Witness Name: Jacqui Reilly
Statement No.: 1
Exhibits: JR
Dated: 05.12.2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF JACQUI REILLY

In relation to the issues raised by the Rule 9 request dated 17/08/23 in connection with Module 2a, I, Jacqui Reilly, will say as follows: -

1. I am Jacqui Reilly of Gyle Square, 1 South Gyle Crescent, Edinburgh, EH12 9EB. I am Professor of Infection Prevention employed by Glasgow Caledonian University and Director of Nursing employed by NHS National Services Scotland (NSS). In my university role I am the co-lead for the Safeguarding Health through Infection Prevention (SHIP) group, which is based in the Research Centre for Health. This is an academic leadership role which contributes to the research centre and group strategy, and I am also involved in research and supervision of PhD students. In my NHS role, I am employed as a Director for Nursing which includes Executive leadership for Allied Health Professions. This is a professional governance role and under a memorandum of understanding, I also provide that service for Public Health Scotland (PHS). As a member of the Executive Management Team in NSS I have executive leadership responsibilities related to quality improvement, healthcare associated infection and whistleblowing. I am not, nor have been, employed by the Scottish Government. The work of the Scottish Government and UK groups I was involved with during the pandemic was unpaid and provided pro bono via agreement with my employers.

2. I have prepared this statement myself with assistance from the Scottish Government COVID Inquiries Response Directorate. I have referred to documents and factual information provided by the Scottish Government COVID-19 Advisory Group (referred to as 'SGCAG' by the UK Inquiry) Secretariat and the COVID-19 Nosocomial Review Group (CNRG) to assist with the preparation of my witness statement. A solicitor has also reviewed a draft of my statement.

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

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

5. The scope of this statement relates to that described in Module 2a and my role in the pandemic response detailed in the scoping questionnaire previously submitted to the Inquiry [JR/001 – INQ00217360] .This relates to being a member of the SGCAG, chair of the CNRG which fed into SGCAG, a member of the Public Health Threats Assessment Group (a sub group of SGCAG) and attending the UK Scientific Advisory Group for Emergencies (SAGE) sub group; the Hospital onset COVID-19 Working Group (HOCWG).

6. I have answered the questions put to me by the Inquiry to the best of my ability. Where I am unable to answer the questions posed, for example because the question falls outside my area of expertise or the events I am asked about took place before I joined the SGCAG on 23/04/20, I have informed the Inquiry of this and the reasons why in accordance with the instructions outlined in the Rule 9 request. I would also note at the outset that the Inquiry has asked me to comment specifically on the rationale for various policy decisions of the Scottish Government. While I am able to comment on relevant advice given by the SGCAG on certain matters, and areas relating to my expertise in healthcare associated infection, I should make clear that any comments I can make on government policy are limited as the role of the SGCAG and its subgroups was to provide scientific advice and these groups were not involved in making policy decisions.

Sources of advice: medical and scientific expertise, data and modelling

Your roles and responsibilities

7. My role in giving advice during the pandemic was as chair of CNRG. It was in this capacity I was a member of the SGCAG. I was asked to chair CNRG by the Chief Nursing Officer (CNO) Scotland [JR/002 – INQ000000] given my expertise in the field of healthcare associated infection (HAI), commonly referred to as nosocomial

infection. This was based on my previous roles within the NHS as a specialist in HAI and Antimicrobial Resistance (AMR) in Health Protection Scotland (HPS) and my current academic role in Glasgow Caledonian University as a Professor of Infection Prevention. My academic qualifications, registrations and outputs have been provided to the Inquiry.

8. The invitation from the CNO invited me as the Director of Nursing in NSS and stated that the work would be led and driven by the Antimicrobial Resistance & Healthcare Associated Infection Scotland (ARHAI Scotland), who are the national experts for nosocomial infection and are based in NSS. ARHAI Scotland collected, analysed and published data and evidence reviews on healthcare associated (nosocomial) COVID-19 in hospitals during the pandemic and were members of the CNRG. An epidemiological situational report and evidence reviews were presented by ARHAI Scotland at each meeting and evidence reviews to underpin CNRG advice. Advice from CNRG was shared by me with SGCAG to inform advice being given as it related to healthcare associated COVID-19, and I provided SGCAG with updates on the work of CNRG at their meetings. These CNRG updates are recorded in the minutes of SCGAC meetings made available to the Inquiry.

b) Principles/policy behind the use of medical/scientific advice in the Scottish COVID-19 pandemic response

9. The overarching principle in giving advice was that best available evidence based scientific advice was given. The remit of these groups in this respect was defined in the Terms of Reference (TOR) [JR/003 – INQ000000] [JR/008 - INQ000217755]. I am not aware of the principles used for decision making by the Scottish Government.

10. It was my understanding that ministers and advisors would be receiving advice from other advisory groups and make policy decisions in the light of all evidence presented to them. I had no personal involvement in the process beyond that described in the TOR for the SGCAG. How this was factored into decision making by the Scottish Government may best be addressed by Chief Medical Officer (CMO) and CNO.

11. I had no involvement in government decision making or evaluating the effectiveness of that decision making and was not aware of all the evidence they had available to them in making their decisions. I was aware that the First Minister was seeking

scientific advice to inform policy and observed this during the deep dive session on scenario planning I attended with her [JR/004 – INQ000218291] (see paragraph 16).

12. I had no involvement in the Scottish Government policy approach and therefore cannot comment on the key policies which underpinned the Scottish Government approach to management of the pandemic. To my knowledge the advice from the CNRG and SGCAG was considered by the Scottish Government for policy making.

13. SGCAG advice was given in the light of current epidemiology and evidence about interventions with the aim of reducing transmission. This involved optimising the prevention and management of COVID-19 to minimise the impacts, including associated mortality. Impacts were substantially improved when treatment and vaccination became available. As noted above, making policy was not within the remit of the SGCAG or CNRG. Therefore, I believe the Inquiry's questions as to whether Scottish Government policy was driven by the idea that 'no death from novel coronavirus is acceptable', or regarding specific policy relating to use of COVID safe measures, might best be addressed by Scottish Government policy makers.

Informal communications

14. SGCAG advice to inform key decisions was discussed and given in the formal meetings and this is recorded in the files submitted. I understand all formal advice of the SGCAG has been provided to the Inquiry by the Secretariat. I am not aware of any informal meetings or messaging platforms being used to give advice. The only platform used by SGCAG was SLACK for the purposes of science and data information sharing by members. It is my understanding, from the Secretariat for that group, that the content was deleted from the SLACK channel once formal advice had been submitted.

15. No informal messaging platforms were used by CNRG, the public health assessment subgroup, or the UK SAGE HOCWG to my knowledge. I confirm I did not use any informal platforms for sharing information other than SLACK for SGCAG and I am not aware of any informal messaging platforms being used by key decision makers or advisors to communicate about key decisions.

16. I did not communicate directly with the First Minister during the pandemic response although I understand advice from the groups, I was involved with may have been passed to her to consider. I attended one deep dive session organised by the SGCAG secretariat, at which the First Minister was present on 4/2/21 on scenario planning, however I gave no advice directly to the First Minister.

17. There were no informal meetings related to the advice given by the SGCAG. The only informal meetings I attended were in relation to setting the agenda for CNRG, with the secretariat for the meeting. There were no minutes of these meetings and the output from such meetings was the agenda for the next CNRG. I also had informal telephone calls and email correspondence with the CNO in relation to the work of CNRG (as presented in General Disclosure). I do not believe these informal communications related to the work of CNRG affected the efficacy of decision making or recording of decisions. I did not use informal platforms for discussing information or advice relating to the SG response to COVID-19; SLACK was used for SGCAG members to share information and scientific advice (as discussed above).

