Wednesday, 25 September 2024

(10.00 am)

MS CAREY: Good morning, my Lady. Please may we call Professor Sir Gregor Smith, who will affirm.

PROFESSOR SIR GREGOR SMITH (affirmed)

Questions from COUNSEL TO THE INQUIRY for MODULE 3

LADY HALLETT: As I said to your colleague, welcome back.

A. Thank you.

MS PRICE: Professor Smith, could you give us your full name, please.

A. My name is Gregor Ian Smith.

Q. Thank you for providing a witness statement for this module of the Inquiry, which is dated 21 February of this year, INQ000484783. I understand you are familiar with that statement and you have a copy of it in front of you, is that right?

A. I am familiar with it and I do have a copy.

Q. Starting, please, with your professional background. You are a general practitioner, is that right?

A. My speciality in medicine is general practice, yes.

LADY HALLETT: Can you have a speciality in general practice?

A. You can, yes. It is a general speciality but it is nonetheless a speciality.

LADY HALLETT: I was only teasing.

MS PRICE: Prior to taking up an advisory role to the Scottish Government, you were a medical director for primary care in NHS Lancashire -- in Lanarkshire, apologies.

A. I was, yes, I was medical director for primary care in NHS Lanarkshire for five years.

Q. In 2012 you became a medical adviser in primary care to the Scottish Government?

A. I did, yes.

Q. Is it right that you became Deputy Chief Medical Officer in 2015?

A. That is correct, yes.

Q. You were the interim Chief Medical Officer from April 2020?

A. From April 6, 2020. Yes, I remember the date very well.

Q. Until December 2020, when you became the Chief Medical Officer?

A. That is correct.

Q. And that's a role you continue to hold?

A. Yes.

Q. Turning, please, to the role of the CMO in the Scottish healthcare system response to the Covid-19 pandemic. As CMO you lead the CMO Directorate, is that right?

A. That's right.

Q. You describe your role and that of your team as

independent clinical advisers to government. You also say that where a decision taken by Scottish ministers is likely to impact upon the health of members of the public, Scottish Government processes ensure that clinical views are sought at an early stage.

In the context of the Covid-19 pandemic, did this mean that once you took up the role of interim CMO in April 2020 you regularly attended Scottish Government cabinet meetings?

A. So, to deal with the different parts of your question, then yes, your interpretation is correct. And my experience of 12 years of working in Scottish Government is that there is early and frequent involvement of clinical advisers in the formulation of policy. The role of myself and my team is to be able to provide that independent advice to officials and to ministers when it is requested, and as part of the response to Covid-19, I gave regular updates by attending cabinet each occasion.

Q. And it is right that you also attended the Scottish Government Resilience Room?

A. That is correct yes.

Q. You have very helpfully exhibited to your statement a list of occasions on which you attended Scottish Government cabinet meetings. It appears from this that

you attended on a weekly basis between April 2020 and April 2023, is that right?

A. I think that is accurate, yes.

Q. You say you attended the majority of Scottish Government Resilience Room meetings. How often did those meetings take place?

A. The resilience meetings took two forms. They took meetings primarily for officials or primarily for ministers supported by officials. During those meetings my deputies tended to attend the officials meetings and I attended the ministerial meetings. There was no regular -- a regularised meeting schedule. Instead, the Resilience Room met when it was decided that it was necessary for it to meet.

Q. Is it right that at cabinet meetings you provided verbal updates on the epidemiology of the pandemic?

A. That is correct, yes.

Q. You describe your approach to these verbal updates at paragraph 10 of your statement. You aimed to explain and translate clinical and scientific advice to enable Scottish ministers to understand it and make decisions?

A. That is correct. The aim of these updates was to try to enable any decision-making which was to take place at that cabinet to be in the context of what the latest epidemiology in Scotland was suggesting and also to

1 provide information or knowledge of recent breakthroughs
2 or recent evidence that was coming to light in relation
3 to the Covid response, both within the UK but also
4 internationally, where that was possible, as well.
5 Q. You explain in your statement at paragraph 13 that
6 ordinarily when advising ministers the CMO would base
7 that advice on trusted sources of evidence such as
8 published peer-reviewed journals. In a novel situation
9 such as Covid-19, the CMO is forced instead to assess
10 whether the evidence that there is is of sufficient
11 quality for the purposes of decision-making.
12 Can you explain, please, how you go about this task
13 and how you express the level of confidence in the
14 available evidence to ministers?
15 A. So this point and for many, many months of the pandemic
16 response there wasn't an evidence base which told us how
17 to go about responding to Covid-19. And so we were very
18 reliant on data information and scientific consensus or
19 clinical consensus as to how to respond. We relied very
20 heavily on inference from the response to similar types
21 of disease where that was possible as well.
22 And all the time in the advisory structures that
23 were put in place across the UK and within Scotland what
24 we tried to do was to create a consensus approach where
25 the centre ground of scientific opinion held the

1 greatest weight, and then from there we would try to
2 judge and try to give a level of confidence that related
3 to that evidence, which we kind of framed of either low,
4 medium or high.
5 Q. You refer in your statement at paragraph 17 to the
6 Scientific Advisory Group for Emergencies (SAGE) and the
7 New and Emerging Respiratory Virus Threats Advisory
8 Group (NERVTAG) as being part of the critical function
9 of how evidence is received and considered.
10 How often did you attend SAGE meetings?
11 A. In the early part of the pandemic I tended to -- well,
12 the invites began to come for SAGE probably by about
13 early February to Scotland, where we had observer status
14 rather than member status at those meetings. That still
15 enabled us to kind of gain the information and the
16 knowledge that was being discussed at those meetings
17 without perhaps fully contributing to some of the
18 questions. But over subsequent weeks and months that
19 relationship changed so that we were able to participate
20 much more fully in those structures.
21 NERVTAG sat a little bit to the side. It was
22 a group which was particularly -- had a particular
23 expertise on it, and we received reports from NERVTAG in
24 relation to the discussions, with opinion from those
25 groups as well.

1 Q. You describe in your statement there being exceptionally
2 good and professional relationships between the UK CMOs.
3 In response to the Covid-19 pandemic, is it right that
4 you met regularly with the CMOs for England, Wales and
5 Northern Ireland?
6 A. I think the first thing I would want to do in answer to
7 your questions is emphasise those exceptionally good
8 professional relationships, and particularly the
9 willingness to engage and share information between the
10 CMOs was quite extraordinary actually, particularly in
11 those early parts of the pandemic response. It wouldn't
12 be uncommon for us to meet if not on a daily basis then
13 every couple of days, and at the very least a couple of
14 times a week we may -- whenever it was necessary -- at
15 any point in the day it was necessary, often evening
16 meetings, often very early in the morning meetings, and
17 we stayed in touch, very, very closely during that time.
18 Q. There were also regular meetings between the CMOs and
19 other senior clinicians and scientific advisers. Was
20 this the Quint Senior Clinicians Group meeting that
21 you're referring to in your statement?
22 A. It is. That was probably the most obvious of the other
23 groups and most important of other groups which met on
24 a regular basis, meeting generally, again, on a weekly
25 basis at the early part of the pandemic. It was made up

1 of senior clinicians from across the UK, the CMOs, the
2 CNOs, the NHS England medical director, national
3 clinical director in Scotland, but also very senior
4 public health officials from across the country as well,
5 where we would examine data that was becoming available
6 or observational studies or evidence from other sources
7 and see how to interpret that and what weight of
8 evidence to apply to that.
9 Q. How often did the senior clinicians group meetings take
10 place?
11 A. At the early part it was once or twice a week depending
12 on need, generally settling to once a week schedule.
13 But as the pandemic response over the years began to
14 make it less necessary, it still met but less
15 frequently, sometimes just once every couple of weeks or
16 every month.
17 Q. Could we have on screen, please, paragraph 15 of
18 Professor Smith's statement that is page 4 of
19 INQ000484783.
20 Six lines up from the bottom of the paragraph you
21 say this:
22 "The evidence presented at these meetings was
23 discussed and carefully considered and where relevant
24 would be used to formulate advice for clinical/medical
25 colleagues, Scottish Government policy officials and

1 Scottish Ministers."
2 Who was presenting evidence at these meetings?
3 A. It would vary according to the meetings. It would
4 sometimes come from different public health agencies.
5 It would sometimes come from invited guests. There
6 would be presentations from some observational studies
7 which were taking place across the UK at that time,
8 CO-CIN, ISARIC. As time went on, we would -- feedback
9 from other observational studies such as SIREN or
10 Vivaldi. There would be data which was made available
11 to us from international sources. It was a variety of
12 people, either members of the group themselves or people
13 who had been invited especially to come to present
14 because of the work that they were leading on.
15 Q. You discussed the thinking behind the establishment of
16 the Scottish Covid-19 advisory group in your statement,
17 provided for Module 2A Inquiry.
18 Could we have paragraph 41 of that statement on
19 screen, please. It is page 9.
20 At paragraph 41 you say this:
21 "As discussed in the Module 1 DG Health and Social
22 Care ... statement ... SAGE was a useful source of
23 evidence and scientific consensus from which the CMO
24 could develop advice for the Scottish Government, but
25 a drawback was that observers and Scottish Ministers

1 could not ask questions directly of SAGE participants.
2 This was why the FM arranged for Dr Calderwood, then
3 CMO, to set up the Scottish Covid-19 Advisory Group ..."
4 The Scottish Covid-19 advisory group was established
5 before you took up the role of interim CMO in
6 March 2020, is that right?
7 A. That's correct, yes.
8 Q. Do you consider -- and that document can come down now,
9 thank you.
10 Do you consider that the Scottish Covid-19 advisory
11 group provided a greater opportunity for observers and
12 Scottish ministers directly to question those presenting
13 the scientific consensus?
14 A. So to answer, firstly, your question, I have no doubt it
15 presented a much greater opportunity for people in
16 Scotland to be able to directly question the scientific
17 advisers. We held a number of deep dives into various
18 topics, run by members of the group, that afforded our
19 very enthusiastic ministers to be able to ask the
20 questions that they were really keen to ask of the
21 expertise in the room. And I think that the Scottish
22 Covid advisory group was a really important and
23 significant, beneficial group in terms of the
24 interpretation of the evidence as it applied to the
25 Scottish healthcare system and population.

1 Q. Your background being in general practice, how reliant
2 were you on the analysis of the evidence done by the
3 Scottish Covid-19 advisory group, SAGE and NERVTAG, when
4 it came to understanding the evolving nature of
5 Covid-19?
6 A. Although my speciality background is general practice,
7 I worked in government and been involved in public
8 health for many, many years before that. So although
9 general practice afforded me a very good clinical
10 opportunity that I'm very proud of, my specialism had
11 evolved over time. So I am sure like -- every senior
12 clinician who was involved in the Covid response have
13 benefited from the advice of expertise, both to discuss
14 different pieces of evidence and compare our
15 interpretation of that but also because of the innate
16 expertise that they also brought to it.
17 Q. Was the consensus within these three groups broadly the
18 same when it came to the epidemiology of Covid-19?
19 A. The consensus was broadly the same although there was
20 different levels of discussions in the groups, and the
21 way that particularly the Scottish advisory group was
22 constructed, meant that there was often very lively
23 debate about the interpretation of some of the findings
24 and often quite challenging conversations in relation to
25 that before a consensus was brought forward.

1 Q. Can you think of an example of that?
2 A. Just off the top of my head, a fairly good example of
3 that would be about the strategy in relation how we
4 begin to control the rates of Covid in the country.
5 Some within the group advocated for a policy to -- for
6 as near to elimination as possible. Others in the group
7 viewed that as being unachievable.
8 Q. Is it right that health protection information was
9 provided to you in Scotland initially by -- well, by --
10 initially to your predecessor by the health -- by Health
11 Protection Scotland, then from April 2020 by Public
12 Health Scotland through the National Incident Management
13 Team?
14 A. Yes, the structure in Scotland at that point in time saw
15 at the beginning of the pandemic Health Protection
16 Scotland as being the lead public health agency for
17 health protection, but during the early stages of the
18 pandemic, a pre-planned move to a separate body, Public
19 Health Scotland, occurred. The same people involved
20 under a different name and under a different governance
21 structure.
22 Q. And the information that was provided, was that through
23 the National Incident Management Team reporting to you?
24 A. That was the most important of the routes was the
25 National Incident Management Team, which was constructed

1 of public health specialists from Public Health Scotland
2 but also with representation from each of the Scottish
3 territorial health boards as well, plus augmented by
4 analysts from various other agencies.
5 **Q.** In terms of the limits on the role of the CMO and the
6 CMO Directorate, is it right that the role was and is
7 not one of operational decision-making?
8 **A.** That's correct.
9 **Q.** The Inquiry understands that in -- the NHS in Scotland
10 was put on an emergency footing on 17 March 2020, is
11 that right?
12 **A.** That's my understanding. That's the date.
13 **Q.** And that was before you became interim CMO?
14 **A.** Yes.
15 **Q.** What impact, if any, did this have on the role of the
16 CMO in the Scottish healthcare system response to the
17 Covid-19 pandemic?
18 **A.** I'm not sure that it changed the role to any great
19 extent because the prime purpose of the role, at that
20 stage, before and after, was still to provide that
21 independent clinical advice to officials and ministers.
22 The remit of the emergency footing fell to ministers
23 rather than to the CMO.
24 **Q.** Did it have any impact on the status on the clinical
25 guidance being issued by you to clinicians?

1 **A.** I don't think it had any impact on the status per se,
2 other than perhaps to say that it became more prominent
3 in the minds of people who were receiving it perhaps.
4 **Q.** We dealt --
5 **A.** And --
6 **Q.** Apologies.
7 **A.** Can I expand on that just a little bit, because one of
8 the important aspects of the Scottish healthcare system
9 that differs quite significantly from the English
10 healthcare system is the lack of the -- NHS England as
11 a separate entity.
12 In England the situation would have arisen where if
13 there was a once-for-the-country approach, NHS England
14 would have overseen that through their governance
15 structure. That same governance structure didn't exist
16 in Scotland under an NHS Scotland body and, in my view,
17 that's an area which my preference would be to see
18 developed further.
19 **LADY HALLETT:** Sorry, I haven't followed that. Could you --
20 **A.** Yes. So England has NHS England as a separate public
21 entity, public body.
22 **LADY HALLETT:** Yes.
23 **A.** There isn't an equivalent in Scotland. Instead you have
24 22 health boards, 14 of which are territorial health
25 boards. So if you want a once-for-Scotland approach,

1 that is much more difficult because you don't have
2 a national entity.
3 **LADY HALLETT:** So you recommend it -- would prefer --
4 **A.** My preference, and this is a personal preference --
5 **LADY HALLETT:** The independent entity?
6 **A.** Yes.
7 **LADY HALLETT:** A separate entity, sorry.
8 **A.** Yes.
9 **MS PRICE:** You dealt with working hours in the statement you
10 made for Module 2A of the Inquiry.
11 Could we have on screen, please, paragraph 28 of
12 that statement, which is page 6.
13 And here you say that after you took up office "as
14 interim CMO in April 2020", you:
15 "... reassessed the capacity of clinical advice
16 available to the Scottish Government and identified that
17 having more senior advisers would be beneficial ..."
18 You deal there with working hours for your senior
19 team, which were generally in the order of 12-16 hours
20 each day, seven days a week:
21 "The intensity of [that] work lasting throughout
22 2020 and beyond, with very little noticeable reduction
23 throughout the period covered by this module."
24 Is it right that you increased the number of deputy
25 chief medical officers from one to three in the summer

1 of 2020?
2 **A.** Yes, the volume of work was quite incredible at that
3 point in time, and one of the first steps that I took
4 was to enhance that senior clinical team, but also to
5 make sure that we were making far better and closer use
6 of the other senior clinicians who worked within
7 government as well, so the Chief Nursing Officer and the
8 national clinical director as well, and that working
9 relationship became very close over the subsequent
10 response to the pandemic.
11 But, critically, it was very evident that if we were
12 going to service the volume of demands that we had from
13 different parts of government to provide advice, we had
14 to make sure that there was adequate clinical capacity
15 there.
16 **Q.** That document can come down now, thank you.
17 **LADY HALLETT:** The stenographer missed it. Did you say made
18 greater use of the Chief Nursing Officer and the
19 national clinical director?
20 **A.** The national clinical director. That's -- at that point
21 in time was Professor Fiona McQueen and
22 Professor Jason Leitch.
23 **MS PRICE:** What was the impact on your team of the workload
24 that you described at paragraph 28.
25 **A.** So the first thing I would want to say is that although

1 I have characterised this for my team here, I don't
2 think my team was alone in working those type of hours
3 in this response, and I saw similar levels of
4 commitment, effort from other areas of government and
5 indeed they have good service as well. It was quite
6 a remarkable effort.
7 But it did have an impact on us all, and we were
8 tired, and it was stressful work. And there's no
9 getting away from that. And there was very little
10 respite from it. So seven days a week, working those
11 excessive hours, certainly has its toll, particularly as
12 leave was just not an option in those -- I can't
13 remember the last -- the first time I actually took
14 leave as part of the response. It was -- it was tough
15 and it was tough not just for us but for our loved ones
16 and our friends as well.
17 **Q.** I would like to deal next with the four harms and the
18 Four Harms Group in Scotland.
19 It is right, isn't it, that the Scottish Government
20 published a framework document in April 2020 setting out
21 the Scottish Government approach to decision-making
22 during the pandemic?
23 Sorry, if you can give your answer verbally.
24 **A.** Yes.
25 **Q.** Thank you. In the four broad ways in which Covid-19

1 caused harm, they were identified in that framework,
2 weren't they?
3 **A.** They were, yes.
4 **Q.** Could we have the section dealing with the four harms on
5 the screen, please. It's page 8 of INQ000369689.
6 Do I summarise the first harm correctly as being
7 direct harm to people's health, which in this document
8 was measured by reference to the number of
9 hospitalisations, ICU admissions and deaths?
10 **A.** Harm number 1 was direct Covid-related harm and there
11 were a number of ways we measured it, including those
12 ways that you have outlined there, but we drew upon data
13 sets which showed rising numbers of infection and, as
14 time went by, we understood that that infection also had
15 impacts on both particular parts of society but also had
16 longer-term sequelae as well.
17 **Q.** And the second harm identified was the wider impact on
18 Scottish health and social care services in Scotland, is
19 that right?
20 **A.** That's correct. We refer to these as the indirect
21 health harms.
22 **Q.** The last sentence in the second paragraph, just
23 scrolling down a little, please, acknowledges the
24 "postponement of other types of care and treatment" in
25 the healthcare system.

