Witness Name: Mary Ethna Black
Statement No.: 1
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF PROFESSOR MARY ETHNA BLACK

I, Professor Mary Ethna Black, will say as follows: -

1. Introduction

1.1 I make this statement in response to a Rule 9 request received from the UK Covid-19 Inquiry ("the Inquiry") on 31st August 2023.

1.2 I am deeply upset and personally affected by the tragic loss of life during this pandemic, and the consequences on society of the measures taken to control the pandemic. This Inquiry is an important exercise which I hope will contribute to establishing a public record. Above all, I hope this Inquiry will contribute to lessons learned as there is no doubt in my mind that another pandemic is likely to occur in future. I am happy to provide the Inquiry with any additional evidence to the best of my ability in respect of specific documents should any be drawn to my attention, as I wish to be as helpful as possible.

1.3. As a former employee of Public Health Scotland ("PHS") I do not have access to all of my papers. I have been assisted in getting access to certain documents by the PHS Covid-19 Inquiry Team, however PHS has failed (despite requests before my departure and assurance in June 2023 that this had been done) to archive any of my phone data (including calls, texts, WhatsApp messages, Teams chats and recordings), and is unable to provide access to my work calendar, saved working files, or any of my emails between 24th March 2020 and 9th November 2020. PHS has formally apologised to me for this error and I have had sight of PHS' explanation to the Inquiry regarding this. The lack of access

to my records has directly affected my ability to answer some of these questions completely and accurately. I note that there are several staff who have full access to their records and are currently working at PHS who will be able to fill any gaps within the questions that have been addressed to me. With that caveat, I can say that I have answered the questions to the best of my ability based on my recollection and the information available to me. I have paid especial attention to the lessons learned section.

1.4 I have been assisted in preparing this document by the legal team instructed on behalf of PHS. Except where I indicate to the contrary, the facts and matters contained in this witness statement are within my own knowledge. Where any information is not within my personal knowledge, I have identified the source of my information or the basis for my belief.

2 Qualifications/Experience

2.1 Qualifications/Memberships

2.1.1 I am a medical doctor with a full licence to practice and Public Health Medicine Specialty registration (General Medical Council Registration 3020959). My qualifications include: a Bachelor degree in Medicine, Surgery and Obstetrics (MB BCh BAO) from Trinity College Dublin, a Doctorate in Medicine (MD) from Trinity College Dublin, a Master degree in Public Health (MPH) from Harvard TH Chan School of Public Health, a Diploma in Child Health (DCH) from the Royal College of Physicians in Ireland, a Diploma in Obstetrics and Gynaecology (DRCOG) from Dublin University, and a Diploma in Tropical Medicine and Hygiene (DTM&H) from the London School of Hygiene and Tropical Medicine. I have completed a 14-month programme for Senior Executive Leaders in the UK NHS.

2.1.2 I am a Fellow of the Faculty of Public Health Medicine UK and the Royal College of Physicians of London, and a former Fellow of the Australian Faculty of Public Health Medicine.

2.1.3 I hold Non-executive Directorships of the UK National Centre for Atmospheric Science and the UK National Centre, for Earth Observation. I am an elected member of the

governing board of Patient Classification Systems International and a Trustee of the UK registered charity Paintings in Hospitals. My current professional affiliations include the Medical Journalists Association, the Guild of Health Writers, and Chapter Zero UK.

2.2 Experience

2.2.1 I trained in clinical medicine in Ireland and the UK, reaching the level of Senior Registrar, and I then completed the North East Thames training scheme in Public Health Medicine. My career has included clinical and public health work in Ireland and the UK, over ten years as a staff member with WHO and UNICEF, and emergency and subsequent post-conflict reconstruction in the countries of the Former Yugoslavia. I was the foundation Professor of Public Health and member of the management board of what is now the James Cook University medical school in far North Queensland. I have advised national governments, public bodies and commercial companies in health improvement, health services, social care and data systems. I have also consulted at national and international level on public health, health management, global household surveys and communicable disease control. My business interests have included helping found two international technology start-ups.

2.2.2 I returned to London in 2011 to establish the secretariat for Harnessing non-state Actors for Better Health for the Poor (HANSHEP), a group of development agencies and countries. In 2012 I was Project Director of the NHS London 2012 Olympic and Paralympic Games NHS Operational Plan and led on evaluation and reporting for the NHS in London. Between 2013 and 2014 I was Director of Public Health (DPH) for the London Borough of Havering and was the coordinating DPH for local authority sexual health commissioning across London. I then completed the NHS Leadership Academy's Executive Fast Track programme based at the Homerton University Hospital NHS Foundation Trust in Hackney, leading the "Healthy Homerton" initiative, assessing where to go next on regulatory compliance, and developing better clinical quality improvement dashboards. Between 2015 and 2017 I was Head of Digital Strategy and a Senior Advisor in Data automation at Public Health England. The role consolidated my UK experience in digital health and data.

2.2.3 In addition to my current honorary Professorship in the School of Medicine at the University of St Andrews and my previous professorial role at the University of Queensland I have

held academic appointments at the London School of Hygiene and Tropical Medicine, the Harvard TH Chan School of Public Health, and the Belgrade School of Health Management. My doctoral thesis examined how data from UNICEF's global household survey does (or does not) inform national policy and it has been useful in connecting numerical data to policy in subsequent global survey rounds and in Bosnia and Herzegovina. I have published in medical journals in relation to infectious diseases, international development, health protection and health policy, and have written long-running columns in the British Medical Journal and the (now defunct) Irish publication Medicine Weekly.