18. For SGCAG, the meetings were held on Zoom and the Secretariat took minutes as summarised advice from what was said in the meeting, inclusive of what was noted in the Zoom chat box during the meeting. To my knowledge these meetings were not recorded, and the chat content deleted after used for the purpose of producing the meeting minutes. These minutes were approved by members as an accurate reflection of what was discussed and have been submitted to the Inquiry by the Secretariat.

19. The Advisory Sub-Group on Public Health Threat Assessment followed a similar process in MS teams and minutes have been made available to the Inquiry.

20. For CNRG these meetings were held on MS teams and not recorded. The MS teams chat from the meeting was used, with what was said in the meeting, to record the minutes and then deleted. A meeting summary was published. Formal advice was sent to CNO directly. Both the minutes, summary notes and advice have been submitted to the Inquiry by the Scottish Government.

21. The minutes were signed off by each group at the start of each meeting as an accurate reflection of what was discussed. Corrections were made, if required in this regard, before publication. I therefore believe the minutes are an accurate reflection

of what was discussed in the meetings. It was made clear in providing advice where there were dissenting views or if there was a lack of consensus.

22. All information related to each meeting, including minutes, papers and summary advice was stored in the Scottish Government's document management platform, Objective Connect and has been made available to the Inquiry. MS teams and Zoom chats were used to inform the minutes for the meeting and deleted thereafter. To my knowledge there are no other key communications relating to the meetings with the exception of email correspondence related to CNRG work to CNO.

23. As regards data retention, I worked in line with the TOR of the group, the Secretariat had responsibility for ensuring adherence to the Scottish Government data retention policies. The Secretariat for the committees confirmed to me adherence to these policies.

d) Scottish Government COVID-19 Advisory group ("SGCAG") and SAGE

24. I was not involved in all of the scientific and advisory structures available to Scottish Government, only SGCAG and its related groups, inclusive of CNRG and the public health threat assessments group. I was also a member of the Care Home Professional Advisory Group in Scottish Government in my CNRG chair role [JR/001 – INQ000000]. Those groups were sufficiently representative in their membership to fulfil the TORs of the group in my view. The groups were not set up in the TOR to cover the competing interest which would be affected by Scottish Government core decisions.

25. In those groups I was involved with there was sufficient advisory capacity for the topics of advice being given and there was also the ability to co-opt additional specialised advice as required to contribute to advice from the group. SGCAG membership included immunology and wider clinical advice representation from the chair of the clinical cell, however there was not health economics, economy or ethics experts on these groups as this was out with the defined TOR for the groups. The subgroups, and wider advisory group structures, had co-opted experts in education, microbiology and virology, amongst others. Some members of SGCAG also attended SAGE and its subgroups on specific topics, which helped support the Group's advice. SAGE had subgroups on all key topics with UK experts informing that advice, this advice was held in high regard by SGCAG and the subgroups I was a member of.

26. SGCAG advice was given in the light best available evidence related to the COVID-19 situation; this would include consideration of potential impacts such as inequalities and educational issues where that evidence was known to the group. Other considerations such as wider impacts and decisions in relation to that advice related to the economy and wider societal issues were taken by the Scottish Government. It is my understanding that there was a Scottish Government group considering balancing harms of advice more formally in this regard. However, I was not a member of this group.

27. In my view, policy decisions require to be made on a range of factors and the evidence from each of the groups submitting advice would be considered for that policy decision by Scottish Government. Experts can only give advice in the context of their own expertise and the SGCAG group focus was on the remit in the TOR. Bringing together of expert advisory groups for collective advice may have added benefit to advice giving, however, managing that in the required turnaround time for advice may have precluded this.

28. I was not involved at the start of SGCAG. I attended from when CNRG was being established on 23/4/20 and in the CNRG chair role. Those involved in pandemic preparedness in Scottish Government may be best placed to address whether SGCAG should have been formed at an earlier date.

Subgroups

29. As set out earlier in my statement, I was involved in a number of SGCAG subgroups. The role of each of the groups is set out below:

- The public health threat assessment group gave advice to inform winter preparedness. I have not evaluated the effectiveness of that advice and this question may best be addressed by Scottish Government in terms of impact on their response.

- The CNRG gave advice to CNO related to healthcare associated (nosocomial) COVID-19. The scope of advice given is detailed in the TOR [JR/003 – INQ000000]. The CNO then considered this advice for policy recommendations

and guidance. The advice was well received by CNO, the effectiveness of this advice may best be addressed by CNO Directorate in terms of policy response.

- Other HAI related advice groups were at the UK level as part of SAGE. In my CNRG role, I was invited on 11/5/23 to be a member of a subgroup of SAGE called the Hospital Onset COVID-19 Working Group (HOCWG). The Working Group was formed under instruction from SAGE to provide an overview of possible nosocomial transmission of SARS-CoV-2 and evaluate evidence, from which, to recommend actions and interventions to reduce nosocomial infection and risk of transmission. The working group met fortnightly. I attended the HOCWG for the month before it was stood down. I took personal notes from that meeting and shared these with CNO by email, as provided through general disclosure, and CNRG verbally, and considered what if anything CNRG should be considering on its agenda in the light of this wider UK information on healthcare associated COVID-19. It was therefore helpful for the chair of CNRG Scotland to be a member of this group in ensuring UK wide learning. The effectiveness of the subgroup in informing Scottish Government advice may best be addressed by CNO Directorate in Scottish Government.

30. The subgroups of SGCAG were not established to conduct research, as this was out with the defined TOR or capacity of the groups. Further, research funding and priorities for COVID-19 in Scotland were developed and funded by the Scottish Government Chief Scientist Office (CSO). The SGCAG subgroups reviewed outputs from research published in the public domain to inform the advice. CNRG gave advice that Scotland should participate in the SIREN research study, supported a proposal for behavioural insights research in hospitals, and identified future research priorities for nosocomial infection [JR/005 – INQ000000], [JR/014 – INQ000000], [JR/042 - INQ000349045].

31. I am not able to comment on what account was taken by the Scottish Government of advice from the SGCAG subgroups. This matter may be better addressed by Scottish Government as I was not involved in these decisions.

32. I am asked to provide a copy of a lessons learned document produced by the CNRG. The CNRG lessons learned document reference was provided to the Inquiry at the time of the scoping questionnaire and has now been submitted to the UK Inquiry with a new reference number [JR/005 – INQ000000].

33. I am asked to explain why the HOCWG was stood down on 30/06/2020 and re-convened as a new group (as outlined in my previous statement, dated 26 June 2023, provided [JR/001 – INQ000217360]). The HOCWG was a SAGE subgroup I was invited to on 11/5/20 and attended from 21/5/20, until it was stood down on 30/06/23. I received a letter from the chairs of HOCWG by email in this regard [JR/007 – INQ000000], which indicated that the move to a new phase of the pandemic required the group remit to move towards operational delivery within the NHS. The new group established to do so was called the Hospital Onset COVID -19 Infection (HOCI).

34. I was not involved in the decision to stand the group down. This question might best be addressed by those involved in that decision (chairs of the group, Dame Ruth May and Professor Mark Wilcox).