1 And then the third paragraph says this:
2 "Despite the NHS remaining open for those who need
3 it, we have seen significant reductions in people
4 seeking help. This will impact on those most at risk.
5 The health impacts brought about by greater inequalities
6 may themselves be significant over years to come. We
7 must adapt to ensure that our health and social care
8 services can resume this wider care as soon as possible,
9 and this forms part of our planning for the period
10 ahead."
11 Was there a recognition by the Scottish Government,
12 even at this early stage, in April 2020 that the
13 pandemic was likely to exacerbate existing health
14 inequalities?
15 **A.** There was a recognition and this was something which
16 worried me greatly at that time. And the decisions that
17 were faced by the Scottish Government is that there were
18 no easy or no risk-free routes to be taken out of this,
19 and almost any decisions the ministers were faced with
20 at that point in time would lead to some level of harm,
21 somewhere in society. Some of those could have been
22 more facing the direct Covid harms if we hadn't taken
23 action. But by taking action it had then an impact on
24 the indirect harms. There was no easy route and it was
25 one of the -- perhaps the most difficult decision-making

1 processes of all the pandemic.
2 **Q.** What was done in April 2020 to try to mitigate the
3 indirect harm that was anticipated?
4 **A.** One of the things that I certainly tried to do in my
5 role as CMO was to make sure that messaging to the
6 public that the NHS remained open for people who needed
7 it was as loud and evident as possible, and I spoke
8 about it on several occasions during the daily lunchtime
9 briefings that I gave with ministers.
10 I was particularly concerned that as we began to
11 receive data that we saw a real fall off in the early
12 referrals for cancer or for possibility of cancer, that
13 people were not presenting with chest pain and heart
14 attacks to hospital. That illness hadn't gone away, it
15 hadn't disappeared but people were perhaps absorbing
16 that.
17 And I think there was a very delicate balance to be
18 given in the messaging to the public, which really had
19 to kind of deal with some of perhaps both people's
20 altruistic sense of protecting the NHS, which was
21 evident, but also some of the fears that they had about
22 presenting to healthcare at that point in time as well.
23 And that was an incredibly difficult thing to do. But
24 messaging was really important, that people with red
25 flags of one sort or another, whether that be chest

1 pain, whether that be suspicious symptoms of cancer that
2 people were seeking help for that. And through social
3 media, through the lunchtime briefings, through any
4 communication portals that I could use I wanted to
5 emphasise that people should -- it was important should
6 still present with that.
7 **Q.** Just focusing on the potential exacerbation of existing
8 health inequalities specifically as opposed to indirect
9 harm, what was done in April 2020 to try and mitigate
10 that effect?
11 **A.** First of all, I think the most important thing was to
12 recognise that there was an effect and then from there
13 work could be done to try to limit the damage that those
14 inequalities to have. Some of that was about supporting
15 people to be able to make the right decisions for them
16 and for their families, particularly when they had
17 symptoms of Covid, so that they were able to isolate,
18 they weren't going to work and they didn't suffer
19 financial losses as a consequence of that.
20 Some of that was about trying to make sure that
21 information which was available to some of our
22 communities was done in as open and as accessible a way
23 as possible, using community leaders, particularly faith
24 leaders to try to get that message across where there
25 was difficulty in doing that, and recognising that there

1 were lots of channels for that really important aspect
2 of communication that lay beyond just clinicians and
3 government ministers by themselves.
4 **Q.** Just before we leave this document, is it right that the
5 third and fourth harms identified in this framework
6 document were respectively the social and economic harm
7 caused by Covid-19?
8 **A.** That is correct, yes.
9 **Q.** Could we have on screen, please, paragraph 239 of
10 Professor Smith's Module 3 statement. That's page 55.
11 At 239 you say this:
12 "Throughout the pandemic, as part of the Four Harms
13 process and the Scottish Government's Framework for
14 Decision Making, CMOD considered how the advice policies
15 or guidance to which it contributed might impact upon
16 groups such as disabled people, older people, people in,
17 'at risk' groups, members of ethnic minority
18 communities, people from disadvantaged socio-economic
19 backgrounds, and/or people with existing health
20 inequalities."
21 Is it right that the CMOD was a contributor to the
22 development of the four harms process through the CMO
23 and DCMO?
24 **A.** That is correct, yes.
25 **Q.** That document can come down now, thank you.

1 Was the Four Harms Group the primary forum for
2 discussion of evidence relating to indirect health harms
3 caused by Covid-19?
4 **A.** At a cross-government level that was the primary group
5 where we would examine that, and the aim of the Four
6 Harms Group was really to try to bring together evidence
7 from different parts of government and to treat that in
8 a balanced way, to look at overall the harms that the
9 country was experiencing as a consequence of the Covid
10 response. I think it was important that both the direct
11 and the indirect harms to the population were harms 1
12 and 2 and were -- had particular importance.
13 But really they had to be balanced. In any kind of
14 national response they had to be balanced by the
15 knowledge and to try to offset the risks of the social
16 harms and the economic harms that the country faced as
17 well.
18 In my view, the four harms process was a very
19 successful way of doing that, and it led not only to
20 really quite rich discussion as to how we might approach
21 different problems at different stages of the pandemic,
22 to try to balance the risks associated with those four
23 harms but also brought the professional advisers in each
24 of those areas much, much closer together within
25 government so that we could have separate discussions as

1 well about evidence as it develops and a better
2 understanding. For instance, for me, of the economic
3 harms and the societal harms that were taking place as
4 well, so we weren't solely focused all the time on just
5 a narrow remit.
6 **MS PRICE:** If we have on screen, please, INQ000317490.
7 These are the minutes of the fourth meeting of the
8 Scottish government CMO advisory group on Covid-19,
9 which took place on 9 April 2020. Is that three days
10 after you took up the role?
11 **A.** It was, yes.
12 **Q.** At this meeting a paper entitled *"Calibrating the
13 impacts of COVID-19 with the impacts of its control
14 measures: informing decision-making on
15 Non-Pharmaceutical Interventions (NPIs)"* was -- this was
16 authored by Dr Gerry McCartney, who was an inequalities
17 expert and a consultant in public health at Public
18 Health Scotland. That report was considered at this
19 meeting.
20 We can see from the minutes that you had sent your
21 apologies and Graham Ellis was deputising for you.
22 Notwithstanding you not being at the meeting,
23 I would like to ask you about the consideration that was
24 given to health inequalities which were likely to result
25 from Covid-19 restrictions.

1 Looking, please, to page 3, paragraph 4, there is
2 a summary of what the paper was addressing here and
3 starting about four lines down it says:
4 "The government's interventions to flat ten the
5 curve have been important to reduce mortality but the
6 negative economic impact will have marked negative
7 impact on health and inequality. The paper included
8 a number of recommendations for how to influence health
9 and wider policy areas, taking the opportunity to
10 address health inequalities that emerge from this."
11 The group's input was sought on the paper's
12 recommendations.
13 There is a summary -- going four paragraphs down --
14 the paragraph starting:
15 "David questioned whether papers shared in the group
16 were aimed at shaping policy or commissioning further
17 research. Sheila and Richard noted that government is
18 considering points raised in the paper and expressed
19 that the paper should feed into broader thinking."
20 There is a comment on "language --speaking of
21 balancing rather than trade-offs".
22 Then in the paragraph below:
23 "Jim commented that while long term issues are
24 clearly incredibly important, there are urgent issues
25 also to address. In the last week of full reporting

1 there were almost 800 care home outbreaks in England.
2 It is important that we address the issues of today as
3 well as tomorrow."
4 It appears from this that the response to the paper
5 was that the expected longer term health inequalities
6 raised in it would be factored into the broader thinking
7 but that this was not, at this stage, a priority. Was
8 that the position?
9 **A.** One of the ways that we have dealt with this over the
10 years in Scottish Government is to think about a three
11 horizons approach to the way that we try to deal with
12 complex problems like this. I think Jim's summary at
13 the end of that paragraph characterises this quite well.
14 There were really important issues that were right up
15 close that we needed to deal with or they were going to
16 cause significant harm. And we needed to deal with
17 those. But that shouldn't stop us beginning work that
18 could have an impact further down the road. And that
19 speaks to perhaps horizon 1, right up close, but horizon
20 2, slightly further away.
21 So it doesn't mean that they are dealt with in
22 sequence but in parallel, I think is probably the way
23 that I would try to kind of frame that.
24 And that type of thinking about the recognition that
25 there was going to be both health and societal harms as

1 a consequence of some of this response that would still
2 need to be addressed at some point didn't mean that we
3 should simply kick that down the road and deal with it
4 at a later stage. Actually the thinking needed to start
5 at that point in time.
6 **Q.** That document can come down now, thank you.
7 Were you made aware that this paper had been brought
8 to the meeting?
9 **A.** I was not only made aware but I remember reading the
10 paper because Dr McCartney has contributed to many of my
11 pieces of writing over the years and to minor reports,
12 and he is an author who I respect his writing.
13 **Q.** Did there come a time when the Scottish Government was
14 able to focus on the indirect health core harm caused by
15 Covid-19 and the health inequalities that might be
16 caused or exacerbated by Covid-19 restrictions?
17 **A.** I think the focus on the indirect harms in particular,
18 as I say, started with, first of all, the messaging,
19 about the NHS remaining open, but really in the recovery
20 phase that people would recognise took place in the UK
21 as the NHS began to kind of more fully re-open and
22 services start to get back to -- I can't say "normal"
23 because I do not think it was normal, but certainly to
24 a greater range of services being available to people.
25 All that was factored in all the way through there and

1 the planning was evident all along. But at those
2 initial stages it really did feel like all hands to the
3 pump to deal with the Covid response.
4 **Q.** Is it right that the First Minister established
5 an expert group to consider the impact of Covid-19 on
6 ethnic minorities in June 2020?
7 **A.** That is correct, yes.
8 **Q.** And later the Racialised Inequalities in Health & Social
9 Care Steering Group?
10 **A.** That's correct.
11 **Q.** My Lady, you will hear more about those groups when
12 Nick Phin from Public Health Scotland gives evidence.
13 I would like to turn, please, to the evolving
14 understanding of Covid-19.
15 Could we have on screen, please, paragraph 209 of
16 Professor Smith's statement. This is the Module 2A
17 statement.
18 And the last sentence of this paragraph you say
19 this:
20 "Much more often than not, there were no risk free
21 options but decisions where 'less bad' choices could be
22 made."
23 Can you give an example, please, of a healthcare
24 system related decision of which this was true?
25 **A.** The most obvious example that I would give in respect to

1 that phrase would be the decision to pause screening.
2 I think that was taken in March 2020 by my predecessor,
3 which was an incredibly difficult decision but it was
4 taken for reasons to try to free up staff and resources
5 to be able to respond to the direct Covid harms.
6 And there -- it certainly wasn't an easy choice but
7 I think it was the right choice at that time, but no one
8 was unaware that it wasn't without risk.
9 **Q.** Would you make that decision again?
10 **A.** Placed in the same position as my predecessor was
11 I would find it probably as difficult as she did to
12 provide advice into that space. The evidence suggested
13 that at that time that it was the right decision to
14 make.
15 I noticed in some of the papers at that point in
16 time that she questioned particularly some of the
17 screening programmes. I think that was the right thing
18 to do. I think the right questions were asked about it.
19 And given the information that my predecessor was
20 given, I think I would probably have made the same
21 decision.
22 **LADY HALLETT:** By "screening", do you mean testing?
23 **A.** No, I mean the national screening programmes looking
24 for, for instance, breast cancer screening or cervical
25 screening or ...

1 **LADY HALLETT:** I see.
2 **MS PRICE:** That document can come down now, thank you.
3 Did the identification of the least bad option when
4 it came to the Scottish healthcare system response to
5 the pandemic involve a balancing of potentially
6 competing considerations, as you recall it?
7 **A.** Yes.
8 **Q.** What is your understanding of the precautionary
9 principle?
10 **A.** So the precautionary principle was something which was
11 applied very often during the response to the pandemic,
12 and where there was doubt in relation to evidence of
13 data in an area that would cause sufficient harm to be
14 concerned about, people tended to err on the side of
15 caution and perhaps over-calibrate a response to that.
16 **Q.** Did the process of identifying the least bad option
17 involve any express consideration of the precautionary
18 principle?
19 **A.** In the example I gave you, I don't think you could say
20 that the precautionary principle was applied in that
21 sense because there was an analysis of data and, as
22 I said, by pausing screening it released staff who could
23 be redeployed into the direct Covid response but also,
24 very importantly, lab resources and skills in relation
25 to labs that allowed the scale-up of really important

1 programmes such as testing in that area.
2 **Q.** Could we have on screen, please, paragraph 32 the
3 Professor Smith's Module 3 statement. That's page 8.
4 You deal in this section of your statement with
5 understanding of Covid-19 transmission routes. In
6 paragraph 32 you identify some factors relevant to
7 understanding transmission routes, including:
8 "Pathogen dynamics, such as viral load;
9 "Environmental factors ...
10 "Host-related factors ... ; and
11 "Wider ... factors, such as prevalence of the
12 disease."
13 Then further down the page, at paragraph 34, you
14 deal with why some routes of transmission were easier to
15 measure than others.
16 Can you explain, please, why it was easier to
17 measure close-range droplet transmission than airborne
18 transmission?
19 **A.** So that point we were very much dependent on
20 observational studies of the way that people became
21 infected, and droplet transmission at that stage was
22 felt very strongly to be the predominant mechanism by
23 which SARS-CoV-2 spread.
24 There was at the very, very early stages of the
25 pandemic response, as we were first identifying cases

1 internationally and then in the UK, a lot of reliance on
2 the dynamics of similar infections to try to judge how
3 SARS-CoV-2 might evolve and spread as well.
4 In that sense, the very close genomic similarity to
5 SARS-CoV-1 -- and there is about an 80% similarity --
6 meant that there was a heavy reliance on that and some
7 other respiratory diseases to try to kind of infer what
8 the most likely mechanisms of spread were in that case.
9 Droplet spread is rather more easy to kind of
10 quantify than aerosol spread because it is so difficult
11 to measure viral particles in any environment like that.
12 But certainly the evidence from these observational
13 studies that -- these initial observational studies
14 certainly seemed to suggest that droplet spread was the
15 predominant spread. But I think importantly it didn't
16 rule out the fact that aerosol spread was still
17 a possibility --
18 **Q.** If I can just stop you there because we will come on to
19 the detail of that, but just in terms of the measuring
20 of those, your position is it was easier to measure
21 close-range droplet transmission than airborne when it
22 came to understand things?
23 **A.** Through the observational studies, yes.
24 **Q.** Paragraph 35 you say this:
25 "... there was a need to balance the level of

1 infection risk from a given transmission route with the
2 frequency and likelihood of exposure to this in
3 day-to-day activities. For example, aerosol
4 transmission across a room may present a low risk from
5 any single exposure, but the ability of one infectious
6 person to expose multiple people at the same time, means
7 it could present a higher population level risk in some
8 settings than for close contact with an infectious
9 person."
10 Could you give an example, please, of the kind of
11 settings in which one infectious person could expose
12 multiple people at the same time?
13 A. I think the best way to try to explain this would be to
14 imagine a closed, poorly ventilated environment. I'm
15 going to pick a hospitality space of some sort. But if
16 it's an enclosed space with poor ventilation and there
17 is even a minimal level of aerosol generation of virus,
18 although the individual risk of a person is relatively
19 low in that respect, if it is a crowded environment,
20 with lots of people there, cumulatively the population
21 risk to that group is much, much greater. So closed,
22 poorly ventilated, crowded environments posed a greater
23 risk for the possibility of aerosol spread even at those
24 early stages. And we saw that with some of the studies
25 in the first superspreader events that took place

1 I suspect.
2 Q. Would hospitals meet that description?
3 A. Generally I wouldn't have considered hospitals as being
4 as part of that description, no, because of the improved
5 ventilation and filtering in modern hospitals.
6 Q. There were some hospitals in Scotland, weren't there,
7 and probably still are, where the structure of the
8 building, the age of the building might make ventilation
9 quite difficult. Factoring that in, does your answer
10 remain the same?
11 A. Again, I would say that it is less evident in hospitals
12 because of the space and the less crowded atmosphere
13 than the type of environments that are enclosed. It
14 doesn't mean that it is impossible but it is less likely
15 than crowded indoor environments such as crowded
16 hospitality settings.
17 Q. At paragraph 36 you say that:
18 "... it was important to retain an open mind [about
19 routes of transmission], as understanding evolved over
20 the course of the pandemic."
21 Then in the last sentence of the paragraph you say
22 this:
23 "It was also important to ensure that absence of
24 evidence was not interpreted as evidence of absence, and
25 that important transmission routes to which there were

1 potential countermeasures were not ignored."
2 Why is it so important that the absence of evidence
3 is not interpreted as evidence of absence?
4 A. So, from my perspective, again, it is the precautionary
5 principle that you outlined beforehand, was that you had
6 to keep an open and not a closed mind to some of this.
7 There was great uncertainty at the beginning as to
8 exactly the range of different ways that Covid-19 could
9 and SARS Cov-2 could spread. Much emphasis has been
10 given on droplet spread but of course at that stage we
11 were also worried about fomite spread, of the faecal
12 spread and even through bodily fluids of other sources
13 as well. So it wasn't just about droplet versus aerosol
14 but actually these other mechanisms of spread were
15 always part of that consideration as well. Until there
16 was much more learning and evidence which was available
17 from the specific virus itself I think it was important
18 that we kept that open mind to the possibilities.
19 And as I say, even some of the early observational
20 studies, particularly one that I recall from China,
21 suggested that in a closed environment that there could
22 be, however minimal, at least some contribution from
23 aerosol spread as well, although it was thought to be
24 much, much less significant than other routes.
25 Q. Could we have on screen, please, INQ000300579.

1 This is a message that was posted on Twitter by the
2 World Health Organization on 28 March 2020 which says
3 this:
4 "FACT: #COVID19 is NOT airborne."
5 It goes on:
6 "The #coronavirus is mainly transmitted through
7 droplets generated when an infected person accuses,
8 sneezes or speaks."
9 Then in the box at the bottom the "fact" of Covid-19
10 not being airborne is repeated again in that bright
11 yellow box.
12 Is this an example of absence of evidence being
13 interpreted as evidence of absence?
14 A. I remember seeing this when it came out and I felt that
15 at that time it was perhaps unhelpful to state so
16 unequivocally that -- the way that this was framed.
17 Because even at that stage and through some of the
18 advisory structures that we had been discussing this, it
19 was felt that, as you say, no matter how small, that
20 there was still the possibility of some aerosol spread
21 at that time.
22 Q. You thought it was unhelpful. Did you raise your views
23 on the WHO statement with your CMO colleagues?
24 A. I think we had discussion at various times round about
25 the role of aerosol spread. I don't remember

1 specifically raising concern about this particular
2 message.
3 Q. Did you raise --
4 A. -- (overspeaking) -- raising about similar messages.
5 Q. I'm sorry, I spoke over you. You had concern about
6 similar messages?
7 A. Yeah, I remember similar messages that came out from WHO
8 that I raised concern about, just about perhaps WHO
9 being less forthright about the possibility of aerosol
10 than I thought they perhaps could have done.
11 Q. In terms of the timing of those other messages that you
12 raised concern about, this was March 2020, when were the
13 other messages you had concern about?
14 A. I could only say some are mid-summer 2020.
15 Q. We will come on to the July messaging. In terms of what
16 you did about your view that this was unhelpful in
17 March 2020, did you raise that view that it was
18 unhelpful with anyone?
19 A. Other than discussion with internal colleagues, no.
20 Q. Did you raise it with ARHAI?
21 A. Not specifically, no.
22 Q. Could we have on screen, please, paragraph 262 of
23 Professor Smith's M2A statement. That's page 65.
24 Here you say this:
25 "It was established that the likely principal route

37

1 of transmission for Covid-19 were respiratory, although
2 secondary routes including faeco-oral were not excluded.
3 From early in the pandemic, three components have been
4 considered potentially important for Covid-19: fomite,
5 droplet and aerosol spread. However, global scientific
6 consensus on the relative importance of these different
7 transmission routes, and the potential role of other
8 routes, shifted as new evidence emerged, and evidence
9 has been continually reviewed as new variants of
10 SARS Cov-2 have become established."
11 Notwithstanding the WHO's message about airborne
12 transmission, is it right, therefore, that aerosol
13 spread was being considered as an important transmission
14 route from an early stage in the pandemic?
15 A. So what I would say is it was considered as a potential
16 route of transmission. The relative importance of it
17 compared to other routes was yet to be established.
18 Q. That was the case by the time you took up your role as
19 interim CMO in April 2020 was it?
20 A. At that point in time it was still unclear as to the
21 relative roles of each of the transmission routes,
22 although it was beginning to crystallise more clearly
23 that there was less emphasis in the faecal-oral route
24 and -- and the exact contribution from aerosol spread
25 was still unclear but not thought to have been zero.

