secretary of State for Health and Social Care that took place in the evening in person at St. Andrews House in Edinburgh. A copy of the note of this meeting is attached at [DG/005-INQ000222972], and the inquiry will note that this included a discussion regarding the difference in approach adopted by Scottish Ministers regarding restricting mass gatherings prior to the UK Government making this decision. The inquiry will wish to note that the rationale for this (as recorded in the meeting note) is set out below:

"…*The Cabinet Secretary for Health explained that it would reduce the pressure on emergency services, particularly police and the ambulance service who support these events at a time when they are likely to be in demand elsewhere.*"

26. The inquiry will also wish to note that there was a discussion on the need to communicate differently with vulnerable groups with a health condition. The relevant text in the record of the meeting is included below that illustrates this:

> "….*The Secretary of State for Health explained that the Prime Minister was very clear for the need to distinguish vulnerable groups and have a differentiated message. The Cabinet Secretary for Health outlined she was still of the view that we needed to treat vulnerable groups with a health condition completely differently to older people as the advice may need to be different.*"

Early Scottish Government structural response

27. The health protection unit worked closely with both the resilience team within the Scottish Government that operated and supported the Scottish Government Resilience function (often delivered through SGoR) and the Emergency Preparedness, Resilience and Response (EPRR) team within DG Health.

28. Prior to January 2020, the resource allocated to the health protection unit was around 1.6 people (1 full time B2, 0.4 of a C2 and 0.2 of my time). Therefore, prior to 16 March when this became a dedicated Directorate I reprioritised the health protection Division to release resource. But I also sought volunteers across the organisation to enable this unit to meet the increasing demands being placed on it and operate on a shift system within a dedicated office space within the Scottish Government building, St. Andrews House, in Edinburgh.

29. This unit grew to become a dedicated Directorate of around 150 staff with a broad range of responsibilities staffed with policy officials at various grades from 16 March 2020. In advance of this, I engaged with Donna Bell as the chair of the people and capability group in DG Health & Social Care to secure resources to support the response. Donna Bell supported this, which I understand included engaging with the Executive Team of the Scottish Government. Between January to March 2020, from

a personal perspective the ability for the organisation to pivot and reallocate resource by prioritising concurrent risk (along with the ability to reassess accordingly) is an issue worthy of further consideration.

30. From 16 March 2020, the newly created Directorate included additional Deputy Director capacity to support the response. Two Deputy Directors were appointed to manage the briefing function (Lesley Shepherd and Willie Cowan) with Daniel Kleinberg (a Deputy Director) working with me on the evolving policy response. Latterly, Daniel Kleinberg and I were joined by another Deputy Director (John Nicholson) and the three of us job-shared this role, until my departure to set up a vaccines Division in June 2020. During this time I and my fellow Deputy Directors reported to Donna Bell and Richard Foggo, who were the lead Directors for this newly established Directorate.

31. The activity of this new Directorate included overseeing the effective flow of information and providing advice to Ministers. My role was focused on the latter although this often involved scoping the extent of the policy challenge and developing a possible policy response before transferring responsibility to a team who were often drafted in at very short notice to refine the policy response and/or operationalise delivery. I, and my colleague Daniel Kleinberg and latterly John Nicholson were therefore often involved in the initial drafting of advice and developing presentations (for deep dives) on many of these issues, supported by a range of policy officials within the Directorate and beyond.

Advice on Testing including prioritising available capacity

32. As the inquiry will be aware, initially there was no test available for Covid-19. However Public Health England (PHE) starting Polymerase Chain Reaction (PCR) testing at their laboratory at Colingdale from early 2020. I have not been able to locate the exact date that testing commenced in this laboratory from my records. The criteria that informed eligibility for a test was based on the case definition (which evolved over time) which at the early stages of the pandemic included both symptoms and a travel history from defined geographical areas in which patients had travelled from. This therefore placed a priority on circulating the case definition as quickly as possible and the health protection unit supported this activity on behalf of the CMO and HPS.

33. Due to the logistics of sending tests to the laboratory at Colingdale and the demands on the capacity of this facility, there were early discussions with HPS colleagues to stand up laboratory testing facilities in Scotland. This was, in part intended to mitigate the delay of around 24 hours (and sometimes longer) before a clinician would receive the results of a test being sent to Colingdale. The first record I have of these discussions were on the 7 February 2020, and related to facilities being stood up in Glasgow and Edinburgh, which came on stream from Monday 10 February with Glasgow having the capacity to process 250 tests per day and Edinburgh 100 tests per day. Dundee followed shortly after bringing the total capacity to 780 tests per day by 18 March 2020.