2.3 Role at Public Health Scotland

2.3.1 From 25th March 2020 until 8th January 2021 I was the Interim Board Clinical Director and Director for Protecting Health at PHS. In January 2021 Professor Nick Phin took up the permanent role. I was therefore the senior clinician and public health doctor in PHS from just prior to its inception on 1 April 2020 until I handed over my responsibilities to Professor Phin. I explain more about this role in section 3.

2.3.2 Between 1st November 2020 and 31st March 2021 I took on additional duties as one of three Strategic Incident Directors to cover the unplanned absence of a senior colleagues.

2.3.3 Thereafter, from 1st April 2021 to 30th Nov 2022, I held a part time medical consultant role in PHS as Senior Advisor in Covid-19 Vaccination which involved advisory but not operational or management responsibilities. I also covered weekend on call Strategic Incident Director duties on a 1 in 4 basis.

3. Sources of advice; medical and scientific expertise, data and modelling

3.1 UK and Scottish Covid-19 Advisory Groups

3.1.1 During my time at PHS I participated in the following Covid-19 Advisory groups:

Scotland:

i. The Scottish Covid-19 Advisory Group (SG C19AG). I was a participant from its inception on 26th March 2020 until 31st December 2020, when I handed over my participation to Professor Nick Phin who subsequently became a full member of the group in 2021.

ii. The Scientific Advisory Group on Testing – I was a member from its inception until 31 December 2020.

UK:

i. The Senior Clinical Advisors Group UK. I attended as part of the Scottish delegation from late May 2020 to31st December 2020.

3.2 My role and responsibilities

3.2.1 As noted at Section 1.2 I am no longer employed by PHS and I have very limited access to any records from this time. Consequently, the evidence within the following sections (sections 3 to 14) is not as complete as I would wish given those limitations. As my style of working and leadership is team-based and inclusive, I am confident that others within PHS will be fully appraised of the issues raised here and I would be more than happy to indicate to the Inquiry which current staff members would hold the most complete information.

Public Health Expertise

3.2.2 My specific areas of expertise within the field of public health, which are relevant to the advice I was asked to provide to the Scottish Government in its management of the pandemic, are as follows. My expertise lies in the area of public health, health protection, statistics and household surveys, digital and data automation, governance, organizational transformation, and teaching medicine and public health at graduate level. I am formally trained in health policy, and I have spent over ten years as an international public health advisor to national governments and development agencies.

3.2.3 My particular areas of expertise related to the health protection response from PHS are as follows. I am formally trained in Health Protection and epidemic response via the

(former) Clinical Surveillance and Disease Centre in London, and I have Health Protection experience within the UK and as a staff member and consultant with WHO and UNICEF. I have additional clinical training in infectious diseases, tropical medicine and bacteriology (microbiology and virology).

Role at PHS

3.2.4 I did not hold a position in any of the predecessor organisations to PHS (apart from a nominal 6 days at the outset of my employment with PHS), nor any other role in Scotland prior to my appointment. As I was not engaged or present during the early stages of the response nor during any pandemic preparedness in either Scotland or UK, evidence I provide in relation to those areas should be read with that in mind.

3.2.5 On appointment as the Interim Board Clinical Director and Director for Protecting Health at PHS I understood that my role would involve the following: providing expert evidence to the Chief Executive, Executive Management Team, the Scottish Government, Convention of Scottish Local Authorities (COSLA) and other organisations as required; leading on all aspects of professional and clinical public health leadership and governance within PHS; having cross organisational professional responsibility for specialist public health professionals; providing leadership and acting in support of emergency and contingency planning in relation to serious threats and events that could cause damage to the public's health; and providing leadership at a national level on all aspects of health protection as well as national professional leadership across Scotland on Health Protection.

3.2.6 In practice, my contributions to the Scottish Government in its management of the pandemic related to communicable disease control, epidemiology, vaccination programmes and digital transformation in relation to Covid-19. I was able to provide context on the current state of affairs within public health practice in Scotland and the UK. I contributed to topic discussions and gave my views on the state of the pandemic. Within PHS I provided oversight for the teams that provided pandemic response, some parts of contact tracing, guidance, Covid-19 data and vaccination. My background in digital health allowed me to contribute to the work of data and digital teams.

3.2.7 As Public Health Scotland was a completely new national body, the role to which I had been appointed had not been fully established. My experience was that in practice some elements of the new public health body were not yet fully developed. In particular, the leadership at national level on all aspects of health protection and the function of PHS in relation to the role of the NHS Boards were to my mind unclear, in particular via coordinating structures. Further, due to the pandemic, some elements that would normally sit with PHS were taken on by Scottish Government. A separate system of coordination for all aspects of the pandemic was put in place, with many elements pulled into Scottish Government-led teams. This was particularly true in relation to the vaccination programme, the testing programme and the advisory programme. I note also that the role and functions of the National Public Health bodies varied between all four devolved nations and care therefore should be taken in comparing decision-making processes.

3.2.8 My PHS team of around 120 staff came from two predecessor organisations and were rapidly reassigned to support the pandemic response. They were supplemented by others from across Public Health Scotland, secondees from other parts of the NHS in Scotland, and rapidly recruited staff, several of whom came back from retirement to help. At its largest around 400 staff were involved. There was a sense of urgency given the nature of the pandemic. As a result, our working hours were arduous, and overtime was extensive. Most staff worked 70 hours or more per week during 2020 and took little leave. We breached European Working Time directives in every month of 2020. Staff were also affected personally by Covid-19. Despite taking all protections in the workplace, putting strict limits on numbers who could be in a room at any time, and moving within weeks of my arrival to completely remote working with attendance by exception, staff members did get ill with Covid-19, as did their families. We had no deaths among the staff, but we did among family members. There was a strong sense of commitment to do everything possible to support the population of Scotland, and staff went above and beyond to fulfil their duties, liaise with colleagues across Scotland, the UK and internationally, solve problems and support each other. The personal and mental health toll on all staff was considerable.