38

1 Q. Going over the page, please, paragraph 265, you discuss
2 in this paragraph the early inference that was drawn
3 from early studies of transmission routes of other
4 respiratory viruses, in particular SARS Cov-1. Three
5 lines down you say this:
6 "In retrospect, this provided mixed early
7 indications, on the one hand, the airborne transmission
8 capabilities of SARS-CoV-2 are similar to SARS-CoV-1; on
9 the other, there are a number of important differences
10 such as in timelines of transmission and the much
11 greater role of asymptomatic transmission seen with
12 SARS-CoV-2. As a respiratory virus SARS-CoV-2 carried
13 the potential for transmission via droplets and
14 aerosols, direct physical contact, and indirect (fomite
15 based) physical contact."
16 In your statement provided for Module 3 of the
17 Inquiry you describe a comparison of genome sequences
18 with other known human pathogens that indicated that
19 SARS-CoV-1 was the closest related human pathogen, with
20 around 80% genomic similarity to SARS-CoV-2.
21 With that in mind, was the initial assumption that
22 there was at least the potential for SARS-CoV-2 to be
23 transmitted by the airborne route?
24 A. Yes.
25 Q. You go on in this paragraph to say this:

39

1 "Existing evidence suggested that close contact with
2 a person with acute respiratory infection carried more
3 risk than a more physically distant contact, implying
4 the importance of close-range droplet and, as now
5 understood, short-range aerosol transmission."
6 But there was pre-pandemic research into other acute
7 respiratory infections which was also drawn upon, which
8 you refer to here. And going over the page, please, you
9 say that showed the importance for transmission of
10 exposure in public spaces:
11 "... including public transport, shops, restaurants,
12 parties, theatres and places of worship, suggesting
13 an additional potential role for more distant, primarily
14 aerosol based, transmission."
15 Given that airborne transmission was harder to
16 measure and the importance of absence of evidence not
17 being interpreted as evidence of absence, the potential
18 for this route of transmission had to be taken
19 seriously, didn't it?
20 A. Yes.
21 Q. That can come down now, thank you.
22 In terms of how the understanding of transmission
23 evolved, could we have on screen, please, INQ000375354.
24 This is a printout of some WhatsApp message on the
25 CMO WhatsApp group from July 2020, and I would just like

40

1 to look at the top message, please, which is from you,
2 is that right?
3 A. That's right, yes.
4 Q. And you say:
5 "I note the less than helpful equivocal statement
6 from WHO this morning on airborne spread. Will no doubt
7 become focus of attention until they produce something
8 more definitive."
9 There does not seem to be a reply to this message on
10 this page, and the remainder of the messages relate to
11 different matters. But this WHO statement was referred
12 to by you in a Scottish cabinet meeting on 8 July, the
13 same day.
14 Could we have the minutes of that meeting on screen,
15 please. The reference is INQ000078577.
16 This was a meeting attended by a number of cabinet
17 members, including Jeanne Freeman.
18 Going to page 2 of the document, please.
19 We can see that you provided an oral Coronavirus
20 update at the meeting, is that right?
21 A. That's right, yes.
22 Q. And paragraph 3 of the minutes deals with the numbers of
23 cases and deaths.
24 **LADY HALLETT:** Just before you go on, Ms Price, the minutes
25 of the meeting held on 30 June, I thought you said the

1 Scottish cabinet meeting was on the same day as the --
2 **MS PRICE:** If we can go back to the first page.
3 **LADY HALLETT:** Ah, right.
4 **MS PRICE:** I think that's the first item on the agenda,
5 which is to check --
6 **LADY HALLETT:** Of course, thank you.
7 **MS PRICE:** -- the accuracy of the minutes.
8 **LADY HALLETT:** Thank you.
9 **MS PRICE:** Page 2, paragraph 3 deals with numbers of cases
10 and deaths.
11 But paragraph 4 deals with the WHO statement, which
12 is said to have been made the previous day. And the
13 summary of your update reads in this way:
14 "The previous day, a representative of the World
15 Health Organization ... had made an equivocal statement
16 regarding the possibility of airborne transmission of
17 the SARS-CoV-2 virus, although further, urgent research
18 was required before a definitive position could be
19 reached. The WHO's position remained that the virus was
20 spread by droplet transmission, but an WHO official had
21 now acknowledged some evidence to suggest that airborne
22 transmission could not be ruled out in crowded, enclosed
23 or poorly ventilated spaces."
24 Pausing there, can you help with why you considered
25 the statement from the WHO on airborne spread to be

1 equivocal and less than helpful, that description from
2 your WhatsApp message?
3 A. So, first of all, the context is that the previous
4 statement -- and this had been unequivocal in that and
5 there was no such thing as airborne spread, and, as
6 I've already said, I felt that was an unhelpful position
7 to adopt at that stage. Moving to a more equivocal
8 position was at least a positive step in that direction
9 but, in my view, it wasn't sufficient to really enable
10 the broader societal discussion about airborne spread
11 and the response that that might necessitate as well.
12 Many of the nations around the world, including our
13 own, placed a great store in the guidance given by WHO,
14 rightly so, given the expertise that they held, but
15 I think that this was one area where there was more
16 uncertainty about the role of aerosol spread than
17 perhaps was generated in their guidance. And,
18 subsequently, as it became ever more clear that at least
19 it had a contribution to make, as we began to kind of
20 re-open society, if I can put it in those terms, one of
21 the most important aspects of that reopening was the
22 emphasis on good ventilation, and my view was that
23 whilst the WHO continued down this track, it made it
24 more difficult to get the necessary levels of investment
25 in place and to convince everybody that actually

1 investing in ventilation was something which was
2 important.
3 Q. Was that something that you wanted more investment to
4 be --
5 A. By that stage, and I'm not going to say by that stage
6 I was convinced because there was still uncertainty, but
7 certainly in my mind it was one of the interventions
8 which I thought was going to become much more important
9 over time was particularly in, if you like -- in opening
10 up places for people to come together for meeting
11 indoors is the ventilation would have to play a big part
12 in how we responded to that.
13 Q. We'll come back to ventilation but, given the store that
14 was placed in WHO's statements and guidance, did you
15 consider raising your concerns about the quality of the
16 guidance and statements coming out of the WHO at this
17 stage?
18 A. So not in a formal sense. So, again, recognising the
19 relationship that Scotland has with WHO, it's not
20 a direct relationship, that becomes difficult. However,
21 there was certainly a discussion round about where WHO
22 were likely to be heading with some of the guidance and
23 their views on aerosol transmission at that stage.
24 Q. Did you discuss your concerns about WHO statements and
25 guidance with your CMO colleagues at this stage in July?

1 **A.** You've seen the WhatsApp conversation there and that was
2 never really kind of developed any further than that, as
3 far as my recollection, although my recollection is not
4 complete at that stage.
5 **Q.** Did you consider raising this with someone from ARHAI,
6 given that those considering IPC measures were, it
7 seems, placing a lot of store in what WHO were saying?
8 **A.** So, again, the -- ARHAI I didn't have a direct
9 relationship with. ARHAI's relationship was with one of
10 my senior medical colleagues, the chief medicine
11 officer, and although there were certainly discussion
12 between the senior clinicians in relation to this,
13 I don't know how that was then taken on in terms of the
14 direct discussion with ARHAI.
15 I do remember frequently discussions both at Quint
16 and in the CMO group about the need to ensure that the
17 national UK IPC cell was continually reviewing the
18 guidance in light of emerging evidence and approaches,
19 not just in this country but from around the world, and
20 that was a point that was pressed home fairly frequently
21 and particularly and most importantly I guess when new
22 variants of concern began to emerge.
23 **LADY HALLETT:** Sorry, Ms Price, you say that you didn't
24 raise it with ARHAI because you didn't have a direct
25 relationship with them, that was with the chief nursing

1 officer but, given your involvement with the chief
2 nursing officer, your discussions with your colleagues
3 across the UK as CMOs, I'm not following the fact that
4 you didn't have a direct relationship means that you
5 couldn't raise it.
6 **A.** So it was raised through the channels that were
7 available for me at that point in time, in terms of we
8 would have a discussion about it and we would decide a
9 consensus as to whether we should take that back to, for
10 instance -- it was generally the UK IPC cell which would
11 be looking at that more closely rather than ARHAI in
12 Scotland.
13 **MS PRICE:** My Lady, would that be an appropriate point for
14 a 10-minute break?
15 **LADY HALLETT:** We usually take 15 minutes.
16 **MS PRICE:** Apologies, 15 minutes, my Lady.
17 **LADY HALLETT:** What we will do is we will compromise. Given
18 it's 11.07 I shall return in -- 11.25.
19 **(11.07 am)**
20 **(A short break)**
21 **(11.20 am)**
22 **MS PRICE:** And just to be clear, did you consider at this
23 stage, in July 2020, that the WHO was failing adequately
24 to acknowledge the potential role of airborne
25 transmission?

1 **A.** I think the context for this is that I thought that they
2 were failing to acknowledge the possibility of aerosol
3 transmission, although even at that stage my own view
4 was that although I thought that it was possibly
5 contributing, its contribution was very small.
6 **Q.** Do you think you should have done more at that time in
7 July 2020 to express your view particularly to the
8 groups who were dealing with IPC measure guidance?
9 **A.** Given that I thought the contribution was very small at
10 that stage in the evidence that was available, no.
11 **Q.** Looking at paragraph 5 of the minutes here, the summary
12 of your oral update continues:
13 "If confirmed ..."
14 And by that do we take it to mean if airborne
15 transmission was confirmed?
16 "... this would alter the measures required to
17 protect against infection and could signal new risks:
18 compared with droplet transmission, airborne (or
19 aerosol) transmission was characterised by the much
20 longer presence of the virus in the air when an infected
21 person had been in a confined space.
22 "6. In discussion it was noted that this
23 unconfirmed development, although potentially worrying,
24 should in any case serve to underline the merits of
25 using face coverings in public. The four Chief Medical

1 Officers of UK countries would continue to monitor
2 closely the research in this area and would be alert to
3 the implications of any changes in the formal position
4 of the WHO."
5 Was it your view at the time that if airborne
6 transmission were confirmed as a route of transmission
7 for Covid-19, that different measures would be required
8 to protect against infection?
9 **A.** My view was that if it was confirmed it was
10 a significant contributor to transmission, and I think
11 the importance there is the clarification as to what
12 extent it was a contributor to transmission overall.
13 Then, yes, I did believe that there would be a need to
14 probably emphasise some parts of the response in a way
15 that was greater than we were currently doing, as I say
16 in particular ventilation.
17 **Q.** Are the measures you refer to here -- and you've just
18 given the example of ventilation, but are you referring
19 to IPC measures in healthcare settings?
20 **A.** All of that would have to be kept under continual review
21 anyway and it was kept under continual review, so I was
22 confident that that would be a process that would be
23 ongoing, but, as I say, I was particularly concerned
24 that we may have to introduce additional measures such
25 as a greater emphasis on ventilation, as I've already

1 said.
2 **Q.** The position you are putting forward here appears to be
3 that a change in protection measures was not required
4 until this development was confirmed, is that right?
5 **A.** My view was that unless there was new evidence that
6 showed that there was a significant level of
7 transmission from aerosol spread, then, yes, we didn't
8 need to take additional measures but we should stay
9 alive to the prospect that that may be the case at some
10 future point.
11 **Q.** Is this not the wrong way round, applying the
12 precautionary principle -- shouldn't such measures be
13 introduced in case airborne spread transmission is
14 confirmed in the future where there is some evidence of
15 it acknowledged?
16 **A.** At the level of evidence with the level of impact that
17 was felt to be the case at that point in time, no, it
18 would have been inappropriate to apply the precautionary
19 principle.
20 **Q.** This unconfirmed development was said by someone
21 involved in the discussion at the meeting to underline
22 the merits of using face coverings in public. Was there
23 any discussion at this meeting of whether this
24 development should prompt further analysis of the merits
25 of altering protection measures in healthcare settings

1 specifically?
2 **A.** I don't recall whether that was part of the discussion
3 or not.
4 **Q.** Well, there's no reference to it in the minutes. Do you
5 think, therefore, that there was no discussion of it?
6 **A.** My view is that if it had been a significant part of the
7 discussion it would have been captured in the minutes.
8 **Q.** Do you think this is something that should have been
9 discussed at the time that this development in the
10 evidence or acknowledgement of the development in the
11 evidence was being discussed?
12 **A.** It was perhaps a discussion that wasn't for cabinet at
13 that point in time, but should advice have been brought
14 forward to cabinet specifically for that purpose, then
15 I would imagine that it would have been a very
16 appropriate thing for cabinet to be involved in the
17 discussion.
18 **LADY HALLETT:** Sorry, I didn't follow that answer, Sir
19 Gregor:
20 "It was perhaps a discussion that wasn't for
21 cabinet ... but should advice have been brought forward
22 to cabinet specifically ... I would imagine it would
23 have been a very appropriate thing ..."
24 Sorry, are you saying it should have been taken to
25 cabinet?

1 **A.** What I'm saying is that if formal advice had been taken
2 to cabinet because it was felt to be so significant
3 a development, then I'm quite sure cabinet would have
4 discussed it in that respect, but at that -- I think --
5 the emphasis that I would want to put in this part here
6 is that this was a very unclear moment as to the
7 significance of the contribution of aerosol spread. At
8 that point in time, it was still felt to be of a very
9 low degree of transmission involved, if any, at that
10 stage, and until there was greater evidence for that,
11 then I can understand wholly why cabinet wasn't
12 discussing it.
13 **LADY HALLETT:** You would have been the person to take it to
14 cabinet, would you, the use of a face mask?
15 **A.** Probably what would have happened in those circumstances
16 would -- from the appropriate policy area, submission
17 would have been made to ministers in relation to advice
18 that was given about face masks, and then the
19 appropriate minister, if the decision lay beyond them
20 and it was a decision for cabinet rather than for the
21 minister themselves, then it would have been taken from
22 there to cabinet. As I've already outlined I wasn't
23 responsible for policy in relation particularly to face
24 masks.
25 **LADY HALLETT:** Can I go back to the point Ms Price was

1 making about the use of the precautionary principle.
2 She established that you accepted the precautionary
3 principle was important, that the absence of evidence
4 doesn't mean -- I can't get it right now, I'm getting
5 everything wrong this morning, including my maths -- the
6 absence of evidence doesn't mean evidence of absence.
7 Why are you looking for evidence of a significant
8 contribution to transmission before you start
9 considering other measures that might be sensible and in
10 accordance with the precautionary principle?
11 **A.** Because at this point in time the evidence suggested
12 that the contribution was small and, therefore, the
13 gains which would be made by applying those additional
14 measures would be so small that it would be
15 a disproportionate response.
16 **LADY HALLETT:** Well, shouldn't there have been some analysis
17 of whether the response would have been
18 disproportionate?
19 **A.** Those type of analyses were continually taken in
20 relation to a number of things. I cannot comment on any
21 analysis that was undertaken in relation to IPC
22 specifically. But in terms of face masks for the
23 general population, which I was more closely involved in
24 providing advice around, I know that health and social
25 care analysis teams in Scottish Government looked at the

1 evidence for and against this very extensively,
2 particularly contributions not only to the protection of
3 those wearing them but source control protection of
4 others.
5 **LADY HALLETT:** Sorry to interrupt, Ms Price.
6 **MS PRICE:** Not at all, my Lady. That document can come down
7 now, thank you.
8 It appears from the documents that SAGE provided
9 advice on airborne transmission on 9 July 2020, the day
10 after the Scottish cabinet meeting that we've just
11 looked at the minutes for. We can see that reproduced
12 in a submission to Scottish ministers dated
13 4 August 2020, and that submission was copied to you.
14 Could we have that on screen, please. It's
15 INQ000380368.
16 This submission related to the proposed expansion of
17 mandatory face coverings to indoor public spaces.
18 Going to page 2 and paragraph 8, please.
19 The first paragraph of quoted text here, which is
20 quoted text from SAGE, we can see that in the bottom
21 right, says:
22 "In light of the WHO's recent communications on
23 the risk of airborne spread, SAGE noted that its papers
24 and guidance have consistently acknowledged that
25 shorter-range aerosol transmission is a risk, especially

1 in poorly ventilated settings featuring
2 a highly-infectious person. The contribution of aerosol
3 transmission relative to droplets and fomites remains
4 unknown, but aerosol is unlikely to be the dominant
5 transmission route. Research is underway on this
6 subject and a UK research consortium has been formed."
7 Did this represent the clinical consensus which was
8 being presented to Scottish ministers at this point in
9 time, August 2020?
10 **A.** So this represented the view that -- as I say, I was
11 more closely involved in formulation of policy in
12 relation to face coverings in public, the view that
13 I felt was important and considering when ministers were
14 making decisions about whether to introduce masking for
15 the public.
16 **Q.** My question is really, this is a view from SAGE. It is
17 being put in a submission to Scottish ministers. Was
18 this being put forward at this point in time as the
19 clinical consensus for Scottish ministers to base their
20 decisions upon?
21 **A.** Yes, it was.
22 **Q.** Could we have on screen, please, INQ000246414.
23 This is a June 2021 *"Review of Physical Distancing*
24 *in Scotland"*, produced by the Scottish Government.
25 Looking at page 7, please. We see reference here

1 towards the end of the second paragraph on this page to:
2 "... increasing evidence of airborne transmission
3 over longer distances in some situations."
4 Does this reflect your understanding of the picture
5 in relation to transmission at that time, June 2021?
6 **A.** It does, yes.
7 **Q.** Could we have on screen, please, INQ000362893.
8 These are the minutes of a Scottish cabinet meeting
9 which took place on 7 December 2021. Again, you
10 provided a verbal update for ministers.
11 Going to page 3 of this document, please,
12 paragraph 12. The update being provided related at this
13 point to the Omicron variant. There is reference to the
14 suspected increased transmissibility of this variant.
15 Going then to page 6, paragraph 23, starting three
16 lines down:
17 "In addition, the public needed to be warned about
18 the increased risks associated with 'super-spreading'
19 events (largely as a result of airborne transmission),
20 which must be understood to encompass almost any
21 gatherings in crowded and/or confined spaces."
22 As far as your assessment of the evidence went, is
23 it right to say that you were of the view that airborne
24 transmission, including aerosol transmission over longer
25 distances, so not just close contact, was by this point

1 confirmed as a route of transmission?
2 **A.** So by this point, yes, I would say that my very clear
3 view was that aerosol transmission was very real.
4 Again, the extent to which it contributed was less clear
5 but it was certainly contributing with this particular
6 variant to some of the superspreading events that we
7 were seeing.
8 **Q.** How did you join the dots, so to speak, between your
9 strengthening view on this and the consideration that
10 was being given to in particular IPC measures by others?
11 **A.** So in terms of joining the dots, again this goes back to
12 the continual review process that was instituted by the
13 IPC cell in terms of how they reviewed emerging
14 evidence. In relation to changes in circumstances, now,
15 those changes in circumstances might be new pieces of
16 evidence that came out or it might be the emergence of
17 a new variant such as Omicron, which would mean
18 a reassessment of the approach.
19 **Q.** Could we have on screen, please, INQ000203978.
20 This is a statement from the WHO dated
21 23 December 2021 dealing with how Covid-19 is
22 transmitted.
23 The first sentence at the first bullet point says
24 this:
25 "Current evidence suggests that the virus spreads

1 mainly between people who are in close contact with each
2 other, for example at a conversational distance."
3 And at the second bullet point there is this:
4 "The virus can also spread in poorly ventilated
5 and/or crowded indoor settings, where people tend to
6 spend longer periods of time. This is because aerosols
7 can remain suspended in the air or travel farther than
8 conversational distance (this is often called long-range
9 aerosol or long-range airborne transmission)."
10 Was this the first official confirmation by the
11 World Health Organization that Covid-19 is transmitted
12 by the long-range airborne or long-range aerosol route
13 as far as you're aware?
14 **A.** I couldn't say with certainty that this was the first
15 communication, but what I could say is that this
16 began -- this was a communication that began to be much
17 more consistent with my understanding of the situation.
18 **Q.** How did this impact upon your assessment of the evidence
19 relating to routes of transmission?
20 **A.** It reaffirmed my thoughts in relation to what I felt
21 were the routes of transmission.
22 **Q.** To what extent do you think the scientific consensus in
23 the UK on routes of transmission was led by the official
24 position of the WHO?
25 **A.** I think you can already see from some of the discussion

1 that we've had so far today is that there was always an
2 acknowledgement of aerosol transmission as a mechanism.
3 As I say, the unclear aspect of that was to what extent
4 it was able to contribute in the real world to
5 transmission.
6 And this was, I felt, a moment in time when the WHO
7 position and the position of many experts in the UK
8 began to kind of become much, much closer together.
9 **Q.** That document can come down now, thank you.
10 Given that some evidence of airborne transmission
11 was acknowledged by the World Health Organization in
12 July 2020, do you think the scientific consensus in the
13 UK was too slow to recognise its role?
14 **A.** I think that's a difficult question to answer, I have to
15 say, The d reason I find it difficult to answer is
16 because I think that there's evidence of part of the
17 response long before that that showed that the
18 possibility of aerosol transmission was built into the
19 response. So, again, I take us back to a point in time
20 in summer 2020, as we began to re-open society, and in
21 light of the WHO Position Statement and that some of the
22 advice that was coming from the UK groups, some of the
23 international evidence that was beginning to gather
24 a greater degree of strength, as society began to
25 re-open there really was an emphasis, you will recall,

1 on safer spaces being either outdoors or in
2 well-ventilated spaces for good reason, and that was
3 because of the possibility of aerosol spread.
4 So I think even before that there was certainly
5 an acknowledgement. I couldn't say whether there was
6 a broad consensus amongst every academic. But it was
7 certainly strong enough for the advice that was being
8 provided to ministers in terms of society re-opening is
9 that we had to take notice of those safer type of spaces
10 and emphasise those particularly during times when the
11 kind of prevailing, higher levels of infection were
12 affecting us.
13 **Q.** Given the groups involved in providing advice it was
14 possible, wasn't it, for the Scottish Covid-19 Advisory
15 Group to take a different view from SAGE, for example,
16 and to provide different advice. Do you agree with
17 that?
18 **A.** It was certainly possible. There were very few
19 occasions where the advice differed significantly at
20 all. I would struggle at this moment in time to be
21 certain of an occasion such as that.
22 However, I think where the Scottish advisory group
23 perhaps placed a different emphasis on some of the
24 advice that was coming out and perhaps either a higher
25 degree of confidence on it or labelled it as being more

1 important, in terms of the response that was taken,
2 again, I would suggest that that cautious approach to
3 re-opening more slowly perhaps than other parts of the
4 UK as we did it, but with a much stronger emphasis on
5 some of the environments that were felt to be at higher
6 risk because of the lack of ventilation and the crowded
7 nature of them, they became one of the features of
8 advice that came not only, I would say, from the
9 advisory group but also from the national INT(?) as
10 well.
11 **Q.** Did you ever instruct your Covid-19 advisory group to
12 look critically at what SAGE were saying in their
13 advice?
14 **A.** Right from the beginning the advisory group didn't need
15 any instruction. They were very critical in every
16 discussion that they had of all the advice and papers
17 that they came across.
18 One of the things that worked very well at the
19 inception of the Scottish advisory group was the
20 reciprocal agreement to share papers with SAGE and from
21 SAGE, from Scottish authors of the advisory group to
22 SAGE and also access obviously to the SAGE papers as
23 well. And what that did was that facilitated really
24 very often direct discussion within the advisory group
25 about the interpretation of some of the evidence.

