Witness Name: Professor Nicola Steedman
Statement No.: 1
Exhibits: [NMS]
Dated: 01 March 2024

UK COVID-19 INQUIRY
Module 2A

WITNESS STATEMENT OF PROFESSOR NICOLA STEEDMAN

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

1. I am Professor Nicola Steedman, currently employed as Deputy Chief Medical Officer (DCMO) for Scotland.

2. This statement covers the period from 21st January 2020, which is the date on which the World Health Organisation (WHO) published its 'Novel Coronavirus (2019-nCoV) Situation Report – 1' and 18th April 2022, which is the date when the remaining Coronavirus restrictions were lifted in Scotland.

3. I have prepared this statement myself and by reference to records and material provided to me by the Scottish Government Covid Inquiry Information Governance Division.

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

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

Personal Details

6. I held the post of Interim Deputy Chief Medical Officer for Scotland from 14th April 2020 until the end of June 2021, following which I took up the substantive post as DCMO, the post in which I currently remain.

7. I was asked to take up the post of Interim DCMO in the CMO Directorate (CMOD) in April 2020 following the appointment of Professor Sir Gregor Smith to the post of Interim Chief Medical Officer.

8. My qualifications include an undergraduate degree from Cambridge University (BA (MA) Hons.) and medical degree from Oxford University (BM, BCh). Other qualifications include the Diploma in Genitourinary Medicine (with distinction) and the Diploma in HIV Medicine. I am a Fellow of the Royal College of Physicians of Edinburgh and a Member of the Faculty of Public Health (through distinction). Since 2021 I have been an Honorary Professor at Glasgow Caledonian University.

9. I trained initially in acute medicine specialties and then undertook higher medical training in Genitourinary Medicine with HIV. A proportion of this training involved time working in Infectious Diseases more broadly. I worked as a Consultant in Genitourinary and HIV Medicine in England from 2008 to 2011, following which I took up a national post in Scotland as a Senior Medical Officer (SMO) for Health Protection within Scottish Government. I remained in this position until 2019, including a five month period as acting DCMO. From 2017 to 2019 I also held the post of Clinical Lead for National Maternity and Sexual Reproductive Health Data in NHS National Services Scotland. In 2019 I was appointed full time as Medical Director for National Procurement, Commissioning and Facilities at NHS National Services Scotland.

10. NHS National Services Scotland continue to be my host employer, and I am on a Service Level Agreement (SLA) to Scottish Government in my position as DCMO.

11. I continued to be active in terms of clinical practice until March 2020, holding an Honorary Consultant Physician position within NHS Lothian in the Regional Infectious Diseases Unit, and with a cohort of HIV-positive patients. I ceased individual clinical practice when the first lockdown was instituted in relation to the SARS-CoV2 pandemic.

Initial understanding and response to Covid-19

12. In terms of my role in the response to Covid-19, I was appointed as Interim DCMO within the Chief Medical Officer Directorate (CMOD) in mid-April 2020. Prior to that I was not in a national government advisory role and had no input into any advice given or decisions made with respect to the pandemic.

13. I therefore cannot comment on the initial 'national lockdown' decision in March 2020, the NIKE conference in Edinburgh in February 2020 or the Scotland v France Six Nations rugby match in Edinburgh in March 2020.

Role during and response to Covid-19

14. The CMOD seeks to achieve the best health and care outcomes for people by working with Ministers and stakeholders to protect and improve public health, and to oversee the effectiveness of healthcare services in Scotland. My role as DCMO is to support the Chief Medical Officer (CMO) in order to achieve the delivery of these outcomes and services. In some instances this will also involve deputising for CMO at meetings or events when he is on leave or otherwise unavailable.

15. As DCMO I provide clinical advice within Scottish Government where and when this is required. From my appointment date in April 2020 until the date specified in this request, and in relation specifically to the Covid-19 response, my areas of clinical focus included the following:

    a. Covid-19 testing
    b. Vaccination

c. Clinical and scientific interfaces (e.g. attendance at SAGE, Scottish Covid-19 Advisory Group), alongside the Chief Scientist Health (CSH)
d. Data and surveillance
e. Therapeutics
f. Covid-19 certification

16. My role in these areas was to provide clinical advice to the CMO, policy colleagues and Scottish Ministers, to support ultimate decision making by Ministers and to inform related guidance. I also had three Senior Medical Officers (SMO) who reported to me and contributed to the clinical and public health advice on the above topics.

17. I was not involved in decisions relating to the timing of the second 'national lockdown' in Scotland in January 2021.