3.2.9 One senior manager and three senior Health Protection Consultants reported directly to me. Kate Harley provided effective leadership in organising the teams, recruiting new members and provided in-depth knowledge of the Scottish landscape. Dr Jim

McMenamin, Prof David Goldberg and Dr Colin Ramsay had many years of experience in health protection in Scotland and shared the senior on-call rota. Dr Jim McMenamin was effectively the most senior consultant in terms of Strategic Response and was a member of several Scottish and UK Advisory Boards. Prof David Goldberg was particularly active in setting up the contact tracing system and in coordinating research, epidemiology and data design. Dr Colin Ramsay was particularly involved in Care Homes advice and the provision of guidance for health protection teams across Scotland. Prof Goldberg and Dr Ramsay were formally named alongside Dr Jim Mc McMenamin as Strategic Incident Directors from mid-2020. Both Prof Goldberg and Dr Ramsay have retired early, and I consider this to be due in great part to the pressures of working on the emergency. It is a great loss to Scotland to lose two such experienced and valuable staff. They contributed beyond the call of duty, as did many others.

3.3 Principles/policy behind the use of medical/ scientific advice in the Scottish Covid-19 pandemic response

3.3.1 The overarching principles which guided core political and administrative decision-making within the Scottish Government were to my mind guided by scientific advice. The First Minister, Nicola Sturgeon, frequently referred to 'following the science' and my personal experience was that she was very closely engaged with this and committed to it. On the very few occasions that I interacted with her on video calls, I observed that she had an eye for detail and wanted to be sure of any facts and to understand them. The Cabinet Secretary Jeanne Freeman was also very engaged with the evidence. However, it was clear that after advice was provided and considered, there was a separate process carried out within Scottish Government which led to the ultimate decisions taken.

3.3.2 The idea that 'no death from coronavirus was acceptable' was discussed internationally and in Scotland during the first year of the pandemic. While every unavoidable death is tragic, I did not get the sense that the Scottish Government policy was driven solely by a belief that coronavirus deaths were completely unavoidable, although the mantra of 'zero Covid' was expressed. As I understood it, the policy intention was to reduce deaths as much as possible, and this was driven by a sense that all Covid-related deaths were preventable. A completely zero rate of either infection or death was not considered feasible by any of the public health experts. This would have necessitated complete closure of

borders and much stricter enforcement of population movement, neither of which was practical or acceptable in the Scottish or UK context. It was also thought to be desirable but impossible to completely prevent transmission within hospital and care settings.

3.3.3 Covid safe measures were introduced to reduce transmission and protect the vulnerable. This involved physical distancing, reduction of face to face contact, face-masks, barriers and handwashing. This followed UK guidelines.

3.4 Informal Decision Making and communication

Informal Discussions

3.4.1 There was extensive use of informal, technology-based discussions by the Scottish Government and PHS throughout the pandemic. These were useful in terms of sharing of information and alerting the relevant people to new events and for mobilising the response. I do not consider that they were used to make substantial decisions. I note, however, that informal meetings and conversations were neither recorded nor minuted. As many online meetings were large (between 20 and 50 people at times) the Chat function on Teams was often used to share thoughts and reactions as people were talking. I often used this function to share useful links and references and to remind participants of the current data and discussions that had taken place previously. I understand that much of this material may not have been retained by the Scottish Government and none by PHS.

3.4.2 The channels that I used were WhatsApp, Teams chat, Slack (rarely), phone texts and messages, as well as phone conversations. The two main WhatsApp Groups I was involved in were: (1) Covid Outbreak Group and (2) Camera Stellata. Records of these have been shared with the Inquiry via PHS colleagues who were also members of these groups. There were multiple messages exchanged throughout the day, into the weekend and across the evening. I, and other senior colleagues in PHS, would be regularly called by Scottish Government for an update of the day. We would also alert our counterparts in Scottish Government if there was an upcoming issue to prepare for upcoming meetings and events, agree agendas and points for discussion and identify barriers to implementation of agreed actions. I considered this reasonable and good practice in what was a national emergency. In my view, informal discussions enhanced the efficacy of

decision-making by allowing the sharing of real time information and airing of issues. They allowed us to prepare for formal decision-making meetings, many of which contained large numbers of people. In particular, the chat function in team meetings was especially helpful in clarifying points that were being made or agreeing between us who might most usefully interject, or whether a particular issue should be taken up elsewhere.

3.4.3 I would like to clarify that all of my interactions with governmental colleagues and with counterparts across Scotland and the UK were carried out via digital means and I held no in-person meetings with politicians, external colleagues or government officials during my period of employment with PHS. I did have occasional in person meetings with senior colleagues within PHS and more frequent meetings with my immediate team, but to comply with guidance on distancing and gatherings these were extremely limited. I would also like to add that the tone of communications was professional, and I observed no instances of misogynistic, racist or unprofessional language. Nor did I experience any conversations where members of the public or groups of people were disrespected, or where people of a certain age or in nursing homes were regarded as less valuable than others. At the time, I recall being glad that I was working in Scotland and not England as the clear impression I gained from informal discussions with colleagues was that interactions with Government were more fraught in England. At times colleagues in Scotland were exhausted and stressed, but in my experience the conversations did not become disrespectful in tone in either formal or informal communications.

3.4.4 It is important to stress the sheer number of groups and meetings coordinated by Scottish Government and their constantly changing format. In contrast, the Health Protection meetings coordinated by Public Health Scotland followed a distinct schedule, referred to as 'the choreography of the day', the timing of which was well-coordinated with the meetings of Public Health England. All meetings were carefully recorded, and information was passed on clearly. Any changes to the 'choreography' of the health protection daily meetings followed a set escalation. I attribute this to the fact that Health Protection is distinct and developed as a profession and involves a similarly trained set of people, who have dealt with outbreaks over decades and know exactly how to work together.