1 **Q.** Okay. But in answer to my question, is the answer no,
2 in terms of you providing direct instruction to that
3 effect, ie could you look critically at what SAGE is
4 saying about transmission?
5 **A.** I would have provided direct instruction if it were
6 required, but it was never required because it was
7 inherent in the way that the group operated.
8 **Q.** We've touched on the indirect health harms caused by
9 Covid-19 and the exacerbation of the health
10 inequalities. I'd like to come now to the evolving
11 understanding of disparities in outcomes to those
12 affected by Covid-19. You deal with this in
13 paragraph 67 of your Module 3 statement.
14 To summarise your evidence here, is it right that by
15 February 2020 there was evidence of increased risk of
16 hospital admission for older adults, men and those with
17 certain underlying health conditions?
18 **A.** Yes. The picture that we were seeing emerging in other
19 countries certainly suggested that there was a -- at
20 that stage, there was a more severe impact on these type
21 of groups.
22 **Q.** In addition, you say that:
23 "... in the first wave, statistics highlighted high
24 rates of hospitalisations among patients of black and
25 Asian ethnic groups compared to white ethnic groups ..."

1 And you cite an ICNARC report dated 10 April 2020
2 which reported on statistics from England, Wales and
3 Northern Ireland.
4 Is it right, therefore, that this disparity in
5 outcomes was something you were aware of from an early
6 point in the pandemic?
7 **A.** It was something which I remember there being discussion
8 on both at the Scottish advisory group but also through
9 the SAGE structures, and people were aware of it.
10 People were also aware that there were many confounding
11 factors which could be contributing to it and which
12 needed to be fully sorted through and understood before
13 there was a definitive position on it. But certainly at
14 that early stage, there was enough evidence to suggest
15 that it really needed to be understood much more
16 clearly.
17 **Q.** I would like to ask you about Public Health England's
18 report beyond the data understanding the impact of
19 Covid-19 on BAME groups dated June 2020. You deal with
20 this at paragraph 69 of your Module 3 statement if that
21 helps you.
22 This was an English report. To what extent were the
23 recommendations applicable to England considered,
24 adapted and implemented in Scotland?
25 **A.** Yes, so there's many of the recommendations which

1 applied equally to Scotland in the way that we had to
2 respond, particularly round about the quality of the
3 data that we would have and, you know, the data
4 collection systems in particular were areas which were
5 looked at very, very quickly, particularly on hospital
6 admissions. But we also acknowledged the importance of
7 having to look at ethnicity data and how that was
8 recorded in primary care systems as well. It wasn't
9 recorded as well as it should be, and that was something
10 which we did address.
11 I recall that ministers also at that point in time
12 set up the expert reference group to examine not only
13 the impacts that pertained to the report but actually
14 some of the broader impacts that related to ethnicity
15 across society as well. I think that was probably
16 August 2020 that that was set up in response to that as
17 well. And subsequently it then reported in November
18 with a series of recommendations which were taken
19 forward as well.
20 **LADY HALLETT:** Could I issue my usual request. Could you
21 slow down, please.
22 **A.** I will do.
23 **LADY HALLETT:** Thank you.
24 **MS PRICE:** I'd like to come to a new topic, please,
25 Professor Smith, and that is Long Covid.

1 Could we have on screen, please, INQ000409591.
2 This is the witness statement of Dr Safia Qureshi
3 from the Scottish Intercollegiate Guidelines Network.
4 I just want to take you to one paragraph in it,
5 which is paragraph 79, which is highlighted on the
6 screen, which reads as follows:
7 "In July 2020 the Scottish Government COVID-19
8 Professional Advisory Group discussed reports of
9 individuals with diverse long-term, persisting symptoms
10 after recovery from acute COVID-19 and supported
11 a proposal for the Clinical Cell to develop national
12 guidance on this topic. It noted that several teams in
13 Scottish Government were working on different approaches
14 to support people with on going symptoms."
15 Then the paragraphs which follow deal with which
16 those teams were.
17 Do you recall discussion at the Scottish Covid-19
18 professional advisory group of such reports in
19 July 2020?
20 **A.** I don't think I was at that particular meeting but
21 I recall the reports that came out of that group and the
22 proposals at that point in time to set up a much closer
23 relationship with SIGN, an organisation in Scotland
24 which is responsible for creating guidelines and
25 a trusted source of information for clinicians in

1 Scotland. And around that same time there were
2 increasing reports from people writing directly but also
3 media reports and social media reports, evidence from
4 other places, of longer-term sequelae in relation to
5 Covid.
6 None of that should really surprise us, because many
7 viral diseases have that type of impact, but there
8 seemed to be particular nuances that people seemed to be
9 experiencing this that may be unique to Covid itself,
10 and we needed to try to learn more about that. So the
11 proposal to try to bring together all these strands of
12 working in an integrated way but also to explore with
13 other UK nations whether they were doing any work in
14 this and to bring that all together eventually led to
15 the joint project between NICE in England and SIGN and
16 the Royal College of GPs to try to bring forward some
17 formal guidance for clinicians on this.
18 **Q.** You say this should not surprise us. Was any work
19 done -- anticipatory work done before reports of
20 long-term symptoms in Scotland?
21 **A.** I'm not aware of any anticipatory work that was done on
22 this.
23 **Q.** Are you aware of any done in the UK more widely?
24 **A.** Again, I'm not aware of any anticipatory work that was
25 done on this that I could confidently refer to.

1 **Q.** So July 2020, the summer of 2020, was that the first
2 time that Long Covid, as it came to be called, was
3 raised with you or came to your attention?
4 **A.** With the degree of confidence that I have in my memory,
5 that would sound about the right time.
6 **Q.** What advice, if any, did you provide to the Scottish
7 Government in July 2020 on Long Covid?
8 **A.** So the main advice was to take forward this work to try
9 to develop a package of -- first of all, to understand
10 what was meant by the term "Long Covid", because even at
11 that stage there was a recognition that there may be --
12 different people who had long-term symptoms were
13 affected in different ways and to try to understand that
14 a little bit better, so to develop the evidence base for
15 this which might then inform some sort of more cohesive
16 longer-term approach.
17 **Q.** That document can come down now, thank you.
18 Just a point of clarification on the Long Covid
19 timeline, if I may.
20 **A.** Yes.
21 **Q.** At paragraph 95 of your Module 3 statement you refer to
22 it becoming apparent by summer of 2021:
23 "... that many patients have ongoing symptoms after
24 recovery which persisted for longer than three months."
25 You cite a Switzerland study from July 2021, and

1 that's the same study that's cited in the CMO's
2 technical report.
3 By starting the chronology in your statement with
4 the state of knowledge in summer 2021 you were not
5 saying, were you, that this was the first time there
6 were reports of long-term --
7 **A.** No.
8 **Q.** -- persisting symptoms.
9 **A.** Reports of persisting symptoms were starting to come
10 through much, much earlier than that.
11 **Q.** Because we know the first version of clinical guidance
12 was in place by December 2020; that's right, isn't it?
13 **A.** Yeah.
14 **Q.** In terms of the progress which was made developing a
15 clinical guideline after discussion of the issue in the
16 summer of 2020, there was a Scottish paper dated
17 2 September 2020, I won't go to it unless you need me
18 to, but that addressed the need for a guideline, is that
19 right?
20 **A.** Could you go to the paper just to clarify.
21 **Q.** Yes.
22 It's INQ000365757.
23 **A.** So this is from SIGN, yes.
24 **Q.** Yes. So I think you have seen this document before.
25 **A.** Yes.

1 **Q.** It essentially sets out what is needed in September,
2 2 September.
3 That document can come down now, thank you.
4 You refer to the clinical guideline which was
5 produced in December 2020 at paragraph 100 of your
6 statement. Is it right that the Scottish
7 Intercollegiate Guidelines Network ultimately
8 collaborated with the National Institute for Clinical
9 Excellence and the Royal College of General
10 Practitioners over the guideline?
11 **A.** That's exactly how the guideline was produced. SIGN as
12 our national guideline organisation with relevance for
13 clinicians in Scotland and NICE is the equivalent
14 organisation in England worked with the Royal College of
15 General Practitioners particularly because of the impact
16 on people presenting to general practice and the need
17 for long-term follow-up to produce a guideline. And
18 although what was produced was different in each
19 country, the differences were really in the formatting
20 and familiarity for clinicians, rather than being any
21 kind of real difference in the content of them.
22 **Q.** Can you help with why it took from July 2020 until
23 December 2020 for a guideline to be produced?
24 **A.** I can't help you as to why there was that length of
25 time. I could speculate but that's not what I'm here

1 for.
2 Q. In May of 2021 you wrote to the medical directors of the
3 NHS boards about implementation support following the
4 publication of the clinical guideline in December 2020.
5 Could we have that on screen, please. The reference
6 is INQ000480831.
7 You refer in the first paragraph -- and this is
8 dated 5 May 2021 -- to the guideline then in the -- you
9 refer in that first paragraph to the December guideline
10 which had been published.
11 And then in the second paragraph you say this:
12 "To support the implementation of the guideline's
13 recommendations, the Scottish Government has produced
14 additional targeted information for primary care teams,
15 developed with input from key stakeholders, including
16 Speciality Advisers to the Chief Medical Officer and
17 senior medical advisers to the Scottish Government. The
18 implementation Support Note provides primary care teams
19 with practical information about implementing the SIGN
20 guideline from a whole system perspective."
21 Can you recall why implementation support was felt
22 to be necessary?
23 A. Very, very often after significant guidelines we look at
24 actually whether additional support was needed in
25 supporting clinical teams to actually implement the

1 guidelines. In this case, because this was a new
2 condition, it was felt that additional -- for instance,
3 one of the most important aspects is being able to
4 identify people who may suffer from this in electronic
5 records, so coding information that was specific to Long
6 Covid, for instance, becomes really important,
7 particularly how that impacts on people. And this was
8 intended to be a supportive tool just to make sure that
9 the actual guidance landed and was adopted as completely
10 and consistently as possible.
11 Q. Was there any particular incident or incidence which
12 prompted the decision to provide this additional
13 support?
14 A. No, I don't recall any.
15 Q. Would it have been possible to provide implementation
16 support earlier and would it have been desirable to do
17 so?
18 A. I'm not able to answer that question. I wasn't directly
19 involved in the development of the implementation
20 guidance, and I -- it would be my view that this would
21 be quite an undertaking in amongst all other activities
22 that were ongoing at that time for a team to be able to
23 develop the type of guidance that was then sent to
24 general practice. Whether it could have been shortened
25 or not, I guess it could have been shortened if

1 additional resource, additional people were available to
2 do that, but even then that's not certain I don't think.
3 Q. In terms of the process, when did you become involved,
4 was it at the point of sending out this letter?
5 A. It was a communication.
6 Q. Is it right -- and that document can come down now,
7 thank you -- is it right that from September 2021 there
8 was a centrally funded Long Covid service in Scotland?
9 A. There was.
10 Q. And the funding consisted of a £10 million Long Covid
11 support fund, is that right?
12 A. To the best of my knowledge that's my understanding.
13 Q. Can you explain, please, how the provision of Long Covid
14 services in Scotland differed before and after the
15 introduction of central funding?
16 A. Before the central funding was available it's my
17 understanding, based on conversations that I've had with
18 the policy team who oversaw this clinical condition but
19 also some of the kind of operational clinical directors
20 responsible in the boards, that much of the approach was
21 more ad hoc and dependent on which board -- health board
22 patients resided in. There may be a different approach
23 to the service with some being more centralised
24 specialist services and some being led within a kind of
25 primary and community setting.

1 There were common features across different boards,
2 common features such as rehabilitation support, such
3 as -- in mainly psychological support but not an extant
4 national specification in that sense, prior to this, the
5 funding, being available. As it has been described to
6 me, we then saw the funding becoming available and there
7 being a much more consistent approach to the way that
8 these services would be designed and delivered within
9 each of the boards supported by that level of funding.
10 Q. And were Long Covid services improved after central
11 funding was introduced?
12 A. I cannot give you an answer to that and I can't give you
13 the answer to that because I have never seen data which
14 shows whether there were material improvements from
15 people's perspective in relation to the care that they
16 felt with us.
17 Q. Were you involved at all in advising ministers on how
18 Long Covid services should be provided or funded?
19 A. I wasn't, no.
20 Q. Could we have on screen, please, paragraph 104 of
21 Professor Smith's Module 3 statement. Here you give
22 your reflections on lessons to be learned from Long
23 Covid, and you say this:
24 "It is important to note for future pandemic
25 preparedness that there may be longer-term consequences

1 of an infection affecting a large percentage of the
2 population, and that adequate surveillance mechanisms
3 should be in place to capture the epidemiology of the
4 condition accurately to allow adequate planning of
5 healthcare resources in the longer term."
6 Was the potential for there to be longer-term
7 consequences of infection with Covid-19 something which
8 should have been recognised from the outset of the
9 pandemic?
10 **A.** I think it is a common feature, as I've already said, of
11 many viral infections, not every viral infections but of
12 many viral infections that there are longer-term
13 sequelae as a consequence of that. It's not unusual of
14 respiratory viruses, although the more common that we
15 see is flu. Even with flu there are some longer-term
16 sequelae that people are aware of. And with Covid-19 it
17 was very unclear as to exactly what those long-term
18 sequelae could be.
19 Viruses are -- for anyone who studies them -- are
20 fascinating organisms in the way that they impact on
21 people, not just in the short term but the way that they
22 can some -- their effects can sometimes persist in the
23 body either through long chronic infection or through
24 the way that the body's immune response fails to turn
25 itself back down afterwards.

1 It was very unclear with Covid at first as to
2 whether it was going to have those kind of effects, but
3 it's not unreasonable to think any virus infection could
4 have longer-term sequelae, hence the reason for my
5 paragraph 104. It's, for me, an important part of
6 looking forward and making sure that we have got
7 surveillance systems not only to identify the pathogens
8 but actually the longer-term effects of those pathogens
9 as well.
10 **Q.** Was Scotland prepared to deal with Long Covid?
11 **A.** The answer to that, in my view, has to be, no, we
12 weren't prepared at that early stage of the pandemic to
13 deal with Long Covid, partly because it was unknown to
14 what extent Long Covid would impact on the population.
15 If you look at the range of impacts that long-term
16 sequelae can have from debilitating conditions like
17 chronic fatigue syndrome through to incredibly complex
18 and difficult sequelae such as Guillain-Barré syndrome
19 which can be life-threatening, there is such a huge
20 spectrum of disease that you could be dealing with, it
21 would have been very difficult to prepare fully in any
22 respect before knowing what you were dealing with.
23 **LADY HALLETT:** Going back to Ms Price's question a little
24 earlier, do you accept that Scotland should have
25 recognised -- and it may well be that all the countries

1 of the UK should have recognised -- the possibility of
2 long-term sequelae at an earlier stage, given that it's
3 a known consequence of many viruses?
4 **A.** Yes. I mean -- so I'm going to qualify this answer to
5 you, my Lady, and I'm going to qualify it by saying
6 I think there was a recognition that it was
7 a possibility but we were unclear in what way it would
8 present and then how to respond to that. So there was
9 certainly an awareness that it was a very distinct
10 possibility, but we weren't prepared to be able to deal
11 with either the volume of long-term sequelae that we
12 were seeing or I think the type of long-term sequelae.
13 **LADY HALLETT:** So having recognised it as a possibility, was
14 anything done other than recording the recognition?
15 **A.** It was really keeping alive to the fact and watching for
16 the evidence arising.
17 **LADY HALLETT:** Right.
18 **MS PRICE:** Thank you, my Lady.
19 Moving, please, to infection prevention and control.
20 To what extent were the proposals of the UK-wide IPC
21 cell considered by you and other UK CMOs before they
22 became guidance?
23 **A.** I don't recall us ever authorising any of the guidance.
24 I don't think that it was -- there was that type of
25 relationship with IPC's cell. We were certainly aware

1 of the cell. We received reports from the cell.
2 Much of their work was channelled through the chief
3 nursing officers, if you like, reporting structures
4 rather than CMOs, although we were certainly aware of
5 the work, but certainly in Scotland IPC fell under the
6 remit of the chief nursing officer rather than chief
7 medical officer, and it was an area which although I was
8 involved in at times and gave views on that I wasn't
9 closely involved in.
10 **LADY HALLETT:** Can I just follow that up. That seems to be
11 the case throughout the UK. With no disrespect to the
12 chief nursing officers or any of the people who are
13 members of the cell, do you think in the future that is
14 a sensible way to approach what is such an important
15 aspect of guidance, infection prevention and control,
16 should you have other people basically either in charge
17 or on such a cell?
18 **A.** From my perspective, the expertise sits with these
19 professions, and the specialisms sits with these
20 professions, and whilst it may be useful to have
21 external challenge in any group, and I don't single out
22 the IPC as a group that they would benefit from that,
23 that is the route of the expertise.
24 **LADY HALLETT:** But to ensure you have the proper measures
25 for infection, prevention and control, sometimes, as

1 Covid proves, you have to have some expertise in some
2 pretty complex scientific developments, and I just
3 wonder whether that expertise could properly be analysed
4 by the membership of the cell as it was during the Covid
5 pandemic.
6 **A.** I think the IPC cell was fairly well equipped for that
7 because not only did they have subject matter expertise
8 and IPC practice but they had public health specialists,
9 they had ventilation specialists. I believe that there
10 was also input from the Health and Safety Executive as
11 well.
12 **LADY HALLETT:** But do you not need expertise in
13 understanding the nature of the virus that you're
14 dealing with?
15 **A.** Which should have come both from the infection control
16 specialists and also the public health specialists in
17 the group.
18 **LADY HALLETT:** So going back to the airborne droplet debate,
19 if you have expertise in how you can control a certain
20 kind of virus that is droplet-based, surely you need to
21 be able to analyse whatever understanding there is,
22 scientific understanding, of whether it is
23 droplet based? Haven't you got to have some kind of
24 expertise to help the people in the cell?
25 So you have somebody who analyses what kind of virus