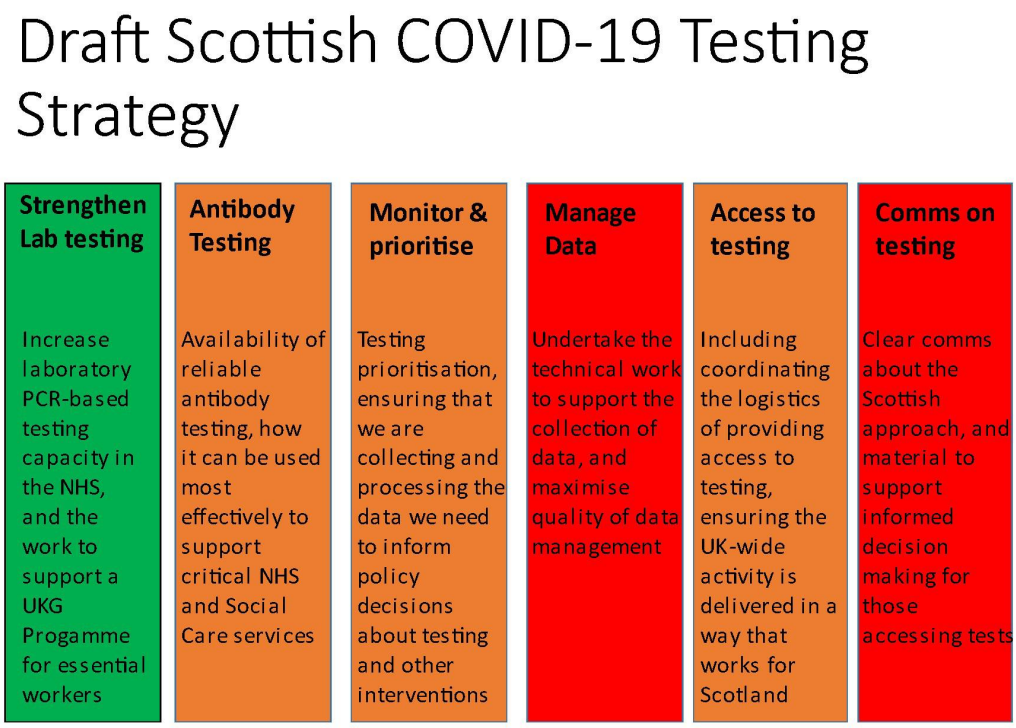
34. But there was an explicit recognition that despite efforts to increase capacity, there was a risk that demand would outstrip supply and on that basis I drafted advice to Ministers on 18 March 2020 regarding prioritising available capacity which included an approach to testing and monitoring following the decision to move from containment to delay in response to the outbreak. On that basis the advice recommended increasing testing capacity, developing a surveillance system and prioritising critical and key workers. At that point however, there was no agreed definition of these workers so the advice defined these as:

    - *Critical workers refers to workers who are needed to perform certain functions where, if these functions were not performed, even for a short period of time, and requiring a physical presence, serious damage to the welfare of the people of Scotland could be caused. This will refer to certain workers directly involved in Covid-19, but also to workers who are essential in keeping the country running. We would anticipate there would only be a small number of resource groups and associated numbers of people in this category.*
    - *Key workers refers to workers who are needed to perform certain functions where, if these functions were not performed, there could be a significant impact on Scotland (but where the response to Covid-19, or the ability to perform essential tasks to keep the country running, would not be severely compromised).*

35. The basis of prioritisation was formed on a recognition that even with the planned expansion of tests to approximately 2,500 to 3,000 tests per day by late April it would be necessary to ensure that capacity was used to best effect taking account of the

increase in demand for patients. Therefore, the advice proposed that prior to testing either critical or key workers, testing would be prioritised for clinical cases up to a given point on the epidemic curve, specifically for whom the result will influence clinical management and infection prevention. A copy of this advice is contained at [DG/006-INQ000222973].

36. I and my unit then coordinated the development of a deep dive presentation with the First Minister (FM) and the Cabinet Secretary for Health and Sport on 3 April and a copy of the deep dive and the agenda is contained at [DG/007-INQ000249327] and [DG/008-INQ000222974]. The inquiry will note that this deep dive set out the proposed elements of a strategic testing strategy as set out below:



37. The priority as set out in this deep dive for the utilisation of testing was to: 1) direct our testing capacity effectively to save lives and protect the vulnerable; 2) enable critical staff to return to work; and 3) undertake surveillance. This strategic framing guided the operationalising of testing with activity such as developing a 'lighthouse laboratory facility' being handed over to a different policy lead (Ian Davidson) who then led on operationalising delivery of the expansion of testing from that point.