3.4.5 During the pandemic I relied on conversations recorded in email chains, Microsoft Teams and WhatsApp groups to store information and respond to issues. PHS kept action lists

and decisions from the Health Protection response meetings during the Incident Directors daily cascade of meetings. In Health Protection and for investigation of outbreaks there is always a nominated a person as 'scribe' to record meetings as part of a formal process. This was used during the investigation of outbreaks and major incidents. I understand that a full record of these has been kept by Public Health Scotland. As explained at section 1.2, I no longer have access to these materials therefore I am unable to provide further details, however Dr Jim McMenamin will be fully appraised of this information.

Policies

3.4.6 Having cast my mind back, I am not aware of any guidance, policies or frameworks regarding retention of communications, messaging or data during year one of the pandemic, however I did raise questions within PHS about how our new remote working tools would retain this information. The rapid introduction of electronic systems in the middle weeks and months of the pandemic may have played a part in this organisational oversight, as their use was quite new. I faced considerable challenges within PHS in terms of a rapidly evolving emergency response structure that soon bore little resemblance to the original operating structure that was envisaged for PHS, and of setting up suitable electronic filing and management systems. These were not properly formalised until almost the end of 2020 and were not embedded until 2021.

New Bodies/Groups

3.4.7 There were existing close coordination mechanisms between the Health Protection teams at national and board level in Scotland and these were rapidly scaled up. PHS held daily consultations with health protection teams at Board level and I spoke frequently to Directors of Public Health across Scotland, as did my senior staff. I have great admiration for the work done at board level in Scotland and for the leadership of the local public health teams. The rapidly changing governance structures meant that new bodies, committees and working groups were formed all of the time, and the organigram of the Scottish Government response teams in particular changed regularly. I informally described the structure as a 'Hydra,' as it reminded me of a living creature that kept extending new parts of itself and seemed at times to be amorphous. There were considerable challenges in

ensuring the key PHS staff attended all the relevant meetings as they greatly outnumbered our available senior and qualified staff.

3.5 Scottish Government Covid-19 Advisory group ("SGCAG") and SAGE

Constitution, membership and role of SGCAG

3.5.1 The initial membership and discussions of both SAGE and SGCAG were weighted towards epidemiological advice, pandemic modelling and the introduction of Covid safe measures. They took account of learning from other countries and for the early stages of the response, they were adequate and essential.

3.5.2 At the outset of the pandemic, the composition was reasonable as the emerging evidence in these areas was fast-paced and benefitted from detailed discussions. This broadened from the middle of 2020 to include wider perspectives as the pandemic progressed and the consequences became more complex, being a mixture of direct effects of the virus and consequences of the measures taken to suppress it. The governance structures evolved to include wider membership and sub-groups, and this added depth to the discussions. I think that contributions from health economics, the economy, ethics and education could have been strengthened from the start of this process, and considered within the first quarter of 2020, as it was, to my mind, clear that this was going to be a global pandemic of large proportions. I think that forward planning and lessons learned came too late, as in my view from previous emergency work, lessons are learned as you go and are best recorded then.

3.5.3 SGCAG responded to direct requests from the Scottish Government in setting the agenda. As issues related to the economy, education, inequalities, vulnerabilities, mental health, and societal issues were brought to the group, discussions were had and advice was given, however these issues were not to the forefront at the outset of the emergency.

3.5.4 It might have been beneficial to have separate fora for different areas of expertise, but then there would need to be a process of melding this information into a consistent set of responses. This should be considered in future pandemics and a structure considered and discussed in advance, as it is very challenging to set one up de facto.

3.5.5 In my view the SGCAG should have been formed earlier. It was clear that localised decision making would occur during the pandemic across all four nations and an advisory structure to mirror that was necessary and useful.

Sub-groups

3.5.6 The Testing SGCAG sub-group of which I was a member, was instrumental in informing the response of Scottish Government to the pandemic. Discussion concentrated on the technical aspects of testing and was open and fact-based and the areas covered were specific, discussion papers were produced, and notes taken. A good range of experts and geographical areas was included. As Chair, Prof. David Crossman invited international experts and set questions in advance for us to consider. The key points of discussion and the presentations were,as I understand it, retained by Scottish Government.

3.5.7 I do not think the role of these groups was to conduct original research, and a separate process would have been needed to commission it, however they did draw attention to gaps in information. There were considerable efforts to spark original research led by Public Health Scotland, and the health protection team was particularly effective in this. Prof. David Goldberg led a large and productive research group which drew in researchers from across Scotland. I also note the leadership of Dr Jim McMenamin in this area, as he authored much of the original research.

3.5.8 I am strongly of the impression that advice of these groups was sought and also acted upon. There were regular presentations of information gathered and policy responses usually followed.

Data

3.5.9 There was a rapid increase in both volume and timeliness of data related to the pandemic, with most of this growth in 2020. Decision makers within Scottish Government expected daily data reports and these were produced as rapidly as possible. Many of the data streams were entirely new. There were limitations to both speed and access at the outset of the pandemic due to lack of everything – qualified staff, data and technology systems,

agreed definitions, and data design. These were systematically overcome but that took time. The most useful systems were those already in place within Health Protection teams and employed within infectious disease outbreak management.

3.5.10 The initial contact tracing system was completely overwhelmed before I arrived in late March 2020 and needed to be redesigned and scaled up. This took time, and that work began in May 2020.