1 it is and the routes of transmission, and then you pass
2 that to the specialist to say, "Right, how do you now
3 protect against an airborne virus or a droplet-based
4 virus that may be airborne as well?" Isn't that what
5 you need, that extra level of expertise?
6 **A.** So my understanding of what you have just described
7 there --
8 **LADY HALLETT:** Yes.
9 **A.** -- my Lady, is exactly what happened in the --
10 **LADY HALLETT:** Oh, right.
11 **A.** -- IPC cell is that there was a multidisciplinary input
12 not just from IPC specialists themselves but actually
13 from public health experts in health protection, from
14 ventilation experts and from others who all contributed
15 to the formulation of the guidance.
16 **LADY HALLETT:** Thank you.
17 **MS PRICE:** Could we have on screen, please, paragraph 145 of
18 Professor Smith's Module 3 statement.
19 In this paragraph you set out some considerations
20 for Covid-19 IPC guidance, and the first of these is
21 emerging evidence on transmission risks.
22 We spent some time earlier this morning on the
23 developing understanding of transmission routes, and
24 this follows on in some ways from her Ladyship's
25 questions to you just now. In circumstances where there

1 was some evidence of airborne transmission by July 2020,
2 should the IPC guidance not have proceeded on the basis
3 that there was a need to guard against the risk of
4 airborne transmission from that point?
5 **A.** I think when IPC guidance was formulated it was
6 formulated on the basis of the best evidence that we had
7 available to them, just now. I cannot comment what
8 evidence that they considered at that time because
9 I wasn't involved in any of the discussions, I'm afraid,
10 and whether they considered the possibility of airborne
11 and how they considered that.
12 I think the point that you make about the
13 possibility of airborne spread at that point in time
14 certainly was recognised that there were certain
15 procedures or points in time where that type of spread
16 was much more likely, and IPC guidance that was
17 formulated at that point in time tried to respond to
18 that.
19 **Q.** The second consideration for Covid-19 IPC guidance which
20 you list in this paragraph is international
21 recommendations regarding best practice for IPC, which
22 you say:
23 "... built on the established evidence base for IPC
24 practices derived from the WHO."
25 So are you saying here that there was reliance

1 placed on what the WHO was saying on IPC guidance
2 specifically?
3 **A.** So that was one of many sources that I understand that
4 the IPC practices were derived from, but I don't think
5 it was the sole source. My understanding from the
6 reading that I've done in this area and from the
7 conversations that I recall from that stage was that not
8 only were they taking advice from international
9 organisations like the WHO, European organisations like
10 ECDC in terms of transmission, but also that they were
11 looking at some of the UK -- the broader UK groups who
12 were reporting as well, and I think subsequently there
13 was a subgroup of SAGE which was set up which provided
14 advice into the cell as well.
15 **Q.** The last consideration on this page is:
16 "Ensuring that guidance is consistent with IPC
17 practice and easily understood by staff and
18 implementable in all ..."
19 Just going over -- oh, it is there:
20 "... and implementable in all health and care
21 settings ..."
22 By "implementable", are you referring to the
23 practical feasibility of implementing IPC measures?
24 **A.** Yes.
25 **Q.** To take the example of ventilation, I've already raised

1 with you the issue of the design of older hospitals and
2 that might be a factor. Might that be a factor which
3 was considered when deciding on ventilation IPC
4 measures, ie the feasibility of introducing ventilation
5 measures in an old hospital?
6 **A.** So I can't speculate whether that was one of the factors
7 that they considered or not but other factors, such as
8 the feasibility of being able to adopt any approach over
9 long periods of time, so, for instance, wearing
10 particular types of PPE over extended periods and how
11 people would respond to that, the feasibility of even
12 either availability or safe checking of the use of
13 certain types of PPE, all of these may have been things
14 which factored into that, but I have to say that some of
15 this is speculative because I wasn't involved in the
16 discussions.
17 **Q.** Taking an example, could we have on screen, please,
18 INQ000492302.
19 This is an email chain, and if we can just start
20 with page 1, please.
21 We can see this is an email chain from January 2020.
22 At this point in time, you were deputy chief medical
23 officer --
24 **A.** Yes.
25 **Q.** -- as opposed to Interim chief medical officer. Going,

1 please, towards the bottom of page 3, which gives the
2 context for the exchange on page 1. Right towards the
3 bottom there is an email from Jim McMenamin,
4 a consultant epidemiologist from Health Protection
5 Scotland to you on 22 January 2020. It's copied to
6 Dr Ritchie among others.
7 And going over the page, please -- well, further
8 down if we are scrolling, the third paragraph on this
9 page there is this:
10 "In our PHE led IMT discussion we have been
11 discussing the IPC support for general practice in the
12 event of a symptomatic returning traveller presenting to
13 general practice and then appearing in a consulting room
14 and only then being recognised as a suspect patient who
15 meets the clinical and epidemiological case definition."
16 Then if we can zoom out, the shared view of all four
17 administrations on how to manage the situation is set
18 out in those bullet points.
19 In short, to summarise, and bearing in mind that
20 this was at a very early stage in 2020 the management
21 was to involve the practitioner leaving the room,
22 closing the door and isolating the patient until an
23 ambulance could transfer the patient to hospital. Is
24 that a fair summary?
25 **A.** That's exactly what the chain says, yes.

1 **Q.** Then about halfway down the page there is identification
2 of the issue you were being asked for your view on,
3 which is:
4 "Reflecting the rurality challenge in Scotland we
5 have suggested that there is a risk that patients could
6 need to be isolated for many hours and thus there could
7 be clinical circumstances where a practitioner may feel
8 that they wish to attend their deteriorating patient.
9 In this circumstance we propose to offer a pragmatic
10 infection prevention and control advice which would use
11 gloves and aprons and surgical (fluid resistant) face
12 masks."
13 If we go back to page 3, please, of this document.
14 We can see your reply in the middle of the page there,
15 and you say:
16 "Thanks for this Jim -- I think you know that I'm
17 a pragmatist, and I can foresee situations where
18 clinicians will feel compelled to check on patients who
19 have been isolated if there are lengthy waits for SORT
20 ambulance. So being able to offer some protection here
21 is desirable.
22 "Can I first ask whether there are any other options
23 that have been considered? And if so on what grounds
24 were these discounted."
25 When you asked about other options, did you mean PPE

1 options other than fluid resistant surgical masks?
2 **A.** So I meant all options as in whether there were either
3 other ways of dealing with this in terms of protection
4 that could be provided or other options in managing the
5 patient, practical options in managing the patient in
6 those circumstances, remembering that this was
7 a contingency that was being thought through here.
8 **Q.** Your email is then directed to Dr Ritchie, who responds
9 the same day on page 1 of this document. She says this:
10 "Re your question about options considered:
11 "• The option for FFP3 respirators is not one that
12 can be easily and quickly implemented in general
13 practice nor effectively sustained -- specifically given
14 the need for fit testing."
15 To place this exchange in context, it is right,
16 isn't it, that Covid-19 had been designated as a high
17 consequence infectious disease earlier that month from
18 13 January? Would you agree that the consequence of
19 that was that respiratory protective equipment was
20 required for healthcare workers treating infected
21 patients?
22 **A.** So, in those circumstances, that would have been the --
23 very much the desirable approach to this, and the
24 context for this discussion is probably the most
25 important.

1 **Q.** I understand that the context for what you were being
2 asked for your view on is nuanced.
3 **A.** Yes.
4 **Q.** But that was the position in terms of the guidance at
5 the time --
6 **A.** Yes.
7 **Q.** -- or the requirement. What Dr Ritchie was saying in
8 this email was that FFP3 respirators, as an alternative
9 to fluid-resistant surgical masks, could not easily and
10 quickly be implemented in general practice, specifically
11 because of the need for fit testing.
12 It was in the context of GPs in Scotland in rural
13 areas and it was quite a specific situation.
14 After you enquired about other options, you were
15 told that this eventuality was discounted because it
16 couldn't be implemented. Is this an example of
17 a specific IPC issue on which there was not consensus
18 being escalated to DCMO level for a view for the correct
19 way to proceed?
20 **A.** So I think this is perhaps an example of -- again,
21 because of my links back to general practice of
22 understanding the nature of general practice, and where
23 general practitioners prior to the pandemic were
24 responsible for providing their own protective equipment
25 within the practice. So my knowledge of that enabled me

1 to -- well, really to know that many practices would
2 have very little or no protection, and certainly very
3 little knowledge of how to use some of the more advanced
4 types of protection such as FFP3 masks. Fit testing in
5 general practice is not something that has been
6 undertaken in the UK. And I suspect that in this
7 occasion this was something which they came to me
8 specifically for advice on because of my links back to
9 general practice.
10 **Q.** Is it also an example of an occasion on which the
11 difficulty of implementation as a consideration has
12 overridden the other Covid-19 IPC guidance
13 considerations which you identify in your statement?
14 **A.** So this is -- as I say, the context is really important
15 here, this is about contingency. This is about making
16 sure that some protection is better than no protection
17 and ensuring that at least there is something at this
18 stage which is being done to try to offer people
19 protection --
20 **Q.** I understand --
21 **A.** -- in very difficult circumstances.
22 **Q.** -- that in terms of the rationale. But just in terms of
23 the decision that's been made, it appears that the ideal
24 would be for them to have FFP3 respirators in the
25 context and in the moment in time that this is, and the

1 reason that that couldn't happen was because of the
2 impossibility of implementation. So am I right in
3 saying that this is an example of a time where the
4 impossibility or the practicability has overridden the
5 other considerations?
6 **A.** So just to be clear, the ideal situation is for these
7 patients not to be anywhere near general practice at
8 all. The ideal situation is to make sure that the full
9 HCID processes can be deployed when assessing a patient
10 within an environment that's appropriate for that level
11 of concern and a disease. This was a contingency in the
12 event that someone should literally pitch up in general
13 practice waiting to be seen and there may be a suspicion
14 that this could be Covid that was causing it. I'm not
15 aware that it ever happened at this stage of the
16 pandemic. But this is about ensuring that all
17 eventualities have been covered just to make sure.
18 **Q.** I appreciate this may be another example of the least
19 bad option, but the IPC decision has been made on the
20 basis that --
21 **A.** It's pragmatic.
22 **Q.** -- another option cannot be implemented, would you
23 agree?
24 **A.** In these circumstances, yes, I agree that's the case.
25 **Q.** Just going further up the page please. Your response

1 was:
2 "Thanks Lisa -- so I think we have a consensus and
3 I'm content to support the approach that's been
4 outlined."
5 So, in the circumstances, were you content that this
6 was the right decision?
7 **A.** I was content that it was the least bad option.
8 **Q.** That document can come down now, thank you.
9 As the evidence about Covid-19 transmission
10 developed, do you recall the difficulty of
11 implementation being a barrier to changes to the IPC
12 guidance when other considerations weighed in favour of
13 measures which might have afforded greater protection to
14 healthcare workers?
15 **A.** As the response progressed, particularly as we began to
16 develop greater knowledge of the virus and stronger
17 supply chains, I don't remember the implementation of
18 the guidance or I certainly was not aware that the
19 implementation of the guidance became a significant
20 problem. But that perhaps is best -- a question that is
21 best directed at some of the operational directors who
22 were responsible for implementing the guidance.
23 **Q.** I would like to ask you, please, about another Covid-19
24 IPC guidance consideration.
25 Could we have on screen, please, INQ000117069.

1 This is an email from Jill Vickerman, the Scottish
2 national director of the BMA. It is dated
3 29 April 2020. It is sent to the DGHSC but it is copied
4 to you. It attaches a letter to the BMA dated
5 28 April 2020. I don't intend to go to that letter in
6 the interests of time but I understand you've had
7 an opportunity to see that letter recently.
8 **A.** Yes.
9 **Q.** That document can come down now, thank you.
10 The letter stressed the need for risk assessment of
11 healthcare workers given their personal characteristics
12 might impact upon the risk they face at work. It raised
13 two points in relation to ethnicity. The first was the
14 disproportionate number of deaths among BAME healthcare
15 workers as well as the disproportionate number of BAME
16 patients admitted to ICU. The second was a result of
17 the BAME survey which found that almost double the
18 proportion of BAME doctors felt pressurised to work in
19 settings where aerosol-generating procedures were being
20 carried out with inadequate PPE.
21 Was the increased risk for ethnic minority
22 healthcare workers a consideration which was taken into
23 account when decisions were being made about
24 Covid-19 IPC guidance?
25 **A.** So the first part of your question I think would be

1 better directed at people who were involved in the
2 direct formulation of the guidance because they would be
3 able to give you an informed answer on that.
4 What I can say to you is that it was a consideration
5 as we received the guidance and interpreted the guidance
6 for use in Scotland. For instance, we were aware of
7 additional staff concerns in some areas. That
8 eventually led us to creating some additional
9 flexibility in what PPE was worn, particularly when
10 using AGP procedures in non-Covid areas.
11 So if we understand the hierarchy of controls
12 approach to IPC, that has a multilayered approach to how
13 you begin to reduce the risk associated with infection.
14 One of the -- you know, the last component of that is
15 actually the personal equipment that people wear in
16 relation to that, and there is many stages before that.
17 But in the non-Covid pathways that had been set up
18 in terms of the advice that was given for what PPE could
19 be worn, in Scotland we adopted an approach that tended
20 to strengthen that and give a little bit of flexibility.
21 It became particularly evident as concerns were raised
22 about what PPE should be worn in response to cardiac
23 arrest. And again, my view in terms of my input to that
24 area, and I know it was shared by other clinicians, was
25 that finding a pragmatic approach that allowed a greater

1 degree of local risk assessment and the deployment of
2 PPE for the circumstances was something which was
3 important.
4 **Q.** Others may be better placed to assist the Chair on the
5 detail of the work that was done on individual risk
6 assessments for healthcare workers in Scotland, but
7 having been made aware of the increased risk linked to
8 ethnicity as well, in that letter, as age, sex and
9 comorbidities by the BMA, did you ask for anything to be
10 done to ensure that Covid-19 IPC guidelines could be
11 adapted to account for the vulnerabilities of these
12 workers?
13 **A.** I recall raising it at one of the Quint meetings that we
14 referred to beforehand, as to whether this was something
15 which needed deeper exploration by IPC authorities
16 across the country.
17 I think there was an action from that meeting, if
18 I recall, that PHE would look at some of the detail of
19 that and then report back.
20 **Q.** I would like to turn, please, to the impact of a lack of
21 complete consensus when it came to Covid-19 IPC
22 guidance.
23 At paragraphs 146 and 147 of your statement, you
24 acknowledge that despite strong relationships between
25 relevant organisations across the UK, broad consistency

1 of approach across the four nations and collaboration
2 and co-operation of external stakeholders, there never
3 was complete consensus across all professional groups,
4 is that right?
5 **A.** Yes, that's correct.
6 **Q.** I would like to explore, please, the impact of this lack
7 of complete consensus.
8 Could we have on screen, please, INQ000478114.
9 This is the statement to the Inquiry of
10 Professor Colin MacKay, provided on behalf of the
11 Glasgow Royal Infirmary. At paragraph 127 here,
12 Professor MacKay says this:
13 "One of the issues which caused greatest staff
14 anxiety was the management of cardiopulmonary
15 resuscitation (CPR). In the event of cardiac arrest,
16 HPS guidance was to use RPE for endotracheal intubation
17 (as this was considered an AGP) but not for chest
18 compression. This would allow immediate resuscitation
19 to commence while full PPE was donned. This pragmatic
20 guidance caused anxiety for staff who felt all aspects
21 of CPR posed significant risk to staff and the situation
22 was further inflamed by Position Statements produced by
23 Royal Colleges and others, stating that chest
24 compressions were also aerosol generating. The
25 circulation of conflicting guidance by colleges and

1 other organisations proved unhelpful and caused
2 unnecessary anxiety for staff across the NHSGGC. The
3 leadership team were clear on the necessity to adhere to
4 statutory guidance rather than ad hoc
5 position statements from other organisations, however
6 well-meaning."
7 At the time, were you aware of the lack of consensus
8 on which aspects of CPR were classified as AGPs?
9 A. Yes, I was.
10 Q. Were you aware of the difficulty that this was causing
11 on the ground, at least, it appears, in this hospital?
12 A. Yes, very much so, and I was aware that there was a very
13 live discussion not only on the ground but actually with
14 many of our -- in the regular discussions we had with
15 the medical royal colleges, they expressed their
16 concerns over some of the conflicting advice in this
17 space as well.
18 Q. What was your view at the time on whether chest
19 compressions should be categorised as an AGP?
20 A. My view at that time was that I had no reason to dispute
21 the evidence or the approach that was being taken by the
22 IPC cell. They had considered it very carefully and the
23 evidence that they presented around -- about chest
24 compressions seemed reasonable.
25 Q. That document can come down now, thank you.

1 Is it right that on 20 May 2020 a joint statement
2 was issued by you, the Chief Nursing Officer and the
3 national clinical director dealing with PPE and
4 aerosol-generating procedures?
5 A. Yes.
6 Q. Could we have that statement on screen, please. It is
7 INQ000477445.
8 We can see there that joint statement heading.
9 Going to page 2 of this statement, the third
10 paragraph on this page says:
11 "Having reviewed the available evidence, NERVTAG
12 concluded that it does not consider that the evidence
13 supports chest compressions or defibrillation being
14 procedures that are associated with a significantly
15 increased risk of transmission of acute respiratory
16 infections."
17 It goes on:
18 "NERVTAG also states that whilst it is biologically
19 plausible that chest compressions could generate
20 an aerosol, this is only in the same way that
21 an exhalation breath would do. An expiration breath,
22 much like a cough, is not currently recognised as
23 a high-risk event or an AGP in addition, NERVTAG states
24 that defibrillation is not likely to cause any
25 significant breath exhalation. Based on this evidence

1 review and NERVTAG's findings, UK IPC guidance will not
2 add chest compressions of defibrillation to the list of
3 AGPs."
4 Underneath:
5 "However, we are an unprecedented times and it is
6 paramount that frontline healthcare professionals are
7 supported to find a pragmatic solution to ensure their
8 safety and that of their patients. NERVTAG recognises
9 that the evidence-base is extremely weak and heavily
10 confounded by an inability to separate out the specific
11 procedures performed as part of CPR, ie chest
12 compressions, defibrillation, manual ventilation and
13 incubation (airway management)."
14 "Therefore, CPR within a hospital setting should be
15 considered as a continuum which is likely to include an
16 AGP as part of airway management. In this case, the
17 precautionary principle should apply and the healthcare
18 professional should be supported by their organisation
19 to make a professional judgement about whether to apply
20 airborne precautions; which would include FFP3 face
21 mask, long-sleeved gown, gloves and eye/face protection.
22 NHS Boards must ensure that this PPE is available for
23 these frontline staff."
24 Can you explain, please, why you and your colleagues
25 took this position and issued this joint statement?