Care home testing

38. Following the deep dive with Ministers, a testing delivery plan was developed and the monitoring of the expansion in capacity (as outlined) monitored and reported to Ministers. I have not provided this as I cannot recall being directly involved in the development of this plan, but as outlined above, this plan was predicated on an ability to deliver between 2,500 and 3,000 PCR tests per day by late (27) April 2020.

39. During this time, testing remained only available to patients (who met the case definition) and key/core workers, as per the advice of 18 March 2020. However, demands for testing to be extended to others remained and I coordinated the drafting of advice on behalf of the then DG Health and Social Care Elinor Mitchell, which was submitted to Ministers on the 20 April 2020. This included advice on testing residents prior to admission in a care home. I have attached a copy of this advice at [DG/009-INQ000249330], but I have done so as the inquiry may not have this via a witness statement given Ms Mitchell is deceased. This advice incorporated the clinical view from the CMO and the following extract from the submission summarises this as:

> "*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*."

40. The inquiry will note that the submission includes an annex summarising the clinical advice from the CMO, Chief Nursing Officer (CNO) and HPS. The recommendation of the submission asks Ministers to:

> "*Confirm whether you wish us to move now to a policy which would see us start to test everyone prior to admission to a care home (in addition to self-isolation for all such individuals), or whether you would prefer the newly established short life clinical task group on care homes to rapidly revisit the utility of admission testing in the wider context of guidance on an 'admissions package' and broader testing regimes*."

41. There was a parliamentary statement the following day (21 April 2020) and the Cabinet Secretary for Health and Sport informed Parliament that individuals would be

tested prior to admission to a care home. This statement included a requirement for all Covid-19 patients who are discharged from hospital to a care home to have two negative tests before discharge and all other new admissions to care homes be tested and isolated for 14 days. Details of this are contained at [DG/010-INQ000222975].

Expanding Capacity to respond

42. During March to June 2020 I, along with Daniel Kleinberg and John Nicholson worked closely with colleagues in various organisations to support the scaling up of capacity to provide a seven day service to ensure they could meet future potential demand. This included, for example, working with National Records Scotland (NRS), Convention of Scottish Local Authorities (COSLA) and the relevant Scottish Government policy officials on their ability to register deaths and to enable the public to do so remotely if required. I was also involved in working with PHS on their process for developing and publishing clinical guidance and supporting policy colleagues who were working with the funeral industry on the need for them to scale up and operate to meet potential demand. Some of these issues, but not all, required decisions by Ministers.

Scotland v France Rugby match, First case and the Nike conference

43. You asked I provide information in relation to the six nations Scotland vs France rugby match that took place in Murrayfield, Edinburgh on 8 March 2020. I can confirm that clinical advice was provided to Ministers from the CMO following consultation with HPS, with additional advice being provided from colleagues in Active Scotland Division regarding potential mitigating actions and economic impact. My unit supported CMO in the drafting of this advice, but the submission did not come from me nor my team so I have therefore not provided this given it is likely to be included in the former CMO's personal statement.

44. In relation to the first positive case, I and my team led on the coordination and briefing activity to Ministers of the tracking and whether any of the suspected cases being tested were positive during February 2020 and informed Ministers of the first confirmed case in Scotland on Sunday 1 March 2020. The inquiry will be aware that this first confirmed case was within the NHS Tayside Board area which was travel-

related with the patient having returned from Northern Italy. I was the Scottish Government point of contact and received notification from HPS, via a phone call and I then informed Ministers and senior officials via an email very shortly after being notified. Given the nature of this alert, I phoned the private secretary of the Cabinet Secretary for Health and Sport and I also texted the Permanent Secretary and the DG Health and Social Care to ensure they were aware of the email that had been sent. I then attended the Incident Management Team (IMT) convened by NHS Tayside remotely as an observer and attended and briefed Ministers in person at the SGoRR meeting convened later that evening in St. Andrews House which was chaired by the First Minister.

45. In relation to the request regarding the NIKE conference held in the Hilton Carlton hotel, Edinburgh between 25 and 27 February 2020, my unit were responsible for the coordination and briefing activity in relation to the consequences of this event linking in closely with HPS who led on the clinical management of this outbreak. In relation to the policy response, decisions on this matter were limited to how Ministers communicated with the public, given HPS were the lead body managing this clinical incident. On this point, I recall there was concern from clinical colleagues that patient confidentiality could be breached should detailed information be made available and therefore the advice to Ministers was urging caution regarding the level of information to be shared.

Lockdown and herd immunity

46. The Cabinet paper I drafted, with input from others, which was agreed on 10 March 2020, drew heavily on the range of options SAGE had reviewed and recommend be implemented in a phased approach, based on the reasonable worst case scenario at that time. This cabinet paper did not consider a full national lockdown and therefore the options set out fell short of this. The options outlined were designed to slow the spread of the virus and were based on the evidence that was available at that time.