3.5.11 Initially, there was a pandemic of modelling itself, with many different models at the outset of the pandemic. Soon this was whittled down to a few reliable sources and when local data was available this strengthened the models used. In my view the work on pandemic modelling was appropriate, and it was supplemented and improved by the emerging real data. The addition of new types of data, for example, from genetic testing was useful. There were routine hiccups in terms of data flows, and teams in both PHS and Scottish Government worked to correct and fix these continuously. By summer of 2020 this production of data had improved immensely, and the national system was working reasonably well. The joint work on data production was challenging but effective.

3.5.12 The Inquiry has expressed interest in my British Medical Journal blog published on 25th August 2023 entitled "Covid-19 heroes—putting faces to the numbers" (MB/1-INQ000351679) which was a collaboration between the UK Charity Paintings in Hospitals (of which I am a Trustee) and NHS Heroes, an art project depicting portraits of NHS staff. At the time I was greatly affected by the unfolding tragedy of Covid-19 deaths, particularly within care homes, and concerned about the well-being of my staff, many of whom were at breaking point. I had several family members working in clinical settings at the forefront of the response, had lost friends and neighbours and had family members with longstanding consequences of infection. I wanted to do something to honour the courage of those who put their lives and health at risk to help others, and also to remind us that every number reported in a table referred to individual lives and, in the worse cases, deaths. This is why I wrote the blog.

3.5.13 I referred to a number of technical terms in the blog and can clarify what they mean as follows: "Statistics" is the science of counting clinical and other events, in this case in relation to the pandemic. "Data capture" refers to the ability to collect and record all such

events. "Automation" refers to processes that enable the production of data to rely less on manual counting and more on coding and other ways of pulling data from recording systems, and "linkage" refers to how we connect pieces of data to each other. All of these underpin the production of data sets.

3.5.14 In the blog I noted *'Lately, I've found myself checking for the meaning behind each covid-19 data point: is that really a case, or a death, or correctly tagged as a healthcare worker?'* The reality with concrete reported numbers is they are a much reduced depiction of real events. For example, the clinical case definition of Covid-19 evolved as we discovered more about the virus. A death attributed to Covid-19 might also represent someone who died from another cause but either had Covid-19 at the time or within the agreed period pre-dating death. The data that assigned occupation to deaths (for example 'health care worker') was also quite dependant on administrative record keeping. One of the tenets of good public health practice in relation to data is to be very clear what you mean when you present numbers. Much time was spent during the pandemic in checking and rechecking data and making sure it was as accurate as possible, and also providing clarification on what that data meant, how to interpret it, and what it might represent.

3.5.15 I have exhibited another piece that I published on March 2020. 'A Love letter to the Royal London Hospital,' (MB/2 – INQ000351677) warns that there will be sad and difficult times ahead and wishes my local hospital well. I understood that the role of public health teams was to prevent illness and infection and that the brunt of clinical care would be felt in clinical settings. I wished to acknowledge this, in anticipation of the scale of the tragedy and the courage of the responders.

International perspectives

3.5.16 In my opinion sufficient attention was paid to emerging international evidence. The SGCAG had a direct link to SAGE. I do not think this communication could have worked any better. There were several notes commissioned on international experience. Further, there was considerable advice available via professional channels and through the media. As a result there were few gaps in information about what was happening across the world. One issue that caused both debate and concern was over the Great Barrington Declaration and concepts of natural immunity. This was discussed at length and I and my

colleagues in Public Health Scotland disagreed with it and advised the Scottish Government accordingly.

Scotland v England

3.5.17 To a large extent, Scotland followed the Non-Pharmaceutical Intervention (NPI) response timeline and scope of the UK. There were some specific differences that I recall were related to the likely pandemic curve in Scotland and also there were differences of approach in relation to school re-openings. These policy differences overall were small. From memory I recall considering that there might be a delay of ten days to two weeks before a rise in figures in England was reflected in the Scottish data, and this was noticeable for periods of 2020. There were also differences between Scotland and England in the numbers of people who were permitted to attend gatherings, and the definitions of households and clusters.

3.5.18 Within PHS we were clear that the 'Eat out to Help Out' scheme would result in a surge of cases. It was equally clear that this was a UK Government decision, and like many policy decisions, it was then adopted in Scotland. My strong impression was that this was a political decision and not based on disease control evidence but fuelled by economic and other drivers.

3.5.19 Public Health Scotland was closely involved in encouraging the opening of schools and advised very clearly that there were direct consequences on children not to do this, and in particular such a decision would adversely affect families with fewer resources. My recollection is that Scotland was more proactive on this than the rest of the UK. Diane Stockton was the senior PHS colleague most closely aligned with advising the Scottish Government on the reopening of schools and can advise in more detail.

3.5.20 As explained already in this statement, I took up my role in Scotland on 25th March 2020 and so cannot directly comment on events in Scotland before that time. However, I gained a general impression that the Scottish Government had access and paid regards to the response of other countries to Covid-19 and were considering this seriously. Furthermore, in my view the Scottish Government stuck quite closely to WHO advice during the pandemic but was also strongly influenced by the timing and content of UK-level decisions.

4. Covid-19 Public Health Communications

4.1 Public confidence

4.1.1 Public confidence is of course very important in relation to matters of public health. In my view Partygate and the Barnard Castle affair were notable breaches that undermined confidence in the UK Government. People were rightly angry, having made considerable sacrifices to obey the rules. I was dismayed and personally lost trust in the individuals involved and in the lack of transparency over these events, and I have been astonished at the revelations so far about behaviour in political and civil service teams in England.

We made strenuous efforts to obey the rules within my own team in PHS. I insisted that we closely replicate the advice given to members of the public within our own practice, and gatherings and parties at work were simply not permitted. I cannot understand why senior UK politicians and civil servants were so lax and unaware of public perception, given members of the public were being fined at the time for such behaviour, and were unable to visit relatives in hospitals and care homes, or to attend funerals. At the time, I found the explanation of Dominic Cummings in relation to Barnard Castle reprehensible and considered his version of events to be questionable. I have not changed my opinion since.