35. The name of the group, TOR and membership changed when the new HOCI group was established. Explanatory papers for both groups have been provided [JR/007 – INQ000000], [JR/43 – INQ000349137] and I understand that full documentation is likely to have been provided to the inquiry by the secretariate of the groups. I was invited to HOCI by email invitation on 2/7/20. My understanding was that the HOCWG gave advice to SAGE and the second group (HOCI) was about operational delivery in NHS England (NHSE). I had observer status on the HOCI group as chair of CNRG representing Scotland.

36. The HOCI group included extended membership from the regional Infection Prevention and Control (IPC) teams in England [JR/009a – INQ000349039] and [JR/009b - INQ000349040].

Operation of advisory structures

37. The advisory function of SGCAG and its subgroups to Scottish Government is as detailed in the TOR, which have been made available to the Inquiry by the Secretariat. To my knowledge, it did not have an advisory function to other organisations. SGCAG included membership of significant organisations and professional groups involved in the pandemic response, such as Public Health Scotland (PHS) and the Director of Public Health (DPH) group chair.

38. The Public Health Threat Assessment group included senior clinicians such as a Director of Nursing and Medical Director representation from territorial boards in Scotland as members. The group's TOR has been made available to the Inquiry by the Scottish Government.

39. CNRG also had PHS on its membership, alongside ARHAI Scotland, and leads from key professional organisations and groups who were leading the local response such as: Directors of Public Health, Scottish Microbiology and Virology Network, Infectious disease physicians, Infection Prevention and Control leads and Occupational Health clinicians. The TOR gives further details [JR/003 – INQ000000]. Advice from the group was also considered by the SG Workforce Senior Leadership Group (WSLG) where appropriate.

40. I am asked by the Inquiry about delays to provision of data as a result of the formation of PHS in 2020, I am not aware of any such delays.

41. With respect to the question asked by the Inquiry about impacts of the CMO resignation in April 2020, I am not aware of any evidence related to the CMO resignation, and its impact on the management of the pandemic or provision of advice from SGCAG to Scottish Government.

42. The nature of the relationship between SGCAG and CNRG and ministerial decision makers was that our advice was issued to the professional advisory leads (CMO and CNO respectively) and either copied or forwarded on to Ministers and others involved in ministerial decisions. Advice was given in writing by the secretariat of SCCAG.

43. I had no role in directly providing advice to cabinet meetings, Scottish Government Resilience Room (SGoRR) or the Four Harms Group, although I understand advice from the groups, I was involved with may have been passed to them to consider.

44. SGCAG gave advice about key topics and questions, rather than all core decisions of the Scottish Government. I contributed to advice related to healthcare associated COVID-19 and evidence underpinning NPIs (such as masks and ventilation) within the hierarchy of controls used in healthcare to prevent transmission of infection. This advice was based on evidence which had been presented at CNRG and advice given to CNO. Advice given is detailed in the SGCAG files submitted to the Inquiry by the Scottish Government.

45. The SGCAG was effectively chaired to ensure all views, the latest Scottish data and wider evidence from SAGE and internationally published papers were taken account of. Consensus views were summarised and formulated effectively in my view and then submitted as advice.

46. The Chief Scientific Adviser (CSA), CMO and DCMOs were members of SGCAG. The National Clinical Director (NCD) was often in attendance. For SGCAG subgroups, DCMOs attended as members. For CNRG, DCMO was a member. All views and advice given were taken account of in the meeting and summary advice given which represented all views. It was recorded in that advice where there were opposing views or uncertainty.

47. I am asked by the Inquiry if there was a risk of information overload, or repetition for key decision makers. I am not aware of the process for receipt of all advice and how this may have impacted decision makers, this might best be addressed by the decision makers.

48. Advice was summarised by the SGCAG Secretariat and sent by email to CMO, copied to Scottish Ministers. I was not directly involved in the way it was communicated. Advice was commissioned by CMO or from the Cabinet Secretary for Health to SGCAG. Advice was also given relating to the current situational report epidemiologically and emergent issues from SAGE and international evidence for consideration in Scotland.

49. There was no feedback to the group about how advice had been assimilated into decisions made by Scottish Ministers. It would have been helpful for SGCAG to receive feedback about how advice had informed policy.

50. I had no knowledge of how CMO sought to focus medical advice to the cabinet.

51. Commissions were received as a question for advice. My understanding is if there was further clarity of the question required, the chair would have done this with the Secretariat in advance of sharing with SGCAG members.

52. To the best of my recollection, I attended two deep dive sessions on 16/12/20 (Jeremy Farrar) and with the First Minister on 4/2/21 (scenario planning). These

meetings had the purpose of focussing on key topics of interest to Scottish Ministers and enabling them to ask questions directly of SGCAG members. I did not lead or directly contribute to these meetings as they were not in my sphere of expertise. The advice given in these meetings is set out in the SGCAG files submitted to the Inquiry.

53. The Scottish Government COVID-19 corporate analytical hub data were presented at each SGCAG meeting, alongside other evidence available from SAGE and its subgroups and published evidence. The data were important, and each meeting had a current situational report as part of the agenda by way of update. It is important to note that data were not subject to the quality assurance of national statistics, which are provided retrospectively once these quality checks are completed. Nonetheless my understanding was they were sufficiently contemporaneous to inform advice.

54. The ARHAI Scotland healthcare associated (nosocomial) COVID-19 datasets were presented to CNRG in the same way as part of the standing agenda. The data included near real time feedback from hospitals on clusters of cases, outbreaks and IPC intelligence.

55. The advice given was in line with the question asked and we were not necessarily aware of all policy options being considered, as this was not the remit of the group.

56. Advice given was based on best available evidence relative to the advice sought, not what policy makers may be considering more broadly per se, which may not have been known to SGSAC unless asked as a question.

57. Advice was summarised based on consensus. This was shared with the group for the purpose of ensuring it was accurate, clear and comprehensible before submission and ensured transparency with the SGCAG members of the detail of what was being submitted. The initial drafts shared with the group were prepared by the secretariat who were experienced in writing briefings for ministers and, as such, were clear and comprehensible for the intended audience. Transparency was further enhanced by the publication of the SGCAG minutes.

58. I am not aware of any challenge having been given to the advice submitted. Clarifications related to advice would have been dealt with via the chair of SGCAG.

59. Meetings were conducted in line with the TOR for the group. The SGCAG chair would agree the agenda with the Secretariat. They would appoint a SGCAG member with expertise in a topic area to lead a paper for review at the meeting and then contributions were invited from all members.

60. I am asked by the Inquiry if I consider that SGCAG's advice was too heavily influenced by one scientific discipline, for example epidemiology/ modelling. Epidemiology and modelling played an important role, alongside evidence reviews from published research studies and expert advice from subgroups. Where there was an absence of evidence about a topic from published studies (and to ensure advice was based on Scottish data context), current epidemiology and modelling were both important to inform advice and I valued the expertise of those members. The membership included a wide range of expertise in public health, psychology and other disciplines. My own view was that there was good balance in the membership and their views, and the group met the remit of the TOR.

61. If there was a lack of consensus or competing views in the group on any matter, then this was recorded in the summary note and any advice given, to ensure transparency in communicating all views in that advice.

62. There was no external assessment or peer review established as part of the TOR for SGCAG. The connection to SAGE advice, for context in SGCAG advice formulation, was important as part of the internal consideration and review of advice. Deep dives involving international experts, such as Sir Jeremy Farrar, provided an opportunity to consider our advice in the light of wider international considerations. [JR/010 - INQ000233316]

63. In giving our advice, I was aware this would form part of wider advice being considered by Scottish Government in balancing harms and considering policy. We were not given feedback about whether advice was followed, or not, as part of the process in SGCAG.