47. In relation to the request regarding herd immunity, I can confirm that the Cabinet paper included a reference to herd immunity in the context of increasing levels of natural immunity through infection based on the projections of spread of the virus over time, rather than a strategy or intended aim in its own right. I seem to recall the prevalent thinking that informed this Cabinet paper was drawn from SAGE deliberations which, in relation to restrictions, highlighted concerns that should

maximum restrictions be put in place in Spring 2020, there would be a second and greater wave of infection later in the year due to a prospective lack of compliance by the general public at that time.

48. I do not recall either Scottish Ministers, senior clinical advisors or any policy official in any of the meetings I attended, or Ministerial advice that I saw, considering a proposal to achieve herd immunity by enabling the virus to spread in an uncontrolled manner as a strategy.

49. At the time of the COBR meetings of 16 March 2020 on partial restrictions and the 23 March 2020 when lockdown was announced, I was not directly involved in the briefing or support to Ministers at these meetings so I am unable to provide evidence or offer a view on this. I do recall though that, similar to other COBR meetings, papers were shared immediately before the meeting with limited opportunity to provide briefing to Ministers. The inquiry may wish to note that for these specific meetings, I was not personally with Ministers, in part as I had chosen to self-isolate from Sunday 15 March as my wife had symptoms of Covid-19. Although this was prior to universal testing being available so it was not possible to confirm if she was positive. I chose to self-isolate as a precautionary measure given the risk that should I have the virus, I could have infected others who were critical to the Scottish Government response. During this period of self-isolation, I was working remotely and did not display any symptoms of Covid-19.

Policy lead for a Covid-19 vaccine

50. The decision to create a Covid-19 vaccine Division was taken by Directors Richard Foggo and Donna Bell in June 2020 at a time when there was a desire to bring additional structure and create Divisions with clear areas of defined policy responsibility. On that basis I was asked to lead a Division to prepare for the future deployment of a vaccine, but this was well in advance of any vaccine being available. This was in my view a really important decision as resource was set aside to prepare despite full knowledge that the development and deployment of vaccines has historically taken years rather than months to come to fruition.

51. In my capacity as head of Covid-19 vaccines, I adopted a role which was beyond a pure policy function in that I had considerable delivery oversight given the impact the operationalising and delivery would have on the ability to respond to the pandemic.

Therefore, my role throughout the vaccine programme was twofold. Firstly, to lead the policy response and secondly, to fulfil the role of Senior Responsible Officer (SRO). The role of the latter involved me creating links (and a relationship) with colleagues throughout the UK and it was agreed with my Director (initially Richard Foggo and then Stephen Gallagher) that there would be value in me fulfilling this role throughout my time leading the Covid-19 vaccine Division.

Structural response to a Covid-19 vaccine

52. Following being appointed as interim Deputy Director for Covid-19 vaccine in June 2020, I recruited a small team which evolved over time to become a Directorate in February 2021 led by Stephen Gallagher. I was supported for a short period (between December 2020 and March 2021) by interim Deputy Director Marion McCormack and Deputy Director Jamie McDougall, who led on inequalities and on all other existing immunisation programmes (between December 2020 and August 2022).

53. There were five Delivery Directors appointed through my time on the Covid-19 vaccine programme. In chronological order these were: Caroline Lamb; Paul Hawkins; Colin Sinclair; Karen Duffy; and Nuala Healy. I do not have the exact dates of their tenure as this information is held by the Programme Management Office (PMO) within NHS NSS and I am unsure if they have yet transferred this information to the Scottish Government. The Delivery Director had operational responsibility for the delivery of the Covid-19 vaccine programme, although key operational and delivery decisions were guided by the policy and if necessary were taken by Scottish Ministers. The way in which Ministers took any decisions was based on advice provided by the Covid-19 vaccine Division, in conjunction with the Delivery Director (and their team) and often with input from clinical colleagues such as DCMO, CMO etc. and if appropriate other policy officials across the Scottish Government.

54. During the whole period of the Covid-19 vaccine programme, there was a dedicated programme management office function to track actions, identify and manage risk and ensure deliverables were achieved. This was discharged by a support team from NHS Nation Services Scotland (NHS NSS). The programme also included a virtual team of clinical, delivery and policy colleagues which included logisticians, digital and technical leads, analysts, nursing and workforce leads and a series of delivery leads seconded to the Scottish Government. At times others were brought into this virtual

team such as other Scottish Government officials, local authority and third sector leads and, when appropriate, the military.