1 A. I think the key statement for me, particularly in that
2 last paragraph, is the idea that CPR within that
3 hospital setting is a continuum of activity. It's not
4 just about a team arriving and starting manual chest
5 compressions because within a hospital setting it's
6 inevitable that that will progress to other forms of
7 intervention as well. And, therefore, recognising that
8 that is a continuum right from the beginning it's
9 important and pragmatic to make sure that people feel
10 fully supported in how they approach this.
11 By writing this letter, myself and the other
12 clinicians involved, wanted, first of all, to show that
13 we understood that there was uncertainty in this area,
14 to recognise that. And, as we state in the letter to --
15 in this case to apply that precautionary principle given
16 that continuum and given local flexibility for teams to
17 be able to adopt the PPE that they felt was appropriate
18 in those circumstances.
19 Q. Was this statement well received by those on the ground,
20 as far as you're aware?
21 A. I am actually not aware. There was some feedback from
22 the medical royal colleges who we were grateful for this
23 clarification of the position. I don't know how it
24 landed on the ground.
25 Q. Professor MacKay in his statement that we've just looked

1 at makes no mention of this statement, in fact saying
2 that they were telling staff they must follow the IPC
3 guidance. What was done to ensure that NHS health
4 boards had got this message?
5 A. It was spoken about -- so, first of all, it was
6 communicated to the executive clinical directors within
7 each health board. It was communicated with the medical
8 royal colleges and updates to them. It was spoken about
9 at meetings with the executive clinical directors as
10 well. So these are all points in time when these
11 messages are able to be conveyed.
12 Q. Was this position that healthcare workers could decide
13 that they wished to wear PPE which protected against
14 airborne transmission in this context, so CPR,
15 maintained in Scotland or did it change?
16 A. It was maintained.
17 Q. That document can come down now, thank you.
18 Turning, please, to IPC measures for preventing
19 nosocomial spread to patients. The Inquiry has heard
20 that a Covid-19 nosocomial review group was set up in
21 Scotland meeting for the first time on 7 May 2020, is
22 that right?
23 A. I'm aware of the group but I was not a member of the
24 group.
25 Q. The evidence that the Inquiry has heard is that although

1 you were not a member of the group, the group reported
2 to you as it did the chief nursing officer, is that
3 right?
4 A. It is not, no. It reported through the chief nursing
5 officer but it also had -- what it did do was it
6 provided input to the advisory groups, the CMO advisory
7 group. But the group itself did not report to me.
8 Q. Does it follow that you did not attend the meetings of
9 that group?
10 A. I was not a member of that group.
11 Q. Were there any issues reported to you even indirectly by
12 the nosocomial review group which led to you providing
13 advice to Scottish ministers?
14 A. I don't recall any specific instances when that was the
15 case. That would have been unusual for me to provide
16 direct advice to Scottish ministers on any elements of
17 IPC as it lay out of the scope of my directive.
18 Q. Could we have on the screen, please, INQ000203933.
19 This is the UK CMO's technical report on the
20 Covid-19 pandemic in the UK.
21 Going to page 363, please.
22 I should say it is dated 1 December 2022.
23 The second paragraph down summarised the findings
24 following computational modelling done to assess the
25 effectiveness of IPC interventions in England during the

1 first wave of the pandemic.
2 That modelling identified that the most effective
3 interventions for the prevention of nosocomial Covid-19
4 infections in patients were decreasing occupancy,
5 increasing spacing between beds and testing patients on
6 admission.
7 The study referred to here was published we find
8 from the footnote in 2021. Were you aware of the
9 results of the modelling done in England during the
10 period relevant to this module, so 1 March 2020 to
11 28 June 2022?
12 A. So I wasn't aware of the specifics of the modelling but
13 some of the outputs from that modelling and I recall it
14 being discussed at meetings such as Quint.
15 Q. Was any equivalent modelling done in Scotland, as far as
16 you were aware?
17 A. I'm not aware. I wasn't involved in any modelling.
18 Q. That document can come down now, thank you.
19 It has been suggested by some that the focus of IPC
20 measures in healthcare settings was primarily on
21 healthcare workers, such as through testing healthcare
22 workers and universal masking, as opposed to means of
23 preventing spread between patients. Do you agree with
24 that?
25 A. I don't wholly agree with that because I recall being

1 involved or listening to discussions in relation to
2 hospital capacity and bed spacing in particular and how
3 important that was, concerns at times being raised about
4 the ability to be able to adequately space beds because
5 of volume of people and to maintain that over time.
6 As people began to look at various solutions for
7 increasing capacity, one of the very strong things which
8 I remember being pushed back was narrowing the bed
9 spacing between people for the very reason of the
10 responsibility of spread between people.
11 Q. You've mentioned ventilation a number of times this
12 morning. As the evidence about modes of Covid-19
13 transmission changed, did you ask for or receive any
14 advice or briefings from the UK IPC cell or any other
15 group about the impact of ventilation or access to clean
16 air?
17 A. I don't recall having any briefing from the IPC cell in
18 relation to that.
19 Q. How about ARHAI?
20 A. I wouldn't be able to answer that with confidence.
21 Q. Do you recall there being a discussion or any advice
22 from anyone on the impact of ventilation and access to
23 clean air on nosocomial infections specifically related
24 to patients?
25 A. Again, I couldn't answer that question with confidence.

1 I think it may have come up during advisory group
2 meetings but I couldn't say with confidence that that
3 was the case.
4 **Q.** So you think that -- sorry.
5 **A.** Could I qualify that by saying there was an awareness
6 that ventilation was an important issue in that respect.
7 **Q.** Given that you were aware that it was an important
8 issue, do you think that you should have asked for work
9 to be done on ventilation access to clean air in the
10 context of either nosocomial infections affecting
11 patients or affecting healthcare workers?
12 **A.** I think it's a reasonable activity to have undertaken,
13 to try to establish the effectiveness of ventilation,
14 particularly in areas where there were concerns about
15 the ventilation if those were arising. Again, I have to
16 say that I wasn't directly involved in these
17 conversations because I didn't oversee any of the
18 infection prevention and control procedures or policy.
19 **Q.** Do you think that ventilation and its role in the
20 prevention of nosocomial infections was given sufficient
21 attention in Scotland?
22 **A.** I remember it being a very, very live topic and one that
23 ministers in particular were very interested in.
24 I think it was given a great deal of attention and
25 I remember the chief nursing officer spending a great

1 deal of time in relation to it.
2 **MS PRICE:** My Lady, that brings me to the end of a topic.
3 Would that be a convenient moment?
4 **LADY HALLETT:** Certainly, I shall return at 1.45 pm.
5 **(12.45 pm)**
6 **(The short adjournment)**
7 **(1.45 pm)**
8 **LADY HALLETT:** Ms Price.
9 **MS PRICE:** Thank you, my Lady.
10 Professor Smith, I'd like to deal next please with
11 some specific PPE challenges and the response to those,
12 starting with the impact of supply constraints.
13 You refer in your statement at paragraph 167 to
14 there being widespread concern expressed informally and
15 formally that measures being recommended were
16 insufficient based in part on a concern that this was
17 being driven by supply constraints rather than science.
18 Dealing first, please, with what those supply
19 constraints were in Scotland. There were three related
20 submissions to the cabinet secretary for health and
21 sport on stock and supply issues with FFP3 masks and the
22 use of time expired FFP3 masks, and those submissions
23 are March 2020. Do you know the submissions I'm
24 referring to?
25 **A.** I do, yes.

1 **Q.** They were all copied to you. Have you had a chance to
2 review those recently?
3 **A.** I have, yes.
4 **Q.** Is that right?
5 **A.** That is right.
6 **Q.** Could we have on screen, please, the last of these
7 submissions dated 24 March 2020, please.
8 It is on the screen.
9 Go to page 2, please.
10 Is it right to summarise the background to this
11 submission in this way: the Scottish supply of FFP3
12 masks was "critical", and that was the word used in one
13 of the previous submissions; efforts had been made to
14 obtain more stock but this was proving difficult because
15 of international supply delays; ministers' approval had
16 been sought to preposition time expired stock of FFP3
17 masks following UK-wide stock validation testing, which
18 had been arranged by Public Health England; and that
19 approval had been given, is that a fair summary?
20 **A.** That's my recollection of those events at the time, yes.
21 **Q.** This submission sought ministerial approval to use the
22 time expired stock which had passed quality assurance
23 tests, is that right?
24 **A.** Again, that's my recollection.
25 **Q.** Paragraph 4 set out the position which had been reached:

1 "My submission of 21 March noted the fragile
2 position in relation to current FFP3 stock and in
3 relation to new supplies. National stockpiles now hold
4 only 16K, after distribution to Boards of 73K last week.
5 We have retained around 1.5 million FFP3 masks (made by
6 3M) which had recently gone out of date (after
7 previously shelf-life extension), from a total of
8 19 million held across the 4 nations. We are now moving
9 to a position where we need to consider using this
10 stock."
11 What steps did you take at this stage, if any, to
12 ascertain whether health boards were still experiencing
13 shortages in supply of FFP3 masks? There was
14 a reference in the earlier submission to reports of
15 a shortage in supply.
16 **A.** So, personally, I didn't take any steps because, again,
17 this lay -- this responsibility lay with a particular
18 team within Scottish Government, a particular
19 directorate and that had been formed looking at the
20 subject of PPE and the supply chains that were related
21 to that, and as one of the health and social care
22 directors we received reports back from that team during
23 the discussions that we had in relation to the position.
24 So I was certainly aware of the difficulties from that
25 perspective but this wasn't an area that I was

1 particularly involved in and active in at that stage.
2 Q. So you were being copied into this submission not
3 because it was your responsibility but to keep you
4 informed --
5 A. This was about information rather than anything else.
6 Q. Over the page, please, at paragraph 13. Deployment of
7 the stock:
8 "The priority is of course to secure deliveries of
9 new stock and to deploy that or other in-date stock to
10 any which is not technically in-date. However, it will
11 also be important to deploy the respirators in a way
12 that maximising they are usefulness. Therefore, it is
13 likely that we would wish to deploy them immediately,
14 and that they will continue to be issued concurrently
15 with any new stock which becomes available, in order to
16 reduce fit testing burdens on Boards and staff."
17 We then have fit testing dealt with at paragraph 14
18 below:
19 "If approved to release the 3M FFP3 stock,
20 additional assurance on safety in using these masks will
21 be provided through the use of the 'Portacount'
22 machines, used to fit test the masks to staff. These
23 machines are already being deployed across Boards.
24 These will be greatly speed up fit-testing, reduce
25 burdens on Boards and have been improving fit-test pass

1 rates to help ensure safe usages in practice. Such
2 results will help to improve staff confidence in their
3 own safety."
4 Is it right that approval was given for the time
5 expired stock to be released to health boards for use?
6 A. Again, that's my understanding.
7 Q. At this time, did you have any concerns about time
8 expired FFP3 stock?
9 A. Given that they had been through a quality assurance
10 process and passed by the health and safety equivalent,
11 no, I didn't have -- express any concerns.
12 Q. Were any concerns raised with you about this, at this
13 time?
14 A. No.
15 Q. Were the porter count machines provided to health boards
16 to assist with fit testing as had been planned, do you
17 know?
18 A. I wasn't aware of that information.
19 Q. Could we have on screen, please, INQ000478114.
20 This is Professor McKay's statement which we looked
21 at earlier provided on behalf of the Glasgow Royal
22 Infirmary.
23 Could we go to paragraph 124. That's already on
24 screen.
25 Professor McKay says this about the Glasgow Royal

1 Infirmary's experience:
2 "By the second week of March 2020, we had used the
3 bulk of our FFP3 supply to complete the fit-testing of
4 our staff. We then received a supply of FFP3 masks ...
5 from the national stock which proved difficult to fit --
6 the initial failure rate being 75%. Fit testing is
7 mask-specific, so the national stock being different to
8 that which we had originally tested our staff to meant
9 that the fit-testing exercise had to be repeated. This
10 was a surprise to us and proved time consuming.
11 A further batch of different FFP3 masks was delivered
12 ... which had [a] failure rate of 45%. These dated from
13 2012 and although they had been revalidated for clinical
14 use, there were concerns that the elastic had lost its
15 resilience there was evidence that some of the straps
16 snapped when donning these masks (these cannot be
17 tightened as fixed straps)."
18 Were you aware at the time that Glasgow Royal
19 Infirmary had these problems with fit testing and there
20 were concerns about the straps on time-expired stock?
21 A. No, I wasn't.
22 Q. Were you aware of wider concerns about time-expired
23 stock falling apart, the filtration device might work
24 but the parts holding an FFP3 together had denatured?
25 That was evidence that the Inquiry heard recently. Were

1 you aware of that at the time?
2 A. I'm afraid I wasn't, no.
3 Q. Did you or your team ever follow up on what the impact
4 of using time expired stock was on healthcare workers?
5 A. Again, that wouldn't have been the remit of my team to
6 follow that information up. That would have been the
7 specific team set up to deal with PPE. And I'm not
8 aware of any of my team being involved in any form.
9 Q. Had these concerns come to you in your role as CMO, or
10 deputy CMO, as you might have been at the time, do you
11 not think there might have been a responsibility to look
12 into the issues, given that they were experiences on the
13 ground of clinical practitioners?
14 A. So if these -- if these issues had been raised directly
15 with me and not through other sources, yes, then I would
16 have taken those issues to the responsible team to look
17 into further.
18 Q. I see. So you would have responded had they been raised
19 to you, but following up on the stock issue and the
20 experience would not have been your role, is that the
21 distinction you draw?
22 A. Yes.
23 Q. The last Covid-19 IPC guidance consideration you listed
24 at paragraph 145 of your Module 3 statement was the
25 impact of the guidance on workforce moral with the aim

1 being to support and reassure clinicians. Some insight
2 into the question of whether clinicians felt supported
3 and reassured was provided by the BMA PPE survey, the
4 results of which were available in April 2020.
5 Could we have a screen, please, INQ000117023.
6 This is an email from Jill Vickerman to you dated
7 7 April 2020.
8 I think that's the day after you took up the interim
9 CMO role, is that right?
10 A. It would be yes.
11 Q. She is flagging up the results of the UK-wide survey,
12 and it appears from this that a call was to be set up
13 with you to discuss the Scottish figures, is that right?
14 A. I have to say I don't recall any such call being set up
15 at that point in time. It may have happened but I've no
16 recollection of that period, the specifics of any call.
17 I know that there were certainly liaison with Jill and
18 other members of the BMA at that time and regular
19 meetings with other members of my team, myself or very
20 often with healthcare workforce who were often
21 responsible for the relationship with the BMA.
22 Q. Did you come to have an understanding of what the
23 Scottish figures specifically showed?
24 A. I am not aware of that understanding, no.
25 Q. Can you help with whether the Scottish figures broadly

1 reflect the UK-wide picture?
2 A. Not at this time, no.
3 Q. The email which was forwarded to you by Jill Vickerman
4 summarised the UK-wide results.
5 At the bottom of the first page is the result that:
6 "More than two thirds of doctors have told the
7 British Medical Association in a new survey that they do
8 not feel safely protected from Coronavirus infection
9 where they work."
10 Going to page 2 of the document. Paragraph 3:
11 "According to the survey, more than half of doctors
12 working in high-risk environments said there were either
13 shortages or no supply at all of adequate face masks,
14 while 65% said they did not have access to eye
15 protection. Alarmingly, 55% said they felt pressurised
16 to work in a high-risk area despite not having adequate
17 PPE."
18 The next paragraph records that:
19 "Almost 90% of GPs in contact with Covid patients
20 reported either shortages or no access at all to eye
21 protection, and 62% reported problems with supply of
22 facemasks. More than half of GPs who responded said
23 they felt they had had to buy their own facemasks or eye
24 protection, with only 2% saying they had felt fully
25 protected against the virus at work."

1 So this survey was suggesting that doctors felt that
2 they did not have access to the PPE which was being
3 recommended. Looking at the paragraph below we can see
4 here the survey shows the doctors are not being provided
5 with the appropriate protective equipment as specified
6 by the government's own guidelines. So this wasn't
7 a disagreement with the IPC guidance it was a -- there
8 wasn't enough PPE to comply with the guidance.
9 What did you do to address the concerns about PPE
10 which were being raised by the BMA on behalf of its
11 members in April 2020?
12 A. So at that point in time there was significant pressure
13 I remember on many of the supplies in relation to PPE,
14 and my recollection, and this is a recollection, again
15 I would emphasise that I wasn't directly involved in the
16 provision of PPE. So this is my recollection from
17 discussion in directors' meetings was that the PPE
18 directorate were establishing those supply lines and had
19 successfully been able to enable central supplies of PPE
20 within Scotland and retain those central supplies.
21 Some of the difficulties that we became aware of was
22 in the -- not in the central part of the supply chain
23 but actually at the very ends of the supply chain and
24 ensuring that within some of the units that were using
25 PPE, that there was problems actually getting them in

1 sufficient numbers to the people who were delivering the
2 care.
3 Subsequent to that, this was an area that after this
4 discussion our cabinet secretary at the time,
5 Jeanne Freeman, took quite a significant interest in and
6 set up a helpline that any worker who was concerned
7 about the supply of PPE -- availability, rather, of PPE
8 in the units that they worked, they could phone this
9 central number to express their concerns and so that
10 those could try to be addressed as quickly as possible.
11 I'm certainly not aware of any direct contact that I or
12 members of my team had in relation to that.
13 And I am aware, again through discussion in
14 particular forums and with the cabinet secretary at the
15 time, that the helpline appeared to be working well in
16 terms of being able to address some of the concerns.
17 Q. That document can come down now, thank you.
18 You have been directed by the Inquiry to a number of
19 paragraphs from Dr Barry Jones' statement to the Inquiry
20 as well as the statement of Ms Gillian Higgins. The
21 paragraphs to which you have been referred, refer to two
22 meetings which you are said to have attended with
23 Ms Higgins, the first being on 21 April 2020 and the
24 second being on 13 April 2022.
25 Do you recall meeting with Ms Higgins now?

1 A. I recall parts of the meetings in both cases. The first
2 meeting I rather more recall the general demeanour of
3 the meeting rather than the specifics.
4 Q. What was the general demeanour of the meeting?
5 A. Generally constructive, positive listening. It was
6 a meeting -- a chance really to listen to the concerns
7 that were expressed.
8 Q. Could we have on screen, please, paragraph 57 of
9 Ms Higgins' statement. It is page 16 of INQ000421873.
10 This paragraph is referring to the 21 April 2020
11 meeting, the first of the two and it says this:
12 "I also specifically recall that the CMO stated that
13 while protecting staff was important, the Government did
14 not wish to 'overreact' by implementing measures of
15 a higher standard than we needed and that couldn't be
16 sustained. My colleague contributed that he did not
17 agree that protecting the workforce, in particular
18 vulnerable members of our community with higher risk of
19 death from COVID-19, with evidence based solutions was
20 an 'overreaction'. I also reiterated that high quality
21 RPE is readily available, would be more cost-effective,
22 and would lead to less nosocomial infection, staff
23 illness and death."
24 Do you recall expressing this view or a similar one
25 at the meeting that the government did not wish to

1 "overreact" by implementing measures of a higher
2 standard than were needed that couldn't be sustained?
3 A. So I wouldn't be able to tell you the exact language
4 that I used, but I do remember speaking about the need
5 to make sure that the response was proportionate,
6 proportionate to the risk that had been identified
7 through the various groups that were examining this, and
8 that in responding in a way which was disproportionate
9 it might actually lead to more concern if those items
10 which were being specified were not sustainable, and the
11 really kind of difficult position of where an
12 over-specification had been made higher than was thought
13 to be necessary by the expert group but wasn't
14 sustainable and we would create unnecessary worry in the
15 minds of staff. Very difficult to retreat from
16 a position of higher specification to lower
17 specification, whether it was necessary or not, and
18 particularly if it was unnecessary -- thought -- felt
19 unnecessary by these groups. And that was certainly
20 a concern.
21 Q. That document can come down now, thank you.
22 Do you recall the potential for re-usable
23 respirators being discussed in the two meetings with
24 Ms Higgins?
25 A. I recall that perhaps more from the second meeting in

1 2022.
2 Q. Of which there are minutes, which I think you've seen?
3 A. I don't think those were minutes but those were --
4 Q. A note of the meeting.
5 A. A note of the meeting and perhaps involved a Teams chat
6 associated with the meeting.
7 Q. What do you recall from discussions about the potential
8 for reusable respirators?
9 A. So I remember the evidence that was presented at the
10 meeting and the discussion that followed, and I remember
11 it was quite a difficult meeting. I think it was at
12 a time when there were some very difficult conversations
13 which took place during the meeting, and one of my --
14 I guess one of my regrets of that meeting in particular
15 is that I probably didn't take my best self into that
16 meeting as well because of other stresses on the day.
17 That said, one of the things I was unhappy about
18 over the course of the meeting was what appeared to be
19 members who had come to speak advocating for
20 a particular company to be approached. It's something
21 that I find quite difficult in the role is that
22 commercial contacts I don't think are part of this role,
23 and I need to keep my independent advice. And
24 particularly in relation to this meeting, it felt as
25 though we had things the wrong way round, and rather

1 than specifying a level of product or approach, which we
2 all agreed was necessary, and then going out to an open
3 procurement process to identify who was best placed to
4 be able to supply that best value, what was being
5 advocated was a particular company who should be
6 approached in order to look at this, and that seemed to
7 me the wrong way round, and I was concerned where the
8 conversation was going.
9 Q. Did you have any involvement in decision-making in
10 relation to the use of re-usable respirators?
11 A. No, I didn't.
12 Q. Moving, please, to shielding and the highest risk list.
13 You explain at paragraph 203 of your Module 3 statement
14 that:
15 "The four UK CMOs jointly identified certain health
16 conditions which could, based on risk from respiratory
17 illnesses [like] flu, mean someone was potentially at
18 higher risk of negative outcomes it they contracted
19 Covid-19."
20 Is it right that there was no divergence across the
21 UK in respect of this identification?
22 A. At that point in time, yes, there was no divergence.
23 Perhaps the only slight divergence that there was,
24 wasn't in the six groups that was identified, but in
25 Scotland we also gave, I think, a greater degree of

1 flexibility at the outset for clinicians to identify
2 additional people that they thought was beneficial to
3 add to the list.
4 **Q.** And just in terms of the date of that, is it right that
5 it was 18 March 2020 that the agreement of the CMOs was
6 reached as to which groups should be on the list?
7 **A.** That would be consistent with my recollection of data
8 during that period. I remember that Dr Calderwood was
9 still CMO at that point in time, but I also remember
10 being involved in some of the conversations myself.
11 **Q.** Given that you were DCMO at the time, to what extent
12 were you involved in that agreement process of the UK
13 CMOs?
14 **A.** It was primarily -- primarily led by the four UK CMOs
15 but with input from DCMOs on specific items.
16 **Q.** And what was your view at the time on the approach and
17 the conclusions reached by the UK CMOs?
18 **A.** So in the absence of other evidence at that stage, it
19 acted as a good starting point from which we could begin
20 to build further information particularly, as I say, in
21 Scotland I felt it was important to have an additional
22 layer of flexibility for clinicians to identify people.
23 **Q.** Do you think that support for those shielding was
24 adequately built into the initial design of the
25 shielding programme?