64. The group could, and did, offer advice on its own initiative. Key topics for consideration were determined by the chair and the Secretariat. I am not aware of any advice that was not sought but which ought to have been sought by the Scottish Ministers.

65. I am asked about the clinical input into the decision making of SGCAG. There were clinicians that were members of SGCAG such as public health clinicians from PHS (Dr Jim McMenamin and Dr Nick Phin) and wider clinical specialty clinicians (DCMOs) as well as Professor Tom Evans who is a clinical academic and worked in his hospital role during the pandemic. The TOR denotes the role of SGCAG, and this did not include giving clinical advice. Clinical advice was the remit of the Scottish Government clinical cell which included wider representation from front line clinicians The chair of the clinical cell, Professor Tom Evans, was a member of SGCAG and CNRG.

66. Patient groups and patient experience related advice was not part of the TOR for SGCAG as the focus was scientific and technical advice related to COVID-19.

67. The deep dive meetings were about specific topics and the science relating to those topics, rather than patient related experience per se, and provided in-depth briefing meetings for Ministers to enable further understanding of the topic. They served their purpose in my view in this respect, and I found them to be helpful in considering single topics at length. I learned more about topics in these meetings.

68. I have been asked to explain the role of SGCAG in relation to relaying information to SAGE groups such as SPI-M/SPI-O/SPI-B and how effective this was. I was not involved in any part of this process. This might best be addressed by those who were members of these SAGE groups and Scottish Government.

69. Consensus was not reached in SGCAG in relation to every matter. Dissent was recorded in the minutes (as discussed above at paragraph 21).

70. Each expert in SGCAG gave advice related to their field of expertise and the chairs from the subgroups also gave expert views from this subgroup advice.

71. In addition to the Scottish Government COVID-19 analytical hub data presented at each SGCAG meeting; data was shared from SAGE and its subgroups. SGCAG members who were in SPI-M groups presented these data, inclusive of data from funded research studies they were involved in. PHS also presented data. I found the data to be well explained and it was possible to triangulate data from these various sources. The data were able to be used to inform advice and so it was effective in this regard. There was little data available on process measures, for example,

adherence with IPC measures in hospitals, this would have been helpful to further interpret healthcare associated infection data. There was also little data related to Occupational health. These healthcare related elements of data were subject to recommendation in the lesson learned exercise from CNRG [JR/005 – INQ000000].

72. I was asked by the Inquiry about delays to data circulation; I am not aware of delays in data sharing.

73. Modelling was led by those SGCAG members on SAGE SPI-M and Scottish Government COVID-19 analytical hub data. Modelling was used to inform advice. I cannot comment on how comprehensive this was as it is not within my sphere of expertise.

74. SAGE was attended by the chair of SGCAG, and summary notes and papers shared with SGCAG from that. In addition, members of SGCAG were members of SAGE subgroups and aware of the data at UK level in this regard. SGCAG took account of SAGE advice in giving advice for Scotland to CMO, this was in line with the TOR. To the best of my knowledge this was done effectively by those involved in the process, as SAGE advice was referenced in SGCAG advice being given. It was also efficient in the sense that SGCAG considered the Scottish advice, in the context of that SAGE advice, and did not duplicate the work of SAGE.

International perspective

75. All members shared international advice related to the expertise they held and international evidence was considered by SGCAG. There was an international lead in SGCAG (Professor Devi Sridhar) who spoke to this on the agenda often. Her international connections, together with those of other members, enabled real time exchange of intelligence, which was not yet published in academic journals and so was effective in this regard. A more formal international engagement process and directory of contacts may be an improvement to ensure there is no such person dependence in future SGCAG arrangements.

76. SGCAG did not have a remit to liaise or co-operate with international organisations or relevant authorities in other countries, although members of academic informal networks were used to this end. Deep dive sessions were arranged with international experts such as Sir Jeremy Farrar, Sir John Bell and Prof David Nabarro, WHO

Special Envoy, and these were very useful for international evidence sharing. International advice and data were considered in the light of country specific epidemiology and reviews of published evidence/ research.

77. SGCAG advice took account of the situation in other countries and shared all evidence available in this regard in giving advice to Scottish Government.

78. The membership of UK groups was an important part of connection of SGCAG to the structures in the UK. There was UK representation on World Health Organisation (WHO) groups which enabled reciprocal information sharing between countries. The structures and ways of working for SGCAG were determined in the TOR.

79. I am asked whether core decision makers at the Scottish Government learned sufficient lessons from the experience of other countries throughout the pandemic. As I was not involved in Scottish Government decision making, this question might best be addressed by core decision makers in Scottish Government.

Funding and powers

80. The SGCAG was well supported by the Secretariat and also the scientific writer resource. I am not aware of wider issues asked by the Inquiry related to structure, resources and funding and the group was not asked to consider such issues.

81. I am asked by the Inquiry about issues faced in SGCAG advisory structures due to limitations imposed by the devolution statement. I am not aware of any such limitations imposed to advisory structures I was involved in during the pandemic.

Local government

82. SGCAG did not provide advice to local authorities or deal with local government, our advice was given to Scottish Government. I have been asked by the Inquiry how the Scottish government liaised with the local government about implementation of local restrictions; I am not sighted on these matters as I was not involved with them.

Conclusions and lessons learned

83. I have been asked by the Inquiry about the process of preparing and communication of scientific advice from SGCAG and if it was fit for purpose, in my view it was and to my knowledge no complaints were received from Scottish Government in this regard. This question might best be addressed by those in Scottish Government in receipt of the advice.

84. I think publishing the papers and minutes from the SGCAG meetings is important for transparency. The connection to the UK SAGE groups was important and acted as a good reference point for SGCAG advice. Additional internal and external scrutiny is always welcome, however requires to be balanced with the need for timeliness in response and the confidential and sensitive nature of advice stated in the TOR for the group.

85. I am asked by the Inquiry to comment on the performance of ministers, senior civil servants, special advisors and/or individuals in charge of a significant aspect of the Scottish response to the pandemic, in particular, regarding their understanding and use of medical and scientific advice. I do not believe I am best placed to comment as I have no knowledge to enable an assessment about anyone else's understanding or what use was made of advice given to them, as I was not personally presenting the advice to them, nor did I receive feedback from them about the advice given from SGCAG.

86. I am asked by the Inquiry if I have any concerns regarding the performance of counterparts in the UK government or devolved administrations, I had dealings with. I have no knowledge about the performance of UK Government or other devolved administration counterparts to inform an answer. Views about performance of other administrations might best be addressed by Scottish Government officials who interacted with them. In my dealings with the UK groups, I was involved with, that are detailed in this statement, I found the performance of members to be professional and collegiate.

B. Initial understanding and responses to COVID-19 in the period from January to March 2020

87. The Inquiry has asked me about a number of events which took place before I was a member of SGCAG from 23/4/20. Comments I am able to make about the period between January 2020 – April 2020 are therefore necessarily limited. I confirm I did

not provide advice to the Scottish Government about the pandemic response prior to joining the SGCAG and CNRG. These questions are best addressed by SGCAG members from this time. I am asked by the Inquiry when I first became aware of COVID-19. My NHS role was not directly related to the pandemic response before being invited to chair CNRG, so my source of information about this matter would have been Health Protection Scotland and any Public Health alerts they sent out to the NHS in this regard assessing the threat COVID-19 posed to Scotland.