Preparatory work in advance of a vaccine

55. Between June and December 2020, when a vaccine became available, my focus was on both engaging with delivery partners to support them in preparing for deployment (predominately with NHS Scotland) and creating the links necessary with policy and delivery colleagues in other parts of the UK and in NHS England and NHS Wales. During this period the vaccine division established a Flu Vaccine and Covid-19 Vaccine (FVCV) programme board which met for the first time on 27 July 2020. My role was to develop the scope and remit of the programme board, identify members and provide the resource necessary to provide a secretariat function, which was discharged through NHS NSS on the behalf of the Scottish Government. The rationale for including seasonal flu was based on the potential impact a prevalent season of flu would have if this were to coincide with high levels of Covid-19 and/or a new variant of concern. On that basis, advice was provided to Ministers to have an expanded flu programme during 2020/21 and this programme oversaw how this would be operationalised.

56. The FVCV was initially chaired by Richard Foggo (between July 2020 and February 2021, Stephen Gallagher (between February 2021 and April 2022) and then myself (between April 2022 and November 2022). The purpose of the FVCV programme board was to provide oversight and assurance to Scottish Ministers. A copy of the terms of reference are attached at [DG/011-INQ000222976]. I frequently attended FVCV meetings to provide a policy update, which could include for example sharing learning from discussions with the other UK nations of their plans, providing progress of vaccines trials, the latest assessment of vaccine availability and if available any updates on emerging thinking from the Joint Committee on Vaccines and Immunisation (JCVI). All of the meetings were minuted, and I am sure can be provided if required.

57. The programme board and the delivery group which reported into it, which was chaired by the Delivery Director met frequently with I or my team attending all meetings and were often active participants. My team also led on the briefings for Ministers which were frequent and sometimes took the form of presentations and/or formal advice via submissions. These provided an opportunity to both update

Ministers on any information on things such as the clinical trials of the various vaccines that were in development from MHRA and others, evolving JCVI thinking, procurement plans from the UK vaccine taskforce and developing deployment plans.

58. It is important to note that up until early to mid-November 2020, there was a general consensus from numerous sources that it was unlikely that a vaccine would be available in 2020 and the general view was that it would be more realistic to plan for one being available in early 2021. However, planning for the deployment of a vaccine within Scotland (and elsewhere in the UK) sought to ensure the infrastructure and capacity was available if a vaccine were to become available earlier than this - which proved to be invaluable.

Policy function of the vaccines activity

59. As outlined above, my team and I provided advice to Ministers on the development and deployment of the Covid-19 vaccine. This included a Cabinet paper prior to deployment on 1 December 2020 which set out the policy objectives the programme would seek to deliver. This guided how the programme would be operationalised in Scotland and it proposed that any prioritisation of cohorts recommended by the JCVI which would be based on clinical risk would be followed, and that a Human Rights based approach would be adopted. This led to the design of the delivery infrastructure and approach that explicitly sought to ensure under-represented groups' and communities' needs were met.

60. This Cabinet Paper set the high level policy outcomes being sought and was tabled and agreed prior to the first vaccine being deployed. But beyond the high level policy, there were a large number of subsequent submissions and advice provided to Ministers throughout the deployment to seek Ministers' agreement to follow and operationalise JCVI advice. Therefore, each time the JCVI offered advice, Scottish Ministers were provided with detailed advice setting out the issues and providing a recommendation. This often included advice on how both interpretation and details of how JCVI advice could be operationalised along with an outline of any risks and how these would be mitigated.

61. However, there were also occasions when JCVI were silent on an issue and therefore advice was provided to Ministers by the Covid-19 vaccines Division to address any identified gaps. This advice was developed in consultation with clinical

and other policy officials across the Scottish Government and on numerous occasions included the use of a policy forum that was established by my team. This was not a decision-making forum, but a mechanism to draw together internal policy and clinical colleagues to help inform the development of advice to Ministers. But this also proved a useful mechanism to support other Scottish Government colleagues to help them engage with their policy specific stakeholders and delivery partners to explain why a particular approach was being taken on the deployment, prioritisation or timing of the vaccine programme.

62. As well as submissions to Ministers providing advice to inform decisions on both the policy position and details of operational deployment, regular written updates were provided on at least a weekly basis to Ministers and senior colleagues. This was complemented by a regular series of presentations and 'deep dives' with Ministers including on occasions the First Minister. My Divisions role included supporting the development of these presentations and attending the meetings, albeit in a virtual capacity. I do not have copies of these as again they were provided by the PMO function, but can be made available should they be required. Over and above this, my Division provided official support to the Cabinet Secretary for Health and Sport on all Ministerial engagements with other UK Ministers on Covid-19 vaccine-related issues.