18. In general, my clinical advice was based on a variety of factors including the prevailing national and international epidemiology (cases and disease severity); Scottish and UK modelling projections; vaccination availability, uptake and efficacy; testing availability and performance; scientific developments (in terms of viral and disease understanding, testing, vaccination and therapeutics).

19. My clinical advice was also informed by that of expert advisory groups including, but not limited to, SAGE, the Scottish Covid-19 Advisory Group and the Joint Committee on Vaccination and Immunisation.

20. In addition to forming my own clinical view on matters, I would sometimes discuss these with other CMOD senior clinicians, including the other DCMOs and CMO himself, particularly if the issue was complex and/or uncertain. This would then enable a clinical consensus view to be achieved and presented as such. Occasionally these senior clinician discussions would also involve the National Clinical Director (NCD) and/or the Chief Nursing Officer (CNO), depending upon the topic.

21. Additional clinical fora groups where issues were discussed and which contributed to the clinical advice within Scottish Government included the Clinical Cell and the multispecialty Professional Advisory Group. These have already been described in the Module 2A DG for Health and Social Care corporate statement, provided to the Inquiry on 23 June 2023 [NMS/001 - INQ000215488].

22. In terms of the wider health, social and economic impacts of the pandemic and response to it, Scotland approached assessment of this through the lens of the 'Four Harms', as described in in the Module 2A DG for Health and Social Care corporate statement [NMS/001 - INQ000215488]. Those harms were: (i) the direct effect on society's health by the virus (ii) the indirect effect on health as a result of the virus (iii) social effects (including issues such as loneliness and education) and (iv) economic impact. The CMO sat on the Four Harms Group, and DCMOs would deputise for him in that role if required. This group also considered the impact of the pandemic on vulnerable and 'at risk' groups.

23. The clinical contribution, including mine, to the Four Harms processes focused on harms (i) and (ii), and the assessment of these. Ministers taking the decisions in government clearly would consider and balance all the identified harms.

    I cannot comment on the extent to which consideration of wider impacts and/or views as to the period of time the public would comply influenced decisions regarding NPIs as these decisions were made by Ministers. In terms of my role in these factors being weighed up as part of Scottish Government decision making, clinical advice in the Four Harms process (including mine) was principally in relation to harms (i) and (ii) as above, however any broad clinical advice on NPIs did include an awareness of the potential benefits and disbenefits.

24. I was not specifically involved in the provision of advice in relation to the 'clinically extremely vulnerable' (previously known as 'shielded') population. In terms of the impact of NPIs on other groups, including those with protected characteristics, my view is that Scottish Government endeavoured to consider these throughout the pandemic response.

25. A number of Equality Impact Assessments (EQIA) were undertaken as part of NPI policy recommendations, and are publicly available. Examples of these include (but are not limited to):

    a. Equality and Fairer Scotland Impact Assessment: Evidence gathered for Scotland's Route Map through and out of the Crisis (July 2020)
    b. The Health Protection (Coronavirus) (Requirements) (Scotland) Regulations 2021 (including the requirements for face coverings)
    c. Coronavirus (COVID-19) domestic vaccine certification (November 2021)

26. I was not directly involved in the writing of these EQIAs.

27. With regards to the lockdowns and other NPIs implemented in Scotland, as mentioned below, my view is that the Four Harms process was an effective vehicle for sharing information and discussion across relevant departments within Scottish Government.

28. Considering communications regarding NPIs between Scotland and the UK, I can only really comment on the clinical and scientific elements of this. In this respect information sharing and communication worked very well, especially between the four nations CMOs. Additionally, the ability of Scotland's senior clinicians (CMO or DCMO) to attend SAGE was extremely valuable in providing consistency of scientific understanding in terms of NPIs.

29. In terms of interactions with Local Authorities, when Scotland was in the response phase with the "levels" system in place there were regular discussions between individual Local Authority leaders and Ministers regarding the assignment of levels. In most cases a senior clinician (the CMO, DCMOs, NCD, Deputy NCD, CNO, Deputy CNO) would also attend these meetings in order to explain the local epidemiology and other clinical considerations. I attended a number of these meetings during that period.

30. The four nations CMOs' and DCMOs' understanding of the virus including its severity, the measures available to limit spread, and how this understanding

developed over the course of the pandemic can be found in the Technical Report on the Covid-19 Pandemic in the UK (published 1st December 2022) written by the four UK CMOs, previously provided to the Inquiry [NMS/002 - INQ000130955].