88. My understanding of COVID-19 epidemiology and impacts was informed by HPS Public Health alerts before becoming a member of SGCAG and thereafter was informed by the evidence from SAGE, the World Health Organisation and in attending SGCAG, via the expert members of the group. The minutes of SGCAG therefore reflect my understanding at the time.

89. I have been asked by the Inquiry to give views on the Scottish Government response early in the pandemic and pre the first lockdown, I not able to answer as (i) I was not a member of SGCAG until 23/04/20 (ii) my role in the NHS prior to being asked to chair CNRG was not connected to the public health response to the pandemic (iii) the role of SGCAG is to provide scientific advise and not to make policy decisions or evaluate those decisions and (iv) my expertise is in healthcare associated infection.

90. I have been asked by the Inquiry if 'herd immunity' formed part of the initial Government strategy. I am not aware that herd immunity was ever given as advice from SGCAG, or that there was a Scottish Government strategy in this regard.

91. I am asked by the Inquiry regarding the significance of certain key events which played or had the potential to play a part in the spread of the virus between January and March 2020. SGCAG published its advice on superspreader events on 2/7/20 [JR/011a - INQ000217729], [JR/011b - INQ000217730]. The common themes from such outbreaks were: indoor (closed settings), with large numbers of people in close proximity for a substantial period of time. It was also noted that superspreader occupations were also important, such as those occupations involving large numbers of interactions with people from different networks (such as supermarket workers and health and care workers). The importance of testing, contact tracing and NPIs were pointed to in this advice.

Testing

92. There was a specific group established by CSO to address testing strategy. Whilst I was not a member of this group, SGCAG contributed to the group's advice on testing on 23/6/20 [JR/012a – INQ000217709], [JR/012b – INQ000217710]. This advice considered testing strategy and emphasised the importance of turnaround time in testing, to rapidly identify contacts of cases. It also noted the importance of continuing to protect the most vulnerable from infection through testing policies in health and care workers, patients and care home residents.

93. My input to testing related to hospital related testing strategies to inform IPC measures. I was aware of the importance of testing patients on admission and healthcare workers routinely, to be able to identify cases and put control measures in place. In my first meeting of SGCAG in April 2020 I submitted (with Jim McMenamin from PHS) considerations about healthcare testing as part of the testing strategy considerations. This was informed by discussions I had with PHS and ARHAI Scotland. This paper was considered by the CSO testing group. CNRG were asked to give testing advice to CNO, this advice is recorded in the CNRG minutes.[JR/013 – INQ000000], [JR/014 – INQ000000], [JR/015a - INQ000349041] and [JR/015b-INQ000349042]. All meeting papers for the group have been provided to the Inquiry.

94. I have been asked by the Inquiry to respond to quoted text from the book *Preventable* authored by Professor Devi Sridhar, however I have not read the book being referred to here, so cannot comment on the excerpts being referred to.

95. My recollection is that the testing advice I gave on hospital related testing strategies for healthcare workers and patients, to inform timely IPC measures and reduce risk of nosocomial COVID-19 infection, was well received by the CSO group. It was included in the overall testing strategy document considerations by the testing group. The wider advice on testing from SGCAG was also included in the testing strategy. [JR/012a – INQ000217709] and [JR/012b – INQ000217710].

96. Testing was a vital part of the response to the pandemic; I was aware of this before joining SGCAG. For hospitals, identifying those who were SARS-CoV-2 positive, inclusive of staff and patients and visitors, was key to implementing IPC measures to mitigate transmission risk. This was important for those who were symptomatic, and those asymptomatic who were at risk of transmission to others without knowing otherwise.

Decisions in relation to non-pharmaceutical interventions ("NPIs")

97. My expertise in support of SGCAG related to healthcare associated infection and the evidence based for IPC measures. I did not give advice on wider public health measures related to restrictions, closures and lockdown as these were out with my sphere of expertise.

98. I supported SGCAG advice on NPIs related to the work CNRG had done matters such as face masks, ventilation and hand hygiene. I have not formally evaluated the Scottish Government use of NPIs and their impacts, so I am unable to give a view on these matters. To the best of my knowledge SGCAG were not asked to evaluate Scottish Government strategy regarding NPI impacts either.

99. SGCAG advice covered at risk groups [JR/020 - INQ000233323], [JR/021 - INQ000217727], risk of long COVID [JR/044 - INQ000000], asymptomatic transmission and transmission risks over the course of the pandemic [JR/045 - INQ000000], [JR/046a - INQ000349133] and [JR/046b - INQ000349134]. This advice extended beyond that of my expertise to the group on healthcare associated infection. The extent to which Scottish Government took account of these factors given in advice from SGCAG, in imposing the NPIs as policy has not been evaluated by SGCAG.

100. SGCAG provided advice on medical and non-medical face masks in different settings on 12 June 2020. [JR/015a - INQ000349041] and [JR/015b - INQ000349042]. Low quality and low certainty evidence suggested face masks would be effective in reducing the risk from infected people, although there was less certainty in relation to the use of face masks as a population level intervention. The evidence available on medical mask effectiveness was more certain in higher risk settings such as healthcare. Face masks are one of the mitigating actions to reduce risk of transmission and work best when layered with other mitigations from NPIs such as reducing contacts, physical distancing and hand hygiene. Face masks therefore featured in much of the broader advice on NPIs given by SGCAG throughout the duration of the pandemic.

101. The best available scientific evidence available during 2020 about the effectiveness of face masks came from the World Health Organisation (WHO) Living

Infection Prevention and Control guidance, based on reviews of available scientific evidence and international expert opinion, it was the international focal point for mask related evidence at this time. Interim guidance was issued by WHO in June 2020, updated in Oct 2020 and then a mask technical briefing updated in Dec 2020 [JR/016 – INQ000000], [JR/047 - INQ000349135]. UK SAGE reviewed face mask evidence via the HOCWG group and the Environmental Modelling Group (EMG) subgroups and SGCAG considered that advice in giving their advice. ARHAI Scotland were also performing real time rapid reviews of evidence for healthcare settings in relation to transmission based precautions, including mask use, and CNRG considered these. The UKHSA also had an independent respiratory panel reviewing masks from February 2021 [JR/048 - INQ000349136], [JR/017 – INQ000000].

102. SGCAG gave advice on facemasks based on the best available evidence. Public messaging related to this was not in the responsibility of the group. I have no evidence base to inform evaluating the public health messaging from Scottish Government in this regard.

103. I was not involved with SG strategy related to NHS capacity and SGCAG gave advice on protecting the NHS and social care capacity in April 2020 before I was a member, noting the need to find ways of living with the virus, including protecting the NHS and social care capacity for citizens [JR/018a - INQ000217504], [JR/018b - INQ000217505], [JR/018c - INQ000217506]. I have been asked by the Inquiry to consider how appropriate and timely the measures imposed in Scotland were on NHS capacity, including issues around staffing, PPE, hospital and ICU beds and ventilators. This was not something SGCAG were asked to evaluate so I am unable to address this.

104. I am unaware of the Scottish Governments rationale for school closure strategy. SGCAG advice related to schools was led by the school's subgroup and thereafter given as advice from SGCAG. I was not a member of this subgroup. I have nothing to add in addition to what is recorded in the SGCAG files.