63. The Covid-19 vaccines Division was also responsible for the development and publication of a number of vaccine deployment plans of behalf of Scottish Ministers, which set out the plans for deployment in Scotland and updated Parliament and others on the progress being achieved. These were all submitted to the Scottish Parliament and my team drafted these as well as all vaccine-related PQs, FMQs, letters to MSPs and the Scottish Parliament Information Centre (SPICe) briefings on behalf of Scottish Ministers. The Division also provided briefings and supporting materials to Ministers for parliamentary debates, committee appearances and any technical briefings to Parliamentarians. There were a number of lessons learnt exercises undertaken which I and the vaccine division were involved in following the various stages of the vaccine programme as well as providing evidence to an Audit Scotland review which led to them publishing a report on the early stage of the deployment programme. The latter is publicly available [DG/012-INQ000222977].

Modelling and communications

64. In relation to support the operational deployment of the vaccine programme, I along with the vaccine delivery director often commissioned substantial modelling and analytical support to provide options to Ministers on the most effective way to operationalise JCVI advice. This was undertaken via analytical colleagues in the Scottish Government, but also with organisations such as PHS.

65. In relation to public health messaging and communications, for vaccines that was led by officials in my Division who (working with Scottish Government marketing colleagues) supported the development of campaigns that were highly dynamic in nature to explain and support vaccine deployment. This included extensive customer insight research to understand the effectiveness of the communication methods used and if necessary amend these accordingly. This worked extremely well and was used alongside daily analysis of vaccine uptake (including by different cohorts) and the use of feedback from the vaccine helpdesk operated by NHS NSS and NHS inform operated by NHS24 which proved to be a rich source of information to allow the team to gauge the effectiveness of any communications activity. Therefore the effectiveness of communications was often assessed in close to real time and led to the refinement of both the messaging but at times the delivery mechanisms.

Operationalising JCVI advice

66. There was often a time lag between JCVI providing advice and being able to operationalise their advice, due to the need to take the actions required to ensure effective deployment. This included, for example, providing the materials and support (including training) of the vaccination workforce, consent material for patients, practical logistical arrangements for venues and the call-up arrangements for individuals. To put this into context, pre-pandemic advice on seasonal flu was often received in December of the year preceding the traditional flu season in Autumn. This therefore provided 9 to 10 months to secure the vaccine and plan and prepare the operational deployment of this immunisation activity. During the Covid-19 programme the time between receiving advice from JCVI and deploying the vaccines was reduced to around 7 days.

67. This did however, require extensive activity to be undertaken at pace necessitating close and effective working relationships with NHS Health Boards, clinical leads and others. This enabled, for example, the production of training materials for staff, consent products for patients and digital systems to invite eligible patients to receive

an appointment or be encouraged to attend a vaccination centre. In my experience, the virtual team approach adopted by the vaccine programme enabled all partners to achieve this, although at times it did place considerable pressure on a relatively small number of key personnel and required them to work very long hours. However, as far as possible, scenario planning was used to help support what was in my view a highly dynamic and responsive deployment model and a high performing team.

Engagement with other nations in the UK on Vaccines

68. As the lead policy official on vaccines within the Scottish Government and the SRO for the programme, I took part in regular (often weekly) meetings with senior policy and delivery colleagues in the other UK nations. This provided an opportunity to share learning on vaccine deployment and during this time there were strong and effective relationships developed coupled with a reasonably high level of trust. This included, for example, the sharing of evidence and material with fellow Government officials as part of drafting of advice to our respective Ministers and sharing, in confidence, emerging thinking from bodies such as the JCVI to facilitate scenario planning. It also provided an opportunity for each nation to provide evidence on the operational implications of an issue which the JCVI was deliberating. However, it should be noted that this evolved over time, as initially although Scotland had two observers on the JCVI, officials were not always involved in the discussions between the JCVI nor the secretariat and the DHSC. The formal governance of the JCVI (who report to the Secretary of State) has not been updated post devolution and this therefore is perhaps an issue worthy of further exploration at some point in the future.

69. Engagement with colleagues in Wales, Northern Ireland and England also provided an opportunity for detailed discussions with colleagues in the Department for Business, Energy and Industry Strategy (BEIS) and the vaccine taskforce which had responsibility for the Covid-19 vaccine supply, storage and distribution. Through this engagement, an agreement was reached by all nations' respective Ministers on the allocation of supply for each nation. This was an area which worked particularly well with a high level of flexibility regarding the phasing of supply to align as best as possible to each nations' deployment plans. This also reduced the level of vaccine wastage, which was a key consideration given the limitations of the initial supplies. There was also a good and effective working relationship with the security SRO and their team from the Home Office which supported operational planning and deployment.