4.1.2 In Scotland, after breaking lockdown guidance with a family outing, the Chief Medical Officer Catherine Calderwood resigned, apologised, and her replacement was speedy and effective (her deputy). I was sorry to see her go as she had reached out to me on my arrival in Scotland and I found her to be effective. I consider that Margaret Ferrier's breach and travel arrangements were of a more serious order of magnitude as her actions put others directly at risk of Covid infection. That affected both professional and public confidence as it showed a clear lack of judgement. Removing a face mask at a funeral was a mistake, but the First Minister apologised clearly, which is something that did not happen in relation to the incidents in England that I refer to in 4.1.1.

5. Initial understanding of and response to covid-19 in the period from January to March 2020

5.1 As a public health doctor, I closely followed the early stages of the pandemic and the emerging information from Wuhan. With the WHO confirmation on 12th January that this was a coronavirus, it was clear that this virus had all the potential for rapid spread, could be transmitted quickly from person to person, and was an airborne virus. This was enough to be on high alert. It became a notifiable disease in Scotland on 20th February 2022, a necessary step in pandemic management. I was not working within the UK public health system at the time but offered through my contacts to assist in the event that the pandemic became serious.

5.2 In Scotland, the first case was reported on 1 March 2020, community transmission (from one person to another in a community setting) was reported on 12th March 2020, and the first recorded death was on 13th March 2020. On March 13th I flew back to London from Norway as the country had announced that airports would be closed, and it was clear to me that a major pandemic was underway. I was approached by Public Health Scotland on 16th March 2020, informally interviewed on 18th March 2020, and accepted the role of Interim Director immediately. On my arrival in Scotland it was clear that the epidemic curve was slightly behind that of England by a matter of perhaps a week or ten days. The Health Protection team were working at full speed and had been visited by Jeanne Freeman in her role as Cabinet Secretary for Health and Sport. The existing contact tracing system was already overwhelmed at this stage as it was suited to small outbreaks rather than a pandemic and it lacked staff, tools and scale.

6. Testing

6.1 Testing was an area that moved rapidly and there was extensive discussion on how to scale up testing. A game changer was the introduction of widespread rapid antigen testing. I was initially sceptical of its use as this seemed to have a very high false positive and false negative rate, and so I was unclear what it might contribute. This was extensively discussed in the SGSAG sub-group on Testing and I could then see how it might be useful.

7. Decisions in relation to Non-Pharmaceutical Interventions

7.1 The vast majority of Non-Pharmaceutical Interventions closely mirrored those that were announced in England. This was the case in all the devolved nations. In terms of advice given to our various governmental colleagues, as advisors we participated in and shared the various scientific advice mechanisms and also had access to and discussed the same data. My understanding was that when the Scottish Government opted for a different set of measures that this was by exception and local arguments were put forward. Due to my lack of access to records, I am unable to provide specific examples or dates. However, the decisions and any variations in measures taken within government circles have been set out clearly in the various PHS corporate statements.

8. Decisions relating to the first lockdown

8.1 During 2020, my efforts were directed at ensuring that the best possible data could be presented as quickly as possible to the Scottish Government to enable good decision-making. The shape of the curve was a key factor in decisions about relaxing first lockdown measures, much effort was spent considering the figures in relation to decisions that would encourage wider circulation of people. We were also closely monitoring the emergence of new strains and analysed how they were moving through the population and if a new strain had any additional characteristics, for example spreading more rapidly or causing more severe disease or death. At this stage we were still learning about the virus and had not yet had a full year of data, and only best guess at the natural history of the infection.

9. Decisions relating to the second lockdown

9.1 By the second lockdown, I concentrated on supporting the vaccination programme and contributing to efforts to scale this up as quickly as possible. In my view this was a key route out of future lockdowns.

10. Care Homes and Social Care

10.1 The situation within Care Homes and Social Care was clearly a catastrophe. At the outset this was compounded by a lack of PPE, and a focus on the hospital sector. Lack of access

to testing was also a factor in the first wave of the pandemic. Considerable efforts were put into addressing the situation with an extensive set of consultations and meetings led by Scottish Government and including the Health Boards and other experts. Within Public Health Scotland my colleague Dr Colin Ramsay took the lead on advising the Scottish Government and developing guidance in this area and was supported by Dr Maria Rossi. I recommend that further information is sought from Dr Rossi in the event that this is needed.

10.2 One area that the Inquiry might consider is the use of genetic testing in relation to understanding the transmission in care homes. Public Health Scotland used a ground-breaking approach to genetic testing to demonstrate in mid 2020 that there was transmission between care homes, most likely due to agency staff and movement of staff between care homes owned within a chain. The Inquiry might wish to consult with Dr. Jim McMenamin on this issue.

11. Borders

11.1 The control of borders was clearly a UK function. What did transpire was the practicalities of responding to the movement of people from England to Scotland, as at times the guidance diverged. There was close communication between PHS, SG and Public Health England on how to advise in relation to borders. There was also effective coordination between PHS, SG and Health Board teams in relation to maritime ports and the oil industry in relation to Covid-cases on board ships and oil rigs.

12. Public health and coronavirus legislation and regulations

12.1 Under emergency powers, there was an increased range of options available in terms of population control. At no stage did I get the sense that either the UK or the Scottish Governments considered the extreme measures that were introduced in China. It was considered that UK society would never tolerate such draconian measures, nor were there the mechanisms in place to enforce such severe lockdowns.

12.2 The introduction of compulsory vaccination for health and care workers was controversial. Compulsory vaccination has not been a feature of community vaccination in the UK and the introduction was likely to have consequences in terms of public trust and confidence and quite likely lead to a backlash. My advice was to avoid compulsory vaccination as it was likely to have a negative effect long-term on all vaccination programmes and it ran counter to the carefully build trust ethos in vaccinations.