105. Whilst not my specific area of expertise, I am aware that SGCAG provided a number of pieces of advice on vulnerable and at risk groups during 2020. This included shielding and protection of vulnerable groups [JR/020 - INQ000233323]; reducing risk and improving outcomes from COVID-19 for minority ethnic and religious communities [JR/021a - INQ000217727], [JR/021b - INQ000217728] and

health and care settings which may involve vulnerable and at risk groups [JR/022 – INQ000217580]. I do not know how the Scottish Government took account of individuals in at risk groups around its impositions of NPIs and these were not subject to evaluation by SGCAG.

106. I have been asked by the Inquiry to explain how those who were medically vulnerable to COVID-19 were defined. SGCAG did provide advice on vulnerable groups and individuals more broadly as part of wider advice, such as when the SGCAG shared comments on proposed final measures with regards to measures to protect the vulnerable [JR/019 - INQ000217916]. SGCAG recommended that measures to protect those who were most vulnerable in care homes and long term care settings be considered. [JR/023a – INQ000218274], [JR/023b – INQ000218275]. Whilst I was unable to attend and it is not my area of expertise, I am aware that vulnerable groups were covered in a deep dive session, which covered the principles that underpin shielding, international approaches to shielding and the impacts of shielding at population level [JR/024 - INQ000218290].

b) Continuation of the first lockdown

107. "Zero COVID" was discussed by SGCAG on the SLACK channel, I recall it was raised by Professor Devi Sridhar and there were differing views on this, however I am not aware of advice being requested from SGCAG or given on this matter. As I understood it, some countries were moving towards an elimination approach, wherein they recognised the lowest risk of transmission was possible if there were border controls, all cases were identified quickly, all contacts traced and all those exposed were isolated. Aiming for elimination, or as close to that as possible, is therefore dependent upon strong border control restrictions, capacity for testing, optimal adherence with testing and optimal adherence being supported for the associated control measures of those identified as infected. Border control is a UK reserved matter, so my understanding was it would not be possible for Scotland to achieve zero COVID-19 without UK agreement to aim for such a strategy.

108. I have been asked by the Inquiry to provide an overview of key advice provided to the Scottish Government about appropriateness and timeliness of core measures including lockdown, extension of lockdown, extensions of restrictions and the COVID-19 framework for decision making, the route map and related lessons

learned. Advice on these wider Public Health measures were within the expertise of other members of SGCAG.

109. My role was to provide scientific advice in relation to healthcare associated infection. It was clear to me from the data being reviewed by CNRG, that decisions about wider public health measures to reduce community transmission of COVID-19 would result in fewer introductions from the community into hospitals via staff, patients and visitors. Such measures would therefore reduce the risk of nosocomial transmission in hospitals also, I was therefore supportive of the advice that was given from SGCAG in this regard [JR/023a – INQ000218274], [JR/023b – INQ000218275].

110. I am not aware of SGCAG being asked for advice on lockdown impacts or having undertaken a lessons learned exercise on this or any other matter. I have not been involved in any evaluation of these matters as they are not specific to healthcare and outwith my area of expertise.

Decisions relating to easing the first lockdown in the period from 29 May 2020 to 7 September 2020

111. I am asked by the Inquiry what evidence was provided by me and the SGCAG regarding the timeliness and appropriateness of specified core decisions during the period 29 May 2020 to 7 September 2020. The SGCAG responded to a request for advice on medical and non-medical face masks in different settings on 12 June 2020. [JR/049 – INQ000000]. Advice on schools was dealt with by the Advisory Sub-Group on Education and Children's Issues, this was not my area of expertise. I am not aware that SGCAG advice was sought or provided on the Eat Out to Help Out scheme.

112. No formal lessons learned exercise was completed as part of SGCAG work. One of the important reflections for me as CNRG chair during this period was the need to focus on optimising the adherence with IPC measures in hospitals in the longer term for this pandemic. The focus of the CNRG agenda towards the end of this period was on the need for IPC indicators to support measurement for improvement and the monitoring of the impact of COVID-19 on wider HAI, inclusive of AMR, in hospitals.

G. Decisions relating to the period between 7 September 2020 and the end of 2020

113. I am asked by the Inquiry what evidence was provided by me and the SGCAG regarding the timeliness and appropriateness of core decisions during the period 7 September 2020 to end 2020. SGCAG advice on these matters, as recorded in the papers, has been provided to the UK Inquiry by the Scottish Government. My expertise is in healthcare associated infection rather than the wider decisions about restrictions in other sectors, so I have nothing to add to that recorded in the SGCAG minutes and advice.

114. The information I had regarding the emergence of the Alpha/Kent variant was that shared at SGCAG by other members, inclusive of summary notes from SAGE. PHS provided updates on Variants of Concern at SGCAG and CNRG, so may be best placed to address key questions on this. Each time a new variant emerged advice was given in the context of what was known about that variant.

115. I am asked by the Inquiry for my views around the possibility of Scotland imposing a "circuit braker" in or around September 2020. I was unaware of the evidence base for circuit breakers and to my knowledge SGCAG did not give advice in support of these.

116. I am not aware of any formal lessons learned exercise as part of SGCAG during this or any other period.

Decisions relating to the second lockdown (January 2021 to 2 April 2021)

117. I am asked by the Inquiry what evidence was provided by me and the SGCAG regarding the timeliness and appropriateness of core decisions during the period January to April 2021. Please see further my responses at paragraphs 89 (iv), 108 and 109 regarding evidence provided by SGCAG. Regarding the decision to relax restrictions for Christmas day in 2020, I am not aware of being asked for advice on this matter. I am asked to explain the rationale and scientific basis for the decision to put Scotland into level four restrictions on 29 December 2020 and the way this was communicated to the public. I have no evidence to evaluate how it was communicated to the Scottish public and such evaluation was not requested of SGCAG.

118. I do not believe the Great Barrington Declaration was something expert advice was sought on in SGCAG, to my knowledge and the content of this is not within my sphere of expertise.

119. I am asked to what extent the Scottish Government learned lessons following the first lockdown and whether these were applied appropriately. This is not something I am aware of as I had no insight to Scottish Government decision making. The role of SGCAG was to provide independent advice. The group was not involved in decision making or lessons learned from that decision making.

120. Please note that advice on schools was dealt with by the Advisory Sub-Group on Education and Children's Issues. I was not a member of this subgroup. I was not asked to evaluate any lessons learned from the experience of the second lockdown as part of my role in SGCAG.

Decisions relating to the period between April 2021 and April 2022

121. I am asked by the Inquiry what evidence was provided by me and the SGCAG regarding the timeliness and appropriateness of core decisions during the period April 2021 to April 2022. Please see further my responses at paragraphs 89 (iv), 108 and 109 regarding my role in evidence provided by SGCAG.

Omicron Variant

122. I am asked when I first received information regarding the Omicron variant. I became aware of the Omicron variant through my membership of SGCAG and so is reflected in the minutes submitted by the Secretariat to the Inquiry. This is not my area of expertise and other members, such as those from PHS, which is the lead organisation in Scotland to communicate public health alerts on Variants of Concern, are best placed to answer questions related to this.

123. I am asked whether I or SGCAG considered that the existing restrictions and systems were deemed to be the most appropriate way to manage the Omicron threat, or whether a further lockdown or restrictions should have been implemented in response to the emergence of the variant. To my knowledge, this was not something SGCAG was sought to provide expert advice on. However, the group did discuss the developing information on Omicron and the potential consequences at its meetings on 2, 9 and 17 December 2021 and 11 January 2022 and the minutes of

those meetings were shared with Ministers. The group also provided advice on the new Strategic Framework on 18 February 2022 [JR/023a – INQ000218274], [JR/023b – INQ000218275] and led a Deep Dive on the future of COVID-19 on 9 March 2022 [JR/024 - INQ000218290]. CNRG gave advice about IPC measures in hospital during the Omicron phase in December 2021 [JR/025 – INQ000000].