1 **A.** I think this was an incredibly difficult thing for
2 anyone to even contemplate what was being asked of
3 people who were asked to shield, and, you know, when you
4 look back on that time and what people who eventually
5 went onto that shielded list were asked to do and asked
6 to sacrifice in particular, I think it's such a -- such
7 a difficult undertaking.
8 The supports that were built in round about it were
9 placed as best as they can to try to support people, but
10 I think inevitably for anyone who is essentially cutting
11 themselves off from society and is surrounded by fear
12 because we've said to them, "You're at a higher risk",
13 inevitably there's additional things that I think we
14 could have done. And I often wonder whether having some
15 sort of inbuilt mechanism for greater mental health
16 support during that period would have been of
17 an additional benefit for them.
18 **Q.** Do you think that would be of additional benefit if such
19 a situation were to arise in the future?
20 **A.** I sincerely hope that we never have to revisit
21 a situation like shielding, but certainly if there was
22 evidence that it was beneficial, then one of the things
23 I would certainly want to do would be to make sure that
24 we had a much greater degree of mental health support
25 for people who are put in that position.

1 **Q.** Do you recall discussions about the dividing line
2 between the clinically vulnerable and the clinically
3 extremely vulnerable?
4 **A.** I don't actually.
5 **Q.** Do you think you weren't involved in those discussions?
6 **A.** I'm not sure that I was involved in those particular
7 discussions, but I'm happy to say, from my view and my
8 perspective, is that I think that those were often
9 discussions which were really difficult to judge as to
10 where a line could or should be drawn, given the
11 evidence that was available, and it was very much about
12 using as much clinical judgment in that space.
13 I guess we should remember it wasn't just the four
14 UK CMOs that drew up these groups and that they in turn
15 received advice not just from the DCMOs who were
16 involved in some of the discussions but also from other
17 clinical groups as well during that time and that this
18 tried to create as judged consensus as possible as to
19 how to take this forward.
20 **Q.** What was your role as CMO in relation to communication
21 with those on the shielding later named Highest Risk
22 List in Scotland?
23 **A.** So, as CMO one of the things that the policy team who
24 was overseeing this part of the response was keen to do
25 was to establish, if you like, a trusted route of

1 communication to people who were shielding. That was
2 something that I was very happy to take part in. So
3 whether it be in terms of the numerous letters that we
4 used to try to communicate with this group or whether it
5 was in the daily briefings just trying to kind of target
6 specific information, I was quite happy to try to be
7 a part of that. And there was a feeling, and I think it
8 is a legitimate feeling, that that communication coming
9 from a senior clinician was better.
10 It also meant that before communications were
11 actually sent out to people, myself and my clinical team
12 could look over those communications and make sure that
13 they captured any clinical information that was
14 contained within them, or information about risk, as
15 fully and as articulately as possible to be understood
16 by the people that were going to be receiving them.
17 There was a lot of concern, particularly in the
18 initial stages, that some of the information which was
19 coming across our desks but I don't think actually made
20 it out to people was perhaps too full of jargon or
21 terminology that might not be fully understood. So
22 working with various groups and working with the
23 clinicians who were involved just to try to make these
24 as plain English as possible was something which I think
25 we tried to contribute.

1 **Q.** Was the question of whether the list should be extended
2 to a wider cohort within the clinically vulnerable
3 revisited by the CMOs?
4 **A.** It was revisited on several occasions, and both in CMO
5 meetings and at the Quint meetings that we referred to
6 this morning. There would be on occasion a proposal
7 which would come forward with data to consider whether
8 such a group could reasonably be asked to undertake
9 shielding as part of the response to try to keep them
10 safe.
11 There were very few groups where the data was so
12 compelling that we actually felt it was -- we should
13 expand the shielding list to include them, as I say,
14 given the scale of the undertaking. But there were --
15 nonetheless, there were -- I can think of two to three
16 groups where that decision was made at a later stage to
17 bring them onto that list.
18 The other thing that worked well for Scotland and
19 which gave us an additional degree of flexibility was in
20 that so-called group 7 that we had where if a clinician,
21 be they a consultant or a GP, felt that one of their
22 patients was at such sufficient risk to undertake
23 shielding there was a mechanism by which they could be
24 notified to the relevant central authorities to add them
25 to the list so that they could be provided with the

1 support necessary. And that was particularly something
2 which worked well with some neurological conditions such
3 as motor neurone disease and some other conditions as
4 well.
5 Even just the prospect of -- in Scotland we have
6 a significant issue with frailty and multi-morbidity,
7 and sometimes just the cumulative collection of diseases
8 that people gather over the years might have been
9 thought to put them at an additional risk that would
10 have allowed clinicians to add them to the list if they
11 felt it was necessary.
12 **Q.** Is it right that the original advice was to shield for
13 at least 12 weeks?
14 **A.** Yes, that's my recollection.
15 **Q.** This was to come to an end on 18 June 2020 --
16 **A.** Yes.
17 **Q.** -- but was extended to 31 July 2020, is that right?
18 **A.** Yes. Again, that's my recollection of events.
19 **Q.** You deal at paragraphs 208 to 209 of your Module 3
20 statement with the approach in Scotland to the phasing
21 out of strict shielding. Is it right that following
22 31 July 2020 there was no return to strict shielding,
23 albeit that guidance to those on the Highest Risk List
24 was amended in accordance with the level of risk in
25 Covid-19?

1 **A.** That is correct. The strict shielding that we asked
2 people to undertake in those early stages and which was
3 so onerous on them I don't think was ever revisited at
4 all. That doesn't mean to say there wasn't periods of
5 times where we asked them to consider additional
6 precautions, but there was an attempt to try to move
7 towards a more risk-based strategy where people were
8 able to -- or provided with sufficient information to be
9 able to try to manage their own risk, recognising that
10 you or I or anyone might have a different attitude to
11 risk or tolerance about what -- given what was important
12 to them.
13 **Q.** What was the rationale behind the shift in approach?
14 **A.** It was that recognition that shielding as a process had
15 the potential to cause harm, had the potential
16 particularly to cause isolation, and what we wanted to
17 do was to try to recognise that each person was
18 different, each person had a different attitude to risk,
19 if isolation was so difficult for them that it was
20 interfering with their health in other ways, to equip
21 them with the ability to be able to assess that risk for
22 themselves and take the approach which was most suited
23 to their risk tolerance.
24 **Q.** Can you help with the transition phase that there was
25 between 19 June and the end of July 2020 and its

1 purpose?
2 **A.** Yes, I remember the conversations relating to that
3 particularly around about the timing of when we could
4 cease the formal approach to shielding, particularly
5 because at that point in time wider society had already
6 begun to open up quite significantly and we were already
7 starting to see fluctuations and case profiles at that
8 time.
9 **Q.** I would like to deal, please, with additions to the
10 shielding list and in particular the addition of adults
11 with Down's syndrome and the addition to the list on
12 30 September 2020.
13 Have I got the date right there, as far as you're
14 aware?
15 **A.** It would certainly be consistent with my recollection,
16 a date around that time.
17 **Q.** It's right, isn't it, that this was a UK-wide decision
18 made collectively by the UK CMOs?
19 **A.** Yes.
20 **Q.** Could we have on screen, please, INQ000470017. This
21 letter is dated 30 October 2020. It is a standard
22 letter in your name which was to be sent to every adult
23 with Down's syndrome in Scotland. We can see that in
24 the first line of the letter.
25 Can you help with why it took a month between the

1 agreement of the UK CMOs that adults with Down's
2 syndrome should be added to the list and the letter to
3 adults with Down's syndrome in Scotland being drafted?
4 A. No, I wouldn't be able to give you an explanation for
5 that.
6 Q. I hesitate to say "sent" because it does appear to be
7 a pro forma letter. Can you help at all with the
8 timeframe of how soon after 30 October that was sent?
9 A. I'm afraid I wasn't involved directly in the sending of
10 these communications, other than to agree the content.
11 Q. Looking at the terms of the letter, and in particular:
12 "Firstly, this letter is not asking you to start
13 shielding, but we want to talk about why we are adding
14 you to the shielding list in Scotland."
15 That follows quickly upon:
16 "[I'm] writing ...
17 "1. To tell you that you have been added to the
18 shielding list in Scotland."
19 Do you think it was potentially confusing for
20 a recipient of this letter to be told that they were
21 being added to the shielding list but not being asked to
22 shield?
23 A. I think the terminology was difficult at that time,
24 because the terminology that was still in common usage
25 by the public was that of "shielding", and certainly

1 there was a desire to move away from that as a term and
2 to speak about people -- the clinical and most
3 vulnerable as a group.
4 With the benefit of hindsight, I would far rather
5 have had a letter that tried to explain things in
6 different terms there. I don't like the term
7 "shielding", I have to say now. I think it was used
8 perhaps out of necessity as the best description that
9 people had for what was being asked of -- at that time,
10 but given that we moved away from shielding as
11 an intervention so early in the pandemic, I think we
12 should have moved away from the terminology and almost
13 started afresh.
14 The terminology is different, of course, from the
15 identification of individuals who needed some level of
16 enhanced protection, whether that be about how we
17 started to sequence people in the vaccination programmes
18 or how we started to communicate people who might be at
19 additional risk at times of changing epidemiology.
20 I just think that by that stage the term "shielding" was
21 probably already out of date.
22 Q. That document can come down now thank you.
23 In terms of review of the impact of shielding, which
24 became the highest risk list, is it right that the
25 Scottish Government commissioned Public Health Scotland

1 to develop an evaluation framework for the shielding
2 programme in 2020?
3 A. That is correct, yeah.
4 Q. Did this work inform the change in approach in Scotland
5 away from strict shielding or did that happen later?
6 A. I think that -- if memory serves me correctly, and I am
7 not sure, I think most of the approach -- the change in
8 the approach to shielding was actually led by feedback
9 directly from people who were -- who had been asked to
10 shield. I think there were perhaps some preliminary
11 findings from that report by Public Health Scotland
12 which also informed the change in approach but
13 I couldn't say that with certainty to you.
14 Q. It appears from the documents that there was a deep dive
15 into the impact of shielding done by the Covid-19
16 advisory group, the Scottish group, and certainly you
17 may have seen in the documents some evidence of
18 feedback. Is that what you are referring to?
19 A. Yes.
20 Q. The Scottish Government shielding division produced
21 a report with the results of a January 2021 Covid-19
22 shielding survey in February 2021.
23 Could we have that on screen, please. It is
24 INQ000147410. Starting on page 32 please.
25 Under the heading "Gaps in support and access":

1 "Survey respondents were asked whether there was
2 anything they were struggling to access at the moment to
3 try to identify where more or additional support could
4 be provided."
5 "The majority were struggling with challenges that
6 are not easily addressed by government support ..."
7 And there are a number of things listed there:
8 "However, there are still people struggling with
9 access to healthcare appointments (23%) which has been
10 identified in previous research with this group.
11 "Many of the comments in the open text responses ...
12 were aligned with existing categories such as healthcare
13 appointments and exercise, but people wanted to provide
14 more specific information about the types of appointment
15 they were missing out on. A number of responses ...
16 highlighted challenges ..."
17 Which is after they returned to work, so unrelated
18 there.
19 What was done by you or your team to address the
20 difficulty that survey respondents were having accessing
21 healthcare appointments, and can you help with what the
22 main reason was for these access difficulties?
23 A. Again, I remember conversations which took place with
24 shielding division in relation to some of the findings
25 of this and with other parts of the health service as

1 well. And one of the common things that came through in
2 feedback was the sense of fear in particular that people
3 had in attending healthcare settings at that point in
4 time. That was something which we found in the general
5 population as a whole, particularly in those earlier
6 stages before people began to get vaccinated, but it
7 seemed to be more disproportionate and more evident in
8 people who had been asked to shield as a consequence of
9 that.
10 There were various ways that we could try to deal
11 with that, and one of the ways was to -- where it was
12 appropriate to do that, was to make a greater emphasis
13 on some of the digital platforms that we were now using
14 for healthcare consultations, such as NHS Near Me and
15 whether that would be a potential medium that could
16 be --
17 **LADY HALLETT:** Could you slow down, please.
18 **A.** Yes. Whether that could be a potential medium that
19 would enable people to access healthcare in a way that
20 they felt safer to do so.
21 It didn't fix every case because -- sometimes
22 because of the underlying nature of people's conditions
23 that these tended to be people with chronic illness.
24 Sometimes it meant that attending healthcare facilities
25 or having clinical staff come into their homes to see

1 them was necessary, and that was still a time of,
2 I remember, great apprehension from many of them.
3 **MS PRICE:** Setting aside the apprehension and the fear, it
4 sounds on the face of this survey as though there was
5 a difficulty -- a logistical difficulty in accessing
6 appointments. Did you see any evidence of that?
7 **A.** I can say that I wasn't involved in any conversations
8 that related to logistical difficulties, but those may
9 have taken place with other parts of government.
10 **Q.** As a final question on shielding, is there anything
11 about the shielding Highest Risk List programme in
12 Scotland that you would do differently with the benefit
13 of hindsight?
14 **A.** Shielding was a really horrible undertaking to have to
15 be asked to do I think. And isolation, I don't think
16 that any of us who were not in that shielding group can
17 really understand what the sense of isolation and fear
18 must have felt like. And people that I've spoken to,
19 that's the bit that comes across more than anything
20 else.
21 So is there anything I would have done differently?
22 I think it was always a question as to whether it was
23 absolutely the right thing to do. But even with the
24 benefit of hindsight, given the information that was
25 available at that point in time, it did seem like one

1 rational way of trying to protect people who were
2 recognised as being at additional risk.
3 The one bit I would change was -- was to ensure that
4 there was a greater degree of mental health support for
5 people who were undertaking the shielding and whether
6 additional supports could be made available just to
7 reduce that sense of isolation that people felt.
8 **Q.** I would like to move, please, to escalation of care
9 protocols.
10 Could we have on screen, please, INQ000485979,
11 page 26.
12 This is a statement provided by Caroline Lamb to the
13 Inquiry.
14 Paragraph 103 here deals with the ICU uplift short
15 life working group, which she says made recommendations
16 to you, the CMO and the COO and then the Cabinet
17 Secretary for Health and Sport, is that right?
18 **A.** Yes, I remember that that was a group which was very
19 active particularly in the early part of the pandemic.
20 **Q.** Of the group's work, Ms Lamb said this:
21 "The [cabinet secretary] took the final decision to
22 implement an additional 30 Level 3 intensive care beds
23 (for patients requiring highest levels of clinical
24 support) across Scotland on a permanent basis."
25 Is this referring to the permanent increase in ICU

1 capacity in Scotland which was decided upon?
2 **A.** So this is part-way through the pandemic when the
3 temporary increase -- the doubling of ICU capacity has
4 already taken place with the ability to be able to go up
5 to three times the previous limit. And what this group
6 had recommended was that there should be an additional
7 30 permanent beds even within that structure within
8 Scotland.
9 **Q.** The last sentence in this paragraph says this:
10 "The SLWG do not have decision making authority.
11 The SLWG was reconvened in November/December 2021 with a
12 reduced membership to make recommendations on changes to
13 the ICU surge escalation policy."
14 Can you help, please, with what the original ICU
15 surge escalation policy covered?
16 **A.** So the original surge escalation policy was -- examined
17 how the ICU beds and available equipment in Scotland
18 would be reconfigured to allow, first of all, doubling
19 of capacity within ICU with ability to be able to surge
20 further to a tripling of capacity, should it become
21 necessary.
22 As far as I can recollect, I don't think it ever
23 went beyond that doubling of the capacity, but
24 sufficient particularly ventilator equipment was either
25 purchased or repurposed in order that there was

1 sufficient ICU beds to double the capacity across
2 Scotland through that initial work.
3 That was a very rapid piece of work that, which was
4 led by, at that point, the chief operating officer with
5 strong input from the Scottish Intensive Care Society.
6 Some of my advisers in government also participating in
7 that and the Royal College of Anaesthetists.
8 The equipment was available to repurpose in
9 Scotland, particularly the ventilatory equipment,
10 particularly with the theatres being less used at that
11 point in time. One of the rate limiting steps was in
12 having sufficient trained staff, particularly trained
13 nursing staff, to be able to safely provide care to all
14 the available beds. That was looked at. People were
15 redeployed, retrained to try to augment that working
16 force.
17 I have to say that this was an area of clinical
18 practice where I have nothing but a huge amount of
19 respect for the huge variety of clinicians, because, you
20 must remember, it's not just doctors and nurses who
21 worked in these ICU units, but there was a whole variety
22 of inputs from various clinicians and the work they
23 undertook in often very difficult circumstances was
24 incredible.
25 Q. Was it any part of this group's role to look at

1 escalation in care protocols, and by that I mean, for
2 example, clinical prioritisation guidance or tools --
3 A. I'm not --
4 Q. -- or, is that escalation simply a reference to the
5 number of beds?
6 A. That surge is -- that escalation there is just about
7 number of beds which were available.
8 Q. So logistics rather than what to do if there aren't
9 enough beds?
10 A. Yes.
11 Q. I would like to ask you, please, about decisions which
12 were made at UK and Scottish level about whether to
13 issue guidance on escalation of care or clinical
14 prioritisation in the context of capacity challenges.
15 Could we have on screen, please, INQ000048276.
16 This is an email chain from March 2020.
17 Could we start, please, on the top of -- on page 7,
18 the email dated 27 March 2020.
19 This is between DHSC employees. It refers to work
20 which had been done on guidance on capacity challenges
21 in critical care.
22 And just scrolling down, please, the information
23 contained below, which is being forwarded in this email
24 by way of background, explains the issue:
25 "The four UK CMOs commissioned experts to develop

1 guidance for clinicians on clinical prioritisation for
2 Covid19. It has been led by [a number of people being
3 named].
4 "The guidance has been developed with engagement and
5 input from a number of stakeholders including the BMA,
6 GMC, National Voices, Royal Colleges and a Moral and
7 Ethical Advisory Group.
8 "It is intended to provide clinicians with a
9 decision-making protocol for use during the COVID-19
10 outbreak when ICU beds are in unprecedented demand.
11 "Although clinicians ordinarily make ethical
12 judgments as part of their work, this tool would
13 [bypass] usual processes and is intended for use when
14 judgements must be made quickly and possibly by more
15 junior clinicians.
16 "The protocol is based on a scorecard system which
17 takes into account age, co-morbidities and frailty to
18 determine the most appropriate clinical pathway for
19 an individual in the event that there are not ICU beds.
20 "It is intended to provide a fair, consistent,
21 ethical and compassionate framework for clinicians to
22 make decisions about critical care pathways."
23 Going up a page to page 6, please, there is an email
24 about halfway down the page sent the same day, again
25 between DHSC officials, and it says:

1 "Hi both
2 "I just spoke to [an official], who had just come
3 out of a meeting with the 4 CMOs and the guidance team.
4 They want to send the guidance and the graphics to
5 Ministers for clearance on Sunday afternoon ideally. So
6 we agreed it would be important to have the comms
7 handling sent up at the same time, as Minsters/CMO are
8 likely to have strong views on how this is
9 communicated."
10 Going to page 2, please, and the email dated
11 28 March 2020.
12 In the middle of the page:
13 "I've just heard from CMO's office that this isn't
14 going to ministers tomorrow and has been paused for
15 now."
16 Then underneath we can see some bullet points there:
17 "SoS and Simon Stevens have spoken and have
18 cancelled the Ministers implementation group tomorrow
19 (was due to be 11am and specifically to discuss the
20 clinical prioritisation tool).
21 "- This is because both are unhappy with issuing
22 this tool as it stands (noting how potentially
23 controversial it is/difficult landing)."
24 And, finally, going up to page 1, the email dated
25 30 March. This is from their private secretary and

1 deputy head of the office from the CMO England office:
2 "This is now paused indefinitely, possibly never to
3 be picked up again, now that there is less/no need for
4 it given early signs suggest demand may stay employee
5 capacity."
6 Taking this in stages, can you explain,
7 Professor Smith, what work the UK CMOs commissioned and
8 why?
9 **A.** I wasn't involved in that, so I'm afraid I can't explain
10 that. This pre-dated my time as CMO, and this didn't
11 involve my role as DCMO.
12 **Q.** You had no involvement when --
13 **A.** No.
14 **Q.** -- you were in your DCMO role?
15 **A.** No.
16 **Q.** Did you receive any handover from your predecessor about
17 this?
18 **A.** No.
19 **Q.** Were you aware this work had been done at all?
20 **A.** I was aware during March that there was some work which
21 was being looked at in relation to escalation policies,
22 but I'm afraid I wasn't in any way involved in it.
23 **Q.** Does it follow that you can't assist with who decided
24 that there would be no UK-wide guidance --
25 **A.** Yes.