13. Key challenges and lessons learned

13.1 Challenges relating to contributing to Scottish Government Pandemic Response

13.1.1 Since receiving my Rule 9 letter I have reflected carefully on my experience of the Covid-19 pandemic. I consider there were four factors that impacted on how I was able professionally to contribute to the Scottish Government pandemic response. The first was that PHS was formed as a new organization on 1 April 2020, 6 days after I arrived. This meant that most of the systems were not in place or clear and meant I spent considerable amounts of time organizing and managing people and resources. I was also new to Scotland. The second was the extent of the pandemic itself, which required an almost complete reorientation of effort and direction. The blueprint for PHS was of little use as it related to an entirely different set of planning assumptions and it was anticipated that the detailed operational plans and organizational structures would be developed in 2020. The third was the abrupt shift to remote working which substantially changed the way teams interacted. The fourth was the sheer size of the Scottish Government response. Very rapidly large teams were put in place, and they also reshaped their structure and teams over time. This affected the lines of communication as they were continuously being redrawn and took much effort to understand and support.

13.2 Lessons learned

Creation of PHS

13.2.1 I have debated on whether the decision to continue with the formation of Public Health Scotland was the right one or not. I believe that on balance it was, but the level of

disruption to the functioning of the Health Protection Teams in particular, and the lack of key supporting infrastructure was under-estimated and then exacerbated by the pandemic I also think that the role of the new national public health agency for Scotland vis a vis the Scottish Government and the rest of the public health system in Scotland had not been fully evolved.

13.2.2 Scotland has significant advantages as the national public health agency has a broad remit. I was dismayed to learn that Public Health England was to be disbanded in the midst of the pandemic and its functions split. In my opinion this seemed to be a political decision to identify an organisational scapegoat for wider failings and I remain convinced that it was a poor decision. In my opinion, there are likely to be knock on effects on public health coordination and response across the devolved nations as Scotland, Wales and Northern Ireland have kept a more integrated approach at the national level.

13.2.3 NHS boards have considerable expertise in public health with good local coordination. The working relationship between PHS and boards in relation to health protection and pandemic response was close and, in my view, effective and supportive.

13.2.4 A key part of restructuring the health protection team was the decision to keep the hospital infection control staff within NSS Scotland – the Antimicrobial Resistance and Healthcare Associated Infection team, otherwise known as ARHAI. This meant that the Health Protection service was divided, with community and hospital infection teams that were originally in one organization now split between two organisations. It was not ideal that this should have happened at the outset of the pandemic and took some time to reconfigure. I am not convinced that these functions should be separate as they were eventually configured, however close coordination should help.

Guidance

13.2.5 There is much to learn about the production and issuing of guidance during a pandemic. The Health Protection team had a key role to issue guidance on health protection issues that was then implemented across Scotland. This had been working well and in place for many years. With the Covid Pandemic, the Scottish Government began to create its own guidance at the national level. Also, UK guidance was continuously being updated and

the Scottish guidance was then adjusted to incorporate local issues. We referred to this process colloquially to 'putting a kilt around the UK guidance.' The pace of change was rapid. There was a particular challenge in relation to getting authorization from the Scottish Government for Health Protection guidance. At one stage guidance approval that was needed by public health teams at board level in relation to care homes was delayed for around six weeks. We put in place a monitoring system and a serious of key steps to mitigate these delays, but reaching agreement and obtaining approval from Scottish Government remained a cumbersome task.

13.2.6 Prior to the pandemic, the health protection team within the predecessor organisation to Public Health Scotland had a comprehensive process in place to agree and update health protection guidelines and sought to include the views of a wide range of stakeholders. Previously, there had been a well-functioning system of slow and deliberate engagement on the development of guidance for public health teams across the entire public health network, however this was simply not feasible during the pandemic. With this shift to Scottish Government leadership of pandemic response, and the rapid changes needed, this system was changed. The emergency system involved guidance developed by Public Health England, adjusted by Public Health Scotland and then signed off by Scottish Government. This process was quite new, and to some extent cut out the consultation steps with wider stakeholders. There were also separate sources of advice from within the Scottish Government and from newly formed and changing committees, and the Cabinet Secretary for Health and Sport insisted on signoff from the CMO office and her own team. This was understandable but did lead to delays, only partly solved by agreeing a formal process. It would be useful to revisit these mechanisms for future emergency situations and create a standing emergency process for health protection guidance that could be put in place from the start of the next emergency.

13.2.7 I consulted with colleagues in England on this matter who briefed me on their 'Triple Lock' system and was advised that reaching agreement and signoff was even more challenging there. My conclusion is that comparison the process of reaching consensus between government and public health colleagues in Scotland was at times challenging but overall it was less fractious than in England. I should add that Public Health England did the bulk of the technical work in developing guidance and Scotland relied heavily on this.

Coordination

13.2.8 Many of the coordinating mechanisms set up by the Scottish Government involved multiple people, the majority of whom were civil servants. An underlying issue was a lack of public health expertise within the Scottish Government, which had been noted even before the pandemic. I am aware through discussions with Dr Andrew Frazer, a senior public health colleague within PHS and former advisor to the CMO in Scotland, that there had been previous recommendations to strengthen the public health advice within the Scottish Government. My impression was that this had been lagging before the pandemic and was noticeable during it and only partly solved by additional temporary recruitment.

Care Homes

13.2.9 The situation in care homes became a catastrophe, with rapid transmission within those settings. A key factor was the discharge of people from hospitals to care homes without a clear negative test. Even when this process was improved, and in fact the Scottish Government instituted a policy of two negative tests before transfer from hospital to nursing home, transmission continued to occur. One key factor was the movement of agency and other staff between care homes. This was a structural issue within the care home sector that preceded the pandemic and there appeared to be no effective means to prevent it.