124. In addition, I am asked by the Inquiry to provide an overview of key advice provided to the Scottish Government by me and SGCAG and my views on the timeliness and appropriateness of these core decisions particularly around the FM's comments regarding Omicron on 10 December 2021, the issue of new guidelines on 16 December 2021, the new measures introduced on 21 December 2021 and further restrictions of 26 December 2021. This advice was beyond my expertise and remit as CNRG chair. As I have indicated above, Omicron was discussed by the group and minutes of those meetings were routinely copied to Ministers. I cannot provide comment on how these matters were communicated to the public as this was not my area of expertise.

125. I am not aware of the rationale for the Scottish Government's decision related to reintroduction of physical distancing in hospitality settings on 27 December 2021. Advice on physical distancing was published by SGCAG in July 2020 [JR/026a - INQ000217731], [JR/026b - INQ000217732]. The advice noted that risk of infection increases with proximity to an infected person. Mitigation measures for the risk of transmission include a reduction in duration of contact, being outdoors or optimised ventilation indoors, using screens in specific circumstances and other measures including hand hygiene, respiratory hygiene and face masks.

126. I was not formally asked to review lessons learned from this period as part of my role in SGCAG and these core public health measures are not with my remit and role re expertise on HAI for the group.

J. Care homes and social care

127. SGCAG advice usually considered health and care settings, given the high risk of infection and vulnerable nature of the population in these settings. Throughout the pandemic measures to protect the vulnerable in hospitals, care homes and long term care settings featured in advice. Specific issues related to care homes would have been considered by the Care Home Professional Advisory group (CHPAG).

128. SGCAG provided advice on care home related issues on two occasions. On 2 June 2020 the group provided advice on the review of lockdown in care homes [JR/027a - INQ000217659], [JR/027b - INQ000217660], [JR/027c - INQ000217661], [JR/027d - INQ000217662], [JR/028a - INQ000217796], [JR/028b - INQ000217797], [JR/028c - INQ000217798]. The SGCAG view was that there was a need to proceed with extreme caution given the vulnerable nature of the residents and high risk of infection in such settings, however there was also a need to consider a risk based and proportionate way to reintroduce some limited visiting and use IPC measures to mitigate risks. On 17 July 2020 SGCAG advice was given on care homes and wider social care sectors (respite care and day care) [JR/029a - INQ000217799], [JR/029b - INQ000217800].

129. In June 2020 SGCAG advised that there were risks for care homes associated with moving to the stage of opening care homes, however recognised the need for these risks to be balanced in a person centred way with the harms of keeping restrictions in place. The view of the SGCAG was that it was possible to move to the next stage of opening care homes. For respite care and day care, SGCAG noted in July 2020, that these services cover a range of different patient groups and in different contexts and environments with different risks; thus, risk assessments would be required at a local level.

130. Care homes are high risk environments for transmission of infection given they are closed settings with multiple occupants, many of whom are at risk from underlying comorbidities and therein adverse impacts from infection. This was well known pre pandemic. Infection Prevention and Control guidance documents were, and are, in place in these settings as a matter of routine to mitigate these risks. Seasonal respiratory infections and norovirus are prevalent in these settings and managed using IPC measures from this guidance each year. Infection prevention and control (IPC) measures need to be risk based and proportionate given these settings are people's homes.

131. I am asked by the Inquiry to address the matter of policy decision making of transfers from hospitals to care homes. I was not involved in these decisions, however testing and isolation are key measures in mitigating risk of onward transmission. In the absence of testing, isolating residents and applying transmission based precautions for the period after transfer from hospital would have mitigated

risks of cross transmission associated with the hospitalised stay. However, it is acknowledged that implementation of these measures, such as isolation, in care homes is challenging depending on the individual's needs and the building design of the environment the resident lives in.

132. The Inquiry has provided me with a copy of a statement made by the Cabinet Secretary for Health and Sport to the Scottish Parliament on 21/04/20 relating to care homes. I am not aware of the evidence underpinning this, as I was not involved in the decision related to the Cabinet Secretary's announcement. This took place before I joined SGCAG.

133. I have not formally evaluated the way in which the risk of COVID-19 in care home residents was managed by the Scottish Government as it was not in the remit of SGCAG. However, beyond my remit in SGCAG, at the request of the Cabinet Secretary for Health, I co-authored an independent rapid review of four care homes with high attack rates of SARS-CoV-2 in 2020, provided [JR/030 – INQ000001279].

134. This care home rapid review used an appreciative inquiry approach to explore the root causes of these outbreaks. It examined the context and conditions of measures to limit the spread of the virus in Scotland, in the light of the included care homes' experiences, to better understand the issues and challenges facing care homes at that point in the pandemic. The review concluded that: high community prevalence, high occupant density, staffing shortages, symptom vigilance, asymptomatic importations, testing turnaround times and IPC control measure timeliness and adherence; were key factors driving transmission of infection in these homes.

135. The review made 40 recommendations covering 15 topic areas including testing, indicators, education, carer perspectives and leadership. These recommendations were taken forward by the Scottish Government as part of the Adult Social Care Winter plan in 2020/21 [JR/031 – INQ000147362].

136. Balancing harms is key in care homes, as these settings are people's homes. Care in these settings needs to be person centred and balanced with the risk of cross transmission of infection to other residents in these multiple occupancy settings. Using IPC measures in a risk based and proportionate way to balance harms is

important. The recommendations made in the care home rapid review of outbreaks (2020) and other reviews undertaken during the pandemic such as those resulting in Anne's Law, which is the Scottish legislation intended to strengthen the rights of people living in care homes to spend time with the people who are important to them, even in the event of an outbreak, are important for future preparedness.

Borders

137. I am asked to provide views on the management of internal and external borders. This is not within my area of expertise.

COVID-19 public health communications

138. I am not aware that SGCAG were asked to evaluate the Scottish Government strategy for communication, and I have no expertise on this topic. My SGCAG role, where requested, would have been about advising on the content of the campaign based on the infection prevention and control evidence for that, rather than the strategy per se.

139. The Scottish Government communications team did attend SGCAG (in December 2020) to brief the group on the awareness campaign they were planning at the time. I raised at this meeting the importance of including ventilation in the mitigating actions and messages going forward (the then extant campaign 'FACTS' did not feature ventilation at that time).

140. SGCAG had given updated advice on ventilation on 18 November 2020 [JR/032 – INQ000217978]. This paper was a summary update on the mitigation of aerosol transmission, in the light of the SAGE Environmental Modelling Group Evidence of 30 September 2020 and the new Chartered Institution of Building Services Engineers guidance of 23 October 2020 [JR/033 – INQ000000], [JR/034 – INQ000000]. The information in these documents was in line with previous SGCAG recommendations on ventilation [JR/035a - INQ000217875], [JR/035b - INQ000217876] and included some additional guidance in support of those principles and highlighted the information available in these documents on the use of CO_2 monitors and UV light, noting the evidence indicated that these were areas for further research.

141. SGCAG advice to Scottish Government was presented in a standard format summarising key points and then detailing the advice and evidence related to the questions as set. The format was defined by the chair and SGCAG Secretariat. The summary note and minutes of meetings, together with meeting papers, were the information available to the public and the format for these was determined by the SGCAG secretariat.