Role in relation to medical and scientific expertise, data and modelling

31. In relation to the Covid-19 response, I was a member of (or, in some cases, deputy for the CMO) a number of clinical and scientific groups, both Scottish and UK including:

    a. The Scottish Covid-19 Advisory Group
    b. The Scottish internal CMOD advisory group of senior clinical advisers
    c. The Scottish National Incident Management Team
    d. The UK Senior Clinical Advisers Group
    e. The UK 4 CMOs Group
    f. The UK Scientific Advisory Group on Emergencies (SAGE)

32. More detail on these groups can be found in Module 2A statement number 4 by the DG Health and Social Care, already provided to the Inquiry on 23rd June 2023 [NMS/003 - INQ000215470]. Additional detail on my role as DCMO in terms of both the Scottish Covid-19 Advisory Group and SAGE can also be found in my Module 2A response questionnaire submitted to the Inquiry on 26th June 2023 [NMS/004 - INQ000221435].

33. In terms of my role in relation to modelling, within Scottish Government the Health and Social Care Analysis (HSCA) teams data on modelling would be presented to senior clinical advisers (including the CMO and DCMO) by analysts. The role of the senior clinical advisers was to sense check the clinical and scientific assumptions used for the modelling i.e. inputs in relation to viral transmissibility, disease severity, vaccine efficacy etc.

34. I do not believe that the Scottish Government was in any way restricted in understanding the full scientific picture at any time. That said, it is very important to emphasise the fluid nature of that picture as the pandemic developed and we

learned more about the virus. I have provided more detail on the scientific, clinical and data areas which I believe worked well, and where there were the greatest challenges, later in this response.

Role in Covid-19 public health communications

35. As part of my role as DCMO I participated in a small number of the televised First Minister daily coronavirus briefings. My role in these was to give clinical and public health advice and to provide clinical and scientific information in response to questions from press journalists and other media correspondents

36. In addition, I was part of a number of technical briefings to the press (e.g. on Covid-19 testing and vaccination) and participated in media interviews as required, some of which were in relation to public health messaging for the public.

37. As DCMO I was also asked to comment from the clinical perspective on a variety of media and public communication lines from Scottish Government, both proactive and reactive in response to enquiries.

38. On request, I recorded social media video messages for the NHS and the public, again giving clinical information or public health advice, for example, in relation to the rollout and availability of Covid-19 vaccines. I also participated in training webinars for NHS staff providing Covid-19 vaccinations.

39. I cannot personally comment on the impact of breaches of rules in relation to public confidence. In Scotland public confidence polls were undertaken on a regular basis in relation to the Covid-19 response and appeared to remain at a good level. This would suggest that communication strategies employed were appreciated by the general public and worked well. At the early stages of the pandemic I think the public found the Ministerial and clinical television briefings particularly helpful, as they were a single source of information, provided reassurance in terms of the response, and gave practical guidance in terms of what was being asked of the public, and why.

Role in public health and coronavirus legislation and regulations

40. As previously outlined in Module 2A statement number 4 by the DG Health and Social Care provided to the Inquiry on 23rd June 2023 [NMS/003 – INQ000215470], during the time period in question the CMO was periodically asked to provide clinical input on whether it was necessary to continue with certain coronavirus legislation and regulations as part of the regular review process undertaken by policy teams and the Scottish Government Legal Directorate (SGLD). On occasions where CMO was on leave I deputised in terms of this function for him and provided this clinical view.

41. At all times the clinical advice on legislation was to only continue it for as long as it was deemed necessary to protect public health. In my view, factors which increased public compliance with such legislation and/or regulations were clear public communications (including the underlying reasons for the legislation), and consideration and mitigation of the wider impact of legislation/regulations (e.g. business or personal financial support during lockdown or self-isolation).

Divergence

42. With the devolution of health responsibilities and therefore differing healthcare structures in England and Scotland, some divergence in approach was natural. In addition, there were other differences between the nations including timing of variants and associated waves, population demographics, geography, and significant events e.g. school and university term dates. These meant that the Covid-19 response in each country needed to be tailored to best protect that particular population at any given time.

43. In my view, the UK nations first began to show divergence in response quite early in the pandemic, with the first stay-at-home order from March 2020 ending in England and Northern Ireland in early May 2020, earlier than in Scotland and Wales. I did not play a role in advice in terms of this divergence of approach.

44. My view is that what was essential and worked well across the nations was the shared understanding of science. As more evidence gathered about the virus, the fundamental scientific and clinical principles underpinning the Covid-19 response in each country were the same, and this consistency of understanding was key in terms of public understanding and confidence.