70. As the SRO, I was also involved in detailed (and at least weekly) meetings with each nations' SRO to discuss our respective operational deployment plans. This was a highly trusted environment with each SRO sharing the detail of their respective plans and rationale, and highlighting potential concerns and learning from their deployment experience. Whilst there was no explicit requirement for all nations to adopt the same approach, nor adhere to the same timeline, these meetings were often used to understand each nations' intention and importantly ensure communications and messaging took due regard of any differences. There was also an informal but helpful challenge function undertaken through these meetings, which is something I personally valued.

71. Outwith these meetings there were also exchanges with the SROs on the operational implications in relation to cross-border issues using mediums such as emails, Microsoft Teams and phone calls, which became more prescient during certification as proof of vaccination became a condition of foreign travel for many countries.

Clinical Governance

72. To support the deployment of the vaccine, PHS established a formal clinical governance group which both reported to and informed the deliberations of both the vaccine delivery group and the programme board. But this group was also used to develop and shape advice to Ministers on issues such as responding to an adverse clinical event of any vaccine as reported through the Medicines and Healthcare products Regulatory Agency (MHRA) yellow card system. As the inquiry will be aware, the yellow card system was used to report suspected side effects to medicines and vaccines adverse incidents for the Covid-19 vaccines. Beyond this the clinical governance group also provided a clinical view to inform the development of advice on an issue the JCVI were either unclear or silent on.

73. This proved to be a useful forum in providing clinical advice to shape deployment and advice to Ministers and I believe is now a legacy of the approach taken to the oversight of all immunisation programmes in Scotland.

Personal view on timeliness of lockdown decision and other NPIs

74. As indicated above, I was not directly involved in the receipt of evidence to inform the respective COBR meetings which discussed and agreed the lockdown decisions, although I was involved in the meetings and production of advice leading up to these. It remains my view that the evidence being received during the period of time I was directly involved was highly dynamic in nature and the understanding of how the virus was transmitted (including asymptomatic transmission), the case definition, the impact on particular groups (including at risk) and the severity of the symptoms were all evolving. The coronavirus action plan agreed on 2 March and the subsequent series of measures proposed by SAGE, as set out in the Cabinet paper of 10 March 2020 (which fell short of a full lockdown) were in my opinion proportionate given the evidence that was available at that time. However, in relation to the timeliness of the specific decision to implement a partial or full lockdown this is not an issue I feel able to offer a view on.

75. I can confirm that the pandemic flu plan was used as the predominant blueprint for the very early stages of the Covid-19 outbreak. There was however, recognition that whilst not directly comparable, it contained useful tools that had been well rehearsed by Governments and partners during various exercises. However, as I've outlined above, my discussions with a number of Deputy Directors across Health and Social Care explicitly raised the potential for the need to plan beyond the parameters of the pandemic flu plan in mid-February 2020. It should also be noted that the coronavirus action plan was developed at pace as the evidence of Covid-19 came to light, and this then superseded the pandemic flu plan. I recall the coordination of policy contributions for the coronavirus action plan being undertaken by colleagues in the Scottish Government resilience unit. I provided a contribution to the drafting of this plan, although it was undertaken at pace over the weekend of 29 February and 1 March in advance of being agreed at a COBR meeting on 2 March 2020. A copy of my comments in relation to this draft plan is attached at [DG/013-INQ000222978]. I cannot comment on the decisions made on lockdown in January or September 2021, as by that time I was leading the vaccines activity and not directly involved in the other elements of the Covid-19 response.

76. I can confirm though in relation to the first lockdown I am not aware there was a framework in place to enable the consideration of the wider impacts of non-pharmaceutical interventions (NPIs) or their specific implications on under-represented groups beyond the direct clinical impact. This was resolved latterly

through the adoption of a Four Harms framework, to guide advice to Ministers and frame any recommendations.

WhatsApp and texts

77. During the early part of the response in 2020, I was part of a number of SMS text and WhatsApp groups used to quickly share information with colleagues. These included a group SMS text and/or WhatsApp chat with HPS, myself and the CMO. I do not have the names of these groups or exactly which individuals were members of these groups. I can confirm that neither texts or WhatsApp groups were used as the sole means to seek decisions from Ministers. However, I do recall there were occasions when this mode of communication was used to convey lines for a media enquiry or provide information in real time during a meeting given I or my colleagues were often supporting Ministers remotely. Similarly in relation to vaccines, there were similar communications groups for officials and the SROs and the virtual delivery team from the FVCV programme.