The Covid-19 Vaccination Programme

13.2.10 The coordination of vaccinations was a function held by the national public health teams which then transferred to the new national body, Public Health Scotland. Requests were made to the Scottish Government vaccination team led by Derek Grieve between June and August 2020 to clarify who would lead the expected vaccination campaign when the Covid-19 vaccines became available, given this vaccination role was held in pre-pandemic times by the Health Protection teams. This was important in relation to planning for the expected massive scale up of service. PHS was finally informed that the Scottish Government would set up a separate process to coordinate the programme. This decision by Scottish Government could and should have been made earlier. There was an alternative model in which the extensive new teams could have been embedded within

PHS but a short-term turnaround would not have been possible. As of writing, coordination has returned to PHS, but it would be useful to know how much of the Covid-related technical developments are useful and suit the delivery of the overall vaccination programme. Also, to agree what would be the arrangements if a scale up would be needed for a future pandemic. In my view, strengthening existing local systems is usually the best option, but this takes forward planning.

Misinformation

13.2.11 The rapid rise in misinformation has had consequences for public trust. The narrative was no longer controlled solely by professional and informed advice. Also, for the first time, vaccination staff were threatened and there were serious security concerns on the ground. The use of social media to both spread information and target individuals was considerable. This will have long-lasting consequences for staff and in my view we need a much more robust way of dealing with this issue.

Ethnicity

13.2.12 It was clear within the first phase of the pandemic in 2020 that Covid-19 differentially affected ethnic groups. In my view having the best data possible in relation to ethnicity within the vaccine programme was going to be important. In my interactions with Scottish Government I was concerned at the lack of data in relation to ethnicity and Covid-19 and strongly recommended that this data be captured within the Covid-19 vaccination programme during its design and during the development of the Covid-19 vaccination digital operating system. When asked by SG to submit key design feature for the Covid-19 vaccination programme, including the digital infrastructure to support it, PHS indicated verbally and in writing that ethnicity was one of the key data sets that should be collected. This advice was submitted to the rather complex and multilayered vaccination design process from September 2020 onwards. The direct advice given by Public Health Scotland was disregarded. The explanation given during committee meetings and conversations with Caroline Lamb, who was leading on the Covid-19 vaccination programme for the Scottish Government, was 'operational issues.' I exhibit a series of emails (MB/3 - INQ000343135) and I note that by the time I left Public Health Scotland in November 2021, this issue had only been partially addressed.

13.2.14 It was possible to obtain proximate ethnicity data by combining other sources of information that gave some insights into ethnicity and Covid, but these were less accurate than recording real time data. This is an example of an underlying issue that needed to be addressed for some time and that was brought strongly to the fore by a pandemic that adversely affected people from certain ethnic groups. It is also an example of how the extraordinary response and sheer scale of the response at times led to issues being pushed to one side as being 'too difficult'. I think it would be important to assess whether the gathering of public health data in respect to ethnicity is now sufficient and appropriate and to ensure identified disparities and any service gaps are addressed through a comprehensive action plan. I would suggest that the Inquiry speak directly to either Dr Jim McMenamin or Prof Nick Phin in relation to this issue.

13.2.15 We have clearly learned from this pandemic that ethnicity, socio-economic status and other factors were directly related to death, severity of illness and long-term consequences of Covid-19. These factors also contributed to the negative effects of control measures. It is really important that reliable data is obtained from the outset of any future pandemic and is factored into decision-making.

Health Protection workforce

13.2.16 The Scottish Government operated a shift system in their response teams. Public Health Scotland did not have the staffing to do that in specialist areas, so we operated on normal working hours plus extensive overtime. This meant often having to explain technical issues to several colleagues within Scottish Government who were encountering them for the first time. I found that the health protection and response teams were under-staffed in PHS and across the NHS Boards, and it would be essential in my view to maintain those teams at a safe level in future and to have concrete mechanisms for scaling up in the event of a future emergency.

14. Documents

14.1 I have explained at 1.2 above the material that is no longer available, including most of my emails. PHS has provided my emails from 30 November 2020 onwards, but no other records are available to me. I have requested that Public Health Scotland send copies of any documents or emails sent by me and copied to others during the period from my appointment to 30th November, however PHS has not yet provided me with that material. I would be happy to respond to the Inquiry if any such material does emerge during the Inquiry process.

14.2 I understand that the WhatsApp Groups I was involved in (and refer to at 3.4.2 above) have been submitted by PHS.

14.3 I do not retain any contemporaneous diary, notes or voice memos relating to my involvement in the Scottish Government's response to Covid-19.

14.4 Any advice or notes to Scottish Government I hope have been retained by them or PHS. I am aware that there has been incomplete retention of records from this period, in particular in relation to Teams records.

14.5 I have published the following blogs relating to the UK and/or Scottish Covid-19 responses:

- Plastic waste from PPE does not need to happen – British Medical Journal, October 27, 2020 (MB/4 – INQ000351680).
- A Love letter to the Royal London Hospital, British Medical Association website news section, 27 March 2020 (MB/2 – INQ000351677).

14.6 I cannot comment on whether any transcripts of evidence are being retained in respect of the decision-making of the Scottish Government in its management of the Covid-19 pandemic to either Westminster or the Scottish Parliamentary committees. As far as I am aware, Public Health Scotland is adopting a policy of full disclosure of all available documents, although I understand that there are gaps in record-keeping.

Statement of Truth

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

Signed:

PD

Prof Mary Ethna Black FPH FRCP MD MPH DTM&H DCH DObst.

Dated:

24 November 2023