45. Having all devolved nations as members of SAGE was enormously helpful in this respect. Another helpful four nations approach was the UK infection prevention and control (IPC) Cell and the production of the joint COVID-19: IPC Guidance. Similarly, the UK Senior Clinicians Group met regularly during the pandemic and was a forum for sharing clinical and public health understanding between senior clinicians across the UK nations. This allowed us to develop common clinical understanding in terms of the effects of the virus and the pandemic, but also to appreciate where divergence in approach or response was necessary for the above reasons.

Key challenges and lessons learned

46. The key challenge in my view was dealing with the unknown – initially planning a response with little scientific or clinical information available, and then having to adapt the response as evidence emerged gradually over time. A further challenge in this respect was the ability of the virus to mutate and produce variants, and in rapid time. As each major variant emerged this necessitated the reassessment of clinical and scientific parameters such as transmissibility, disease severity and population susceptibility in order to gauge the appropriate response.

47. There were challenges developing the evidence base on the impact and effectiveness of individual NPIs, especially in real-world settings and on a population level. Adding to this the need to estimate the impact of 'packages' of different NPIs when used together increased uncertainty. The scientific breadth and expertise of SAGE and the Scottish Covid-19 Advisory Group worked extremely well to distil what was known and also to model likely impacts. I have already highlighted above in this response that I believe the joint approach to

scientific advice in the pandemic was one of the elements of the response which worked very well in general.

48. A further key challenge, particularly in the early stages of the pandemic, was access to robust data in as close to real time as possible. Hospitalisation and mortality are necessarily later effects of the virus and by the time these were rising any response was already 'lagged' in terms of the number of infections which were in the population and yet to emerge as illness and death. Asymptomatic infection added to this challenge. In this respect the contribution of the Office for National Statistics (ONS) Coronavirus (Covid-19) Infection Survey (CIS) was absolutely essential in ascertaining likely population prevalence of infection, as well as contributing to the evidence base on symptoms, transmission and eventually vaccine uptake and efficacy. What also worked particularly well with ONS CIS was that it covered the four nations, providing the ability to ascertain data at both national and UK levels.

49. Understanding the effect of the pandemic itself, and of the response to it, through consideration of the 'Four Harms' process adopted in Scotland was, in my view, very helpful. This allowed decision makers to have a well-recognised, broader framework upon which to base complex decision making, and ensured consistent consideration beyond the immediate effects of the virus itself on the population.

50. Senior clinician contact and sharing of information and expertise across the four nations was exemplary in my view and deserves to be highlighted. The regular meetings of the four CMOs (and deputies) and the wider forum of the UK Senior Clinicians were essential sources of information, evidence and indeed support. Beyond that, these senior clinical colleagues were always available (even at very late hours and on weekends) to be brought together at very short notice if the need arose. There were no organisational or geographical barriers in terms of the interactions between senior clinicians across the four nations and this is as it should be with our particular roles and shared purpose.

51. A number of evaluations and 'lessons learned' activities and reports have been, and continue to be, undertaken in relation to the Scottish pandemic response.

Some of these are detailed in the Module 2A statement number 3 by the DG Health and Social Care provided to the Inquiry on 23rd June 2023 [NMS/001 - INQ000215488].

52. As mentioned before, the UK CMOs and DCMOs have jointly contributed to a report that provides much greater additional detail in terms of our learning on the clinical and scientific aspects of management of the pandemic - Technical Report on the Covid-19 Pandemic in the UK (published 1st December 2022) [NMS/002 - INQ000130955]. I was an author on this publication and my views are well represented within it. This document contains reflections and advice for a future CMO or Government Chief Scientific Adviser (GCSA) in terms of future pandemic responses.

53. I am a member of the Scottish Standing Committee on Pandemic Preparedness, commissioned by the First Minister of Scotland to provide advice on preparedness for future pandemics. The terms of reference, meeting papers, minutes and interim report are all published and available on the Scottish Government website and have already been passed to the Inquiry Solicitors.

Informal communications and documents

54. During the period referenced I was a member of a number of WhatsApp groups, necessary to allow contact between key individuals at all times in a rapidly changing situation. These included: Scottish Government Health and Social Care Directorate Directors; Scottish Government Senior Clinicians; UK CMOs and DCMOs.

55. Messages on these WhatsApp groups have not been retained, as either a default timer for disappearing messages was set or they were manually deleted by the group administrator.

56. Clinical advice was always communicated to policy colleagues via official Scottish Government emails, and to Ministers within official submissions, and not by informal means, including WhatsApp groups. All views and decisions on the clinical

advice were fully recorded through Scottish Government information retention systems, as required by Scottish Government Records Management Policy (February 2021) [NMS/005 – INQ000226436].

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

Professor Nicola Steedman
Deputy Chief Medical Officer for Scotland

Dated: 01/03/24