78. The purpose of these WhatsApp groups was to quickly disseminate information to relevant personnel and at times develop responses to media enquiries out of hours. But my recollection of the use of this medium was that if there were any critical information shared via this route, I or my team within the health protection unit would follow this up with an email to relevant policy officials or if appropriate, to Ministers and this was retained on the corporate file. That was particularly true if Ministers were being asked for a view on a decision or a critical piece of information was passed through this route in which Ministers needed to be alerted to. As illustrated when I was contacted by HPS regarding the first positive case as this was followed up by an email and in parallel I phoned and texted relevant officials to make them aware of this issue. These follow-up emails were copied to either the Scottish Government coronavirus mailbox that was created in January 2020 or the vaccine mailbox, as were relevant policy interests and senior officials, and are part of the official record within the Scottish Government electronic filing system.

79. I do not have access to these WhatsApp messages as I left a number of these groups and for those that I remained in there is an auto-delete function enabled. I can confirm though that I did not deliberately delete these to hamper the progress of this or any other inquiry. Rather, I did not back these up and my phone has been through a number of upgrades so these (as far as I can tell) are not recoverable.

However, it would appear that my SMS messages may have been backed up, but I am in the process of seeking support to recover these and should I do so I shall of course provide these to the inquiry.

80. I have access to my emails during my time saved as part of the corporate record on the Scottish Government electronic filing system.

Key Challenges and Learning

81. You have asked me to consider whether the Scottish Government appreciated the seriousness of the threat of Covid-19. Before I respond to this it would be appropriate to highlight that a key challenge in relation to the very early part of the response (January to March 2020) was a lack of evidence of the virus, compounded by an incomplete understanding of the severity of its impact. On balance I believe those involved in the direct response from within the Scottish Government did appreciate the gravity of the situation as it was evolving.

82. There were however capacity constraints influencing the ability to deal with a pandemic and a time lag to develop and deploy the response at a sufficient scale to become fully effective. The pivoting of resource to support this took time and there was a period during which there was a high reliance on a small number of critical personnel such as policy and clinical officials within the Scottish Government and clinical leads in HPS. This resulted in a number of personnel working long days 7 days a week for a prolonged period of time and under high levels of stress. The core team of Scottish Government officials and HPS colleagues were dealing with multiple, complex and challenging issues concurrently often trying to both understand the issues at hand and developing a potential policy response for a novel coronavirus pandemic which had never been encountered in recent times. Importantly, the evidence was continually evolving which required assumptions or former understanding to be frequently revisited in light of new evidence within a highly dynamic environment.

83. I have also been asked to reflect on what worked well and whether there were any missed opportunities in relation to Covid-19 public health communications. I am not a communications expert so I am not sure I am able to offer an informed view, but on a personal level I have reflected on the impact an earlier public health issue during 2019 had on our collective approach to public health messaging. In June 2019, I and

my team were involved in a public health issue in NHS Lanarkshire where there was concern from parents and the public regarding the possibility of the water being contaminated within Buchanan High which was a large secondary school in the Coatbridge area. Public health officials from the local Health Board met with the parents and the wider community which included local public health leads addressing a large community meeting but this did not satisfactorily address the concerns of the community.

84. It is my belief that this had an impact on the Scottish Governments and Scottish Ministers' approach on how to engage with the wider public on Covid-19. Not least as the approach to communication through Covid-19 explicitly took due regard of peoples concerns and worries and did not adopt an overly clinical approach. The approach was also based on being really open about what the Scottish Government did not know as much as what they did. I believe during the event in 2019, members of that local community felt that the approach to communicating with them on the risk of contaminated water was very clinical and dismissed or at least diminished their concerns which in turn fuelled further anxiety and concern.

85. I have also been asked as to whether any breaches of rules had an impact on public confidence in the Scottish Government response. I do not feel able to offer a view on this as I was not directly involved in the research of communications activities in relation to compliance of NPIs that both assessed and informed the Scottish Government's approach.

86. On a personal level, I have reflected on the demands placed on the relatively small number of vaccine policy officials (by Scottish Ministers beyond Health and their officials) conveying their stakeholders' view on the policy position agreed through the Cabinet paper tabled and agreed on 1 December 2020 on issues such as prioritisation. This proved to be time-consuming, and at times detracted in the ability for the policy team to fully focus on deployment and is something therefore worthy of further consideration.

87. Notwithstanding this, the ability of multiple stakeholders and partners to work in a collegiate manner as part of the response over 2020 in my view created the conditions for the dramatic scaling up of the deployment infrastructure needed to deploy the Covid-19 vaccine at pace. Specifically for the deployment of the vaccine this was underpinned by a very strong culture of collaboration and support with

partners and that was particularly true of the collegiate approach taken between policy officials, specialists such as clinicians, local authority colleagues, the third sector and many others. The well-established mechanisms to engage with four nations colleagues at policy and delivery level, underscored by trust and respect, also contributed to an extraordinarily successful vaccine deployment programme in all areas of the UK.

Statement of truth

88. 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: _____8 November 2023_____