142. SGCAG advice was given on risk communication on 6 August 2020 [JR/036 - INQ000217837]. This was led by Mark Woolhouse, Aziz Sheikh, and Stephen Reicher and covered three main topics: COVID-19 risks; Tools to measure risk from COVID-19; and the principles of risk communication. I did not give specific advice to inform this and am not aware of how the advice was received or acted upon by Scottish Government. This has not been subject to evaluation by SGCAG.

143. I am asked about whether the messaging of the Scottish Government about its approach to the management of the pandemic promoted public confidence. I am not aware of any evidence to base a response to this on, and it is not my area of expertise. I am not aware the SGCAG was asked for advice regarding combatting misinformation, nor did I provide any advice on this to SGCAG.

144. Guidance was given in the TOR [JR/008 - INQ000217755] on confidentiality, and at the meetings by the chair, to make clear that if members were speaking to external parties, they made clear they were doing so in an individual capacity and not as member of the committee.

145. I am asked by the Inquiry to give a view on the role of high profile government member breaches in undermining public confidence. This is not my area of expertise. I am not aware of evidence related to undermining of public confidence related to any of the high profile breaches of COVID guidance.

146. I have no expertise in evaluating public health communications and I am not aware of the evidence base around public confidence in the Scottish Government's public health communications. I therefore do not have any specific comments on areas which worked well, any issues or how improvements could be made for future preparedness.

Public health and coronavirus legislation and regulations

147. Public health legislation and regulations is not something I have expertise on and am not aware that SGCAG advised on. The group gave advice, which was then used by Scottish Government to make policy decisions and may have informed legislation, recommendations or guidance during the course of the pandemic in Scotland, however the group had no involvement in those decisions.

Key challenges and lessons learned

148. I was not involved in providing any written or oral evidence to the UK Parliament, Scottish Parliament or their committees regarding the response to the pandemic.

149. I contributed to a lessons learned exercise as chair of CNRG [JR/006 – INQ000000], this assessed the role of CNRG related to its Terms of Reference in order to help inform future pandemic preparedness (see paragraph 32). I also took part in an independent review of care home outbreaks (see paragraphs 134-135 above) and chaired an independent UK CMO commissioned panel of High Risk Aerosol Generating Procedures (AGPs) [JR/038 – INQ000000].

150. As referenced above at paragraph 134, the CNRG lessons learned document details the learning from the group related to the Terms of Reference as these were set out. All CNRG members were able to contribute to this via discussions in the meeting and by email correspondence thereafter. The report contains 42 recommendations in ten topic areas, inclusive of: governance and connection to wider advisory group structures, the subgroup work, information sharing, surveillance, research and wider aspects of nosocomial infection prevention in the context of the pandemic.

151. Wider lessons learned on the core decision making of Scottish Government and the provision of timely scientific advice to inform this was not done by SGCAG and is not within my expertise to comment on.

152. I am not aware why the members of SGCAG were not involved in a formal lessons learned exercise undertaken by the Scottish Government. I believe this would have been helpful for future pandemic considerations.

153. I have been asked to consider if I would serve again on such a group as SGCAG and what could be done to make contributions more effective. Being a member of SGCAG was a good experience, as a result of the effective chairmanship and collegiate way all members worked together for a common goal, in line with the TOR for the group. CNRG was well supported by the members who gave their time freely and continued their commitment to these meetings over the duration of the pandemic. I am grateful for that support of CNRG members and of the ARHAI Scotland team who supported the work of CNRG. It was challenging to keep up with all the information and involved working very long hours and weekends for a sustained period of time, with limited ability to do academic research and putting many planned pieces of work (and personal life) on hold.

154. I would serve on SGCAG, CNRG or a similar group again. Communication on how long the commitment can be, inclusive of the additional work required for Inquiries, would help future planning. This planning could include formalising back fill for roles and managing expectation of employers and future candidates for membership of such advisory groups.

155. On two occasions I recall the SGCAG chair sought feedback on what was going well and what could be improved in the way the group was being managed. This was informal feedback to support improvements where these may be needed, I do not recall any recommendations for change arising from these discussions, although I found this a helpful exercise to check in with members in this way. The Chief Medical Officer (CMO) also asked group members whether the Advisory Group had met their expectations [JR/039 - INQ000217609].

156. In August 2023, the Scottish Government Chief Science Advisor (CSA) also asked for Scientific Advice from SGCAG for the Standing Committee on Pandemic Preparedness. Members of SGCAG met in groups to discuss key considerations. My advice related to that is detailed in the CNRG lessons learned report detailed above at paragraph 150.

157. In my view, national systematic review infrastructure surge capacity, to ensure clinical and other evidence is reviewed consistently, done once and in line with standard methodology during a pandemic would be helpful. The Australia National COVID Task Force approach is worth considering in this regard. This task

force had national level capacity and a standard methodology for all reviews done and these were published on a single website belonging to the taskforce, creating a single transparent source of evidence for all guidance.

158. SGCAG gave advice to Scottish Government based on best available evidence, to enable Scottish Government decision making. The process worked well, and I believe the SGCAG met the requirements of the Terms of Reference set out for it. There was no feedback on how this advice was received or used to inform policy decision making and this would have been welcomed.

159. Two other reports I contributed to during my time as CNRG chair may be of interest to the Inquiry. The first [JR/040 – INQ000349044] is an NIHR research priorities document which I participated in as part of the UK CMO AGP panel work, I chaired. The NIHR AGP team used an approach to develop consensus of the existing evidence by experts from science, engineering, infection prevention and others from the healthcare system and the conclusions note the evidence gaps in much of the science underpinning AGPs. Five priority areas for research were identified: Understanding the fundamental aerobiology, Risk factors for transmissibility, mitigating precautions and their components, Transmission of COVID-19 and other pathogens, and understanding infective risk perception, behaviours and acceptability of mitigation strategies.

160. The second [JR/041 – INQ000000] is a review of the Personal Protective Equipment (PPE) considerations of transmission based precautions in IPC. This was carried out by the European Centre for Disease Control (ECDC) expert group, of which I was a member. The Evidence to Decision (EtD) framework was used to develop expert consensus. The results pointed to the COVID-19 pandemic having highlighted a potential limitation of the underpinning theory related to droplet and airborne precautions and therein the application of transmission-based precautions, as used during the past decades. The group recommended that the IPC community should consider revisiting the current transmission-based precaution framework, regarding modes of transmission, definitions of terms related to transmission, and the consequence of infection as part of the criteria. It also highlighted that there are evidence gaps, and high-quality applied clinical research is required to address these gaps and strengthen the evidence for any future revision of transmission-based precautions.

161. The methods, results, conclusions and recommendations of lessons learned exercises and reviews I was involved in are summarised in paragraphs 32, 149 and 150 for CNRG lessons learned; paragraphs 133-135 for the care home rapid review and in paragraphs 159 and 160 for the two additional reports of interest submitted to the Inquiry.

162. In terms of the Scottish Government's response to these exercises, for CNRG advice on lessons learned, this advice was given to CNO for consideration and recommended to be shared with the SG pandemic preparedness group. The care home root cause analysis report recommendations were taken forward by Scottish Government in the 2020/21 adult social care winter plan (as detailed at paragraph 135 above). The additional reports detailed in paragraphs 159 and 160 were shared with CNRG and CNO.

Statement of Truth

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

Signed: Personal Data

Dated: 05.12.2023