1 **Q.** -- issued on clinical prioritisation?
2 **A.** I'm afraid I would be unable to offer you any insight
3 into that.
4 **Q.** That document can come down now, thank you.
5 Did you consider whether such guidance was
6 necessary?
7 **A.** I was aware that there was similar guidance which had
8 been put in place as a document in response to the
9 pandemic flu, written by NHS England in the early 2010s,
10 in relation to what steps may be necessary if a health
11 service became overwhelmed with cases of a pandemic flu.
12 At that point in time in the pandemic response, although
13 it was certainly becoming evident that there was going
14 to be quite significant pressures on healthcare
15 services, the agreed strategy, if you like, was to try
16 to expand the capacity of key points of the service
17 rather than look at these type of escalation policies.
18 **Q.** Did you give any consideration to issuing such guidance
19 in Scotland regardless of what the UK position was on
20 guidance?
21 **A.** No.
22 **Q.** The last email we looked at suggests that the decision
23 to shelve the draft guidance was ultimately made because
24 it was felt that capacity would not be reached after
25 all, would you agree with that reading of it?

1 **A.** Certainly the capacity with the ability at that stage in
2 the modelling we were receiving suggesting that there
3 was still sufficient capacity should we need to
4 increase, if you like, the next stage of surge planning,
5 which was to increase the capacity in ICU to three times
6 the original amount, that we still wouldn't reach that
7 capacity, I would not have said that there was a need to
8 address that through this type of guidance or policy,
9 whatever you want to call it, at that stage.
10 **Q.** Research conducted on behalf of the Inquiry for
11 Module 3, by way of a survey of 1,683 healthcare workers
12 in the UK is summarised in the report at INQ000499523.
13 Can we have that on screen, please.
14 Have you had an opportunity to look at this report?
15 **A.** I have, yes.
16 **Q.** If we could go to page 14, please.
17 It is reported here that for both the first and the
18 second waves of the Covid-19 pandemic, over half, 54%,
19 of respondents reported that some patients could not be
20 escalated to the next level of care due to lack of
21 resources.
22 We needn't go to it, unless you wish me to, but the
23 executive summary also records that A&E doctors, at 71%,
24 and paramedics, at 62%, were more likely to have been
25 unable to escalate care due to a lack of resources at

1 either wave.
2 Accepting that it's not possible to know what
3 proportion of the respondees were based in Scotland or
4 the relevant areas, do the results of this survey
5 surprise you?
6 **A.** In some sense they do. So particularly -- they don't
7 surprise me in terms of the overall capacity within
8 hospitals, which was running at a level which was really
9 quite -- the number of people who were in hospital was
10 really quite immense and exceeded capacity on several
11 occasions, with hospitals having to adopt novel
12 approaches to how they used other clinical areas to
13 effectively provide care in as well.
14 Where it surprises me is that, given that there was
15 the ability to be able to -- certainly in Scotland, and
16 I can only speak for Scotland in these circumstances --
17 to expand the capacity for care further, particularly
18 with ICU capacity, and the fact that we at no stage went
19 into that further expansion of capacity, it surprises me
20 slightly from that perspective that that was never
21 necessary.
22 **Q.** Were you told at any point in the relevant period for
23 Module 3 that resource-based escalation of care
24 decisions were being made in Scotland?
25 **A.** No.

1 **Q.** That document can come down now, thank you.
2 I'm helpfully being told could we have that document
3 back up, please. The bottom of page 8, please.
4 We can see that there are -- 138 of the respondees
5 were from Scotland, which is about 8%. Just to make
6 sure that we're being complete about it.
7 **A.** Yes.
8 **Q.** Had you become aware that healthcare workers were
9 finding themselves in the position of having to make
10 resource-based escalation of care decisions, would it
11 have changed your view or would it have informed your
12 view on whether there was a need to have a clinical
13 prioritisation tool or set of guidance?
14 **A.** So I think, first of all, I would have wanted to fully
15 understand exactly why people's perception was that they
16 were unable to escalate care and what resources were
17 limiting that fact, and if that was a resource which
18 could be rectified, which could be addressed either
19 through expanding into pre-planned surge capacity or by
20 additional equipment, my preference would certainly have
21 been to make sure that we were taking steps to do that.
22 If, however, it was an issue of overwhelming demand
23 that was meaning that people could not expand beyond the
24 existing capacity either through lack of equipment or
25 lack of space to expand into, then I think that leaves

1 very, very difficult decisions for clinicians. It's one
2 of the reasons that during the early part of the
3 pandemic in Scotland certainly we set up a network of
4 ethics committees within each of the health boards to
5 assist clinicians when they were faced with difficult
6 decisions about treatment for patients. Those ethics
7 committees provided support to clinicians in each of the
8 health boards, but there was also a central ethics
9 committee that they could refer back to if necessary or
10 mutual aid if an ethics committee in one area in
11 particular became overwhelmed by requests, and that
12 would have been a second stage, I think, prior to
13 adopting a formal escalation policy, because, you know,
14 let's be clear, by adopting an escalation policy we are
15 asking clinicians to make very, very difficult decisions
16 about who goes onwards for particular types of treatment
17 and who doesn't. Often that's clear-cut, that's the
18 role of clinicians to be able to do that, to be able to
19 take decisions based on the clinical evidence as to who
20 might benefit from a treatment or for whom unfortunately
21 we have to say a particular path of treatment is futile
22 and is the wrong approach.
23 But what we were asking -- potentially asking
24 patients to do -- if the service was becoming completely
25 overwhelmed in those circumstances really asking

1 clinicians to kind of pre-select and judge, even when
2 treatment may have some beneficial impact, who should go
3 forward for that as well. So that's not a place that
4 any clinician or anybody wants to be and, therefore,
5 I would see an escalation policy that started to outline
6 that type of approach as very much an approach of
7 there's nowhere else to go and nowhere else to explore
8 first.
9 **LADY HALLETT:** How should this information have got to you?
10 If this is how the healthcare workers felt, I appreciate
11 it wasn't by any means a perfect world, but, you know,
12 what would be the system for getting that information to
13 you or to people at your level?
14 **A.** I mean, it would usually rely on chains of
15 communication. So your particular areas were reporting
16 that there was a clinical governance issue. And I'm
17 going to use an example of, let's say, an acute medical
18 ward which finds that it's so overwhelmed with seriously
19 ill people that can't escalate out of there --
20 **LADY HALLETT:** Yes.
21 **A.** -- to ICU. So that would be a clinical governance
22 incident, if you like, which would -- at a local level,
23 using the local governance structures would be looking
24 to see what we could try to do about it.
25 **LADY HALLETT:** But there ought to be in place a chain of

1 communication that would then get the information --
2 **A.** And that relies on the regular dialogue that we have --
3 certainly from my position with medical directors around
4 the country, from a medical director's point of view
5 with the clinical directors that they have within the
6 hospitals and so forth, that relies on that chain of
7 communication being as strong as possible.
8 And there's also, it has to be said, that in
9 Scotland certainly, and I can, again, only speak for the
10 Scottish experience, there is the ability for people who
11 feel that their concerns are not being addressed or
12 listened to, specific whistle-blowing channels that
13 people can take to raise that information as well.
14 **MS PRICE:** Thank you, my Lady.
15 Any consideration that was given to whether there
16 should be guidance issued on this subject, would it have
17 been an important consideration to assess the impact
18 particularly of a scoring system on older people and
19 those with comorbidities or disabilities? And would
20 that have been -- that consideration have formed
21 a factor in the decision one way or the other?
22 **A.** It would have to have been. An important part of the
23 consideration is to look to see how this was impacting
24 in different groups. I think -- and I think that's the
25 basis of my point here is that what we're -- it

1 should -- should you enact a policy like that, you have
2 to be very, very clear about the ask that you're making
3 of people and how that impacts on individuals and their
4 families.
5 **Q.** Turning, please, to the use of DNACPRs, starting,
6 please, with the policy and guidance on this. Is it
7 right that there was in place before the pandemic a do
8 not attempt cardiopulmonary resuscitation policy dated
9 August 2016?
10 **A.** So there was a policy which related to DNACPR which
11 formed part of a wider process, which was about
12 anticipatory care planning.
13 **Q.** Could we have on screen, please, INQ000429278.
14 This is the policy which is dated August 2016.
15 Going to page 17 of the document, there is a section on
16 advance decisions about CPR decision, about CPR
17 treatment.
18 The paragraph underneath the heading says:
19 "Advance decisions about CPR can be difficult and
20 can cause considerable emotional distress but, when
21 discussed in the context of goals of care and choices
22 about available treatment options, they can also be
23 extremely reassuring and a huge relief for some
24 patients. There is evidence that patients experience
25 conversations about DNACPR as positive and empowering

1 when they happen within the context of wider discussion
2 about emergency care planning and end of life care goals
3 ... The appropriateness of CPR should always be
4 considered on an individual patient basis. There is
5 never a justification for blanket policies to be in
6 place."
7 And then it goes on to set out the two situations in
8 which an advance decision that CPR should not be
9 attempted can be made.
10 So it was clear from this guidance, wasn't it, that
11 DNACPRs should be always considered on an individual
12 basis, and there is never a justification for a blanket
13 policy, would you agree?
14 **A.** I agree very strongly with that.
15 **Q.** Could we have on screen, please, INQ000429276.
16 This is a letter from you to GP practices and chief
17 executives of NHS boards dated 10 April 2020.
18 The letter deals with anticipatory care plans for
19 vulnerable and high-risk patients which a DNACPR might
20 be part of but should not be equated with, is that
21 right?
22 **A.** And I think that's a very important point that you have
23 picked up on there as well: not to conflate the two
24 issues of anticipatory care planning and DNACPR.
25 Anticipatory care planning is a much wider approach

1 to how you express preferences of a patient in the way
2 that they receive their care. DNACPR may be a part of
3 that but does not have to be a part of that, and that's
4 an important aspect of this type of ACP planning.
5 **Q.** You refer in this letter to an earlier letter which was
6 sent to GPs and hospital clinicians addressing plans for
7 supporting patients identified as being at the high risk
8 of mortality and severe morbidity from Covid-19. That
9 earlier letter included the wording in bold towards the
10 bottom of the page which says:
11 "In addition for some patients in this group it may
12 be appropriate to discuss their Anticipatory Care Plan.
13 This discussion should be done by a clinician but again
14 it doesn't have to be a GP."
15 The letter goes on:
16 "In fact for many patients in the very high risk
17 group it would be more appropriate for them to have
18 their ACP conversation with their treating consultant,
19 who may be in a better position to discuss appropriate
20 treatment options based on the patient's individual
21 circumstances."
22 The reader was signposted to an ACP template. There
23 are some key points about ACPs set out in the letter.
24 Then at paragraph 4 over the page, please, there is
25 this:

1 "We recognise that DNACPR discussions are always
2 difficult ones to have, even more so when being done
3 over the telephone. It is recognised that CPR has
4 a very low chance of success when cardiopulminary arrest
5 is in the context of severe Covid illness. Therefore we
6 would like to reassure clinicians that there is no
7 specific requirement to have a DNACPR discussion as part
8 of this ACP conversation, unless the patient raises this
9 and wishes to discuss it, or the clinician feels
10 strongly that they need to discuss it. Instead the
11 focus should be on supportive discussions with patients
12 about what matters to them should they call ill with
13 Covid. The HIS ACP template provides a framework for
14 your discussions, with the option to complete the DNACPR
15 section, if this is discussed."
16 And then there's guidance about difficult
17 conversations attached to annex B.
18 The Inquiry understands that there was a statement
19 made on 7 April 2020, so just before this letter, by
20 a group of UK age sector organisations, including
21 Scottish Care and Age Scotland, and they raised concern
22 that blanket decisions appeared to be being made around
23 the care and treatment options available to older and
24 vulnerable people who had felt pressurised into signing
25 DNACPR forms.

1 Do you recall that statement being made?
2 A. I don't recall the particular statement you're referring
3 to actually. What I do recall, and just to expand on my
4 answer there just a little bit, I do recall we had
5 become aware from feedback from sources -- and I can't
6 remember what those sources were -- that there were some
7 concerns about the interpretation of how ACPs were being
8 conducted in some places.
9 Q. The reference we looked at on the first page of the
10 letter, the wording in bold from the previous letter,
11 was there a concern that that previous letter had been
12 interpreted wrongly as saying that DNACPR conversations
13 should be happening?
14 A. I don't recall any specific concern in relation to that
15 but, given the concerns that were being raised from
16 other sources, one of the things that I wanted to do was
17 to reinforce actually what the purpose of the letter
18 was, and that was to have good conversations with people
19 about their wishes for care and to be able to -- one of
20 the important aspects of the anticipatory care plan is
21 to be able to capture that in a way that is shared
22 across the healthcare system. It seems ludicrous in
23 this day and age that we don't have systems that talk to
24 each other across primary care into secondary care, and
25 so we rely on mechanisms such as this.

1 In Scotland we have this instrument we call the
2 electronic key information summary that acts as, if you
3 like, a portal and a conduit in sharing the most
4 important information about people's care from that
5 primary care setting into secondary care setting.
6 Q. Okay.
7 A. And this was really an attempt to make sure that we had
8 got this right and that people were concentrating on
9 information that was relevant and important to people
10 about their care, and not to be conflated with anything
11 else.
12 Q. At the time of writing this letter, were you aware there
13 were concerns of blanket policies --
14 A. Yes, I --
15 Q. -- and a lack of individualised assessment?
16 A. I would be -- I couldn't say for certain I would be
17 aware that there were -- this was being interpreted as
18 a blanket policy, but I was certainly aware by this
19 stage that there were concerns about the interpretation
20 of how some of these conversations would be conducted.
21 Q. What I want to understand is what this letter was aiming
22 to address. Was it aiming to address reports of
23 inappropriate use of DNACPRs?
24 A. Primarily it aimed to address the importance of getting
25 the right information at an ACP and please don't be

1 distracted about conversations around DNACPR, but if
2 you're going to have them, do them in the proper way.
3 Q. If there was a concern being raised about blanket
4 policy, something which is clearly not justified on the
5 face of the policy that was in place at the time,
6 wouldn't it have been better to have said that in terms
7 in this letter?
8 A. I don't think that -- I couldn't say to you whether we
9 had that information or not at the time that this letter
10 was written. I do recall being questioned by
11 a journalist about it at one of the lunchtime briefings
12 that I gave, but I couldn't say with certainty whether
13 that was before or after this letter was written.
14 Q. Did you see any evidence of a correlation between the
15 use of DNACPR notices and the availability of beds,
16 staff, ventilators or oxygen supply?
17 A. No.
18 Q. Could we have on screen, please, INQ000236625.
19 This is the statement of Jim Elder-Woodward on
20 behalf of Inclusion Scotland.
21 Going to page 11, paragraph 40, there is this:
22 "There is an absence of official data on the number
23 of DNACPR notices made during the pandemic. In England,
24 the Care Quality Commission was commissioned by the
25 Department of Health and Social Care to conduct

1 a special review of DNACPR decisions taken during the
2 Covid-19 pandemic. No equivalent investigation has
3 taken place in Scotland."
4 Do you agree with Mr Elder-Woodward's observations
5 about an absence of official data on the number of
6 DNACPR notices made during the pandemic?
7 A. I would agree, and I have to say that I've never seen
8 any data in relation to that.
9 Q. Is it right that there has been no review in Scotland of
10 DNACPR decisions taken during the pandemic?
11 A. You could certainly question as to why that there hasn't
12 been a review --
13 Q. Well, my question, first of all, is, is that right that
14 there hasn't been?
15 A. Yeah. I mean, I think it's -- it's a reasonable
16 question to ask, to which Scotland would not have
17 an answer.
18 Q. Okay. So you can't help with why there has been no
19 review?
20 A. No.
21 Q. Do you consider that such a review should take place?
22 A. If the data were available to be able to provide
23 an accurate review, then it would certainly add
24 additional learning into the practices that were
25 undertaking at that time. I would -- my own view would

1 be it would be more useful not to examine just the
2 DNACPR notices but also to examine the wider ACP
3 production at that time and to try to determine how
4 useful they had been in terms of the care that was
5 provided.
6 **Q.** I would like to turn, please, to stay-at-home messaging.
7 You refer at paragraphs 229 to 230 of your statement to
8 reports that during the stay at home messaging periods
9 there was anecdotal evidence that urgent suspicion of
10 cancer referrals was falling and that some data
11 suggested reduced presentations at emergency departments
12 for chest pain or myocardial infarctions. What did you
13 and your team do to address these concerns?
14 **A.** This became a concern that people either through
15 altruistic motives or through -- as I think I've said
16 before, through apprehension and fear of attending
17 healthcare facilities, they were simply avoiding them,
18 even at times when they were particularly ill. The data
19 suggested the presentations for chest pains and
20 myocardial infarction at emergency departments were
21 lower than we would have expected. I mean, given that
22 that illness is not suddenly going to change within a
23 population that that was a great concern. But also
24 urgent cancer referrals had dropped off really quite
25 significantly as well. And, again, there's no logical

1 explanation as to why that should happen.
2 So it suggested there was unmet need within the
3 population. So trying to address that was about
4 allaying fears about presenting, and trying to
5 discourage those particularly who had altruistic motives
6 to put those aside and to seek the help that they
7 required.
8 So through various communication channels,
9 mainstream media, through our lunchtime briefings,
10 through social media we tried to really raise the
11 message that -- certainly in Scotland the message was
12 not "protect the NHS" but actually if you've got
13 a problem that has serious and significant symptoms,
14 particularly if those symptoms are lasting, then you
15 should seek attention for it.
16 **Q.** Do you think the stay at home message got the balance of
17 risk right, that is the risk to people contracting
18 Covid-19 with the consequences of that risk and the risk
19 that people would take the message at face value and not
20 seek medical help if they needed it?
21 **A.** I think the stay at home message by itself probably got
22 the balance of risk right, I think where additional
23 messaging was layered on top of that. So I think k the
24 stay at home message had to be layered, nuanced and be
25 accompanied by, however, you know, if you need medical

1 attention you should continue to seek it.
2 There was perhaps messaging from other parts of the
3 UK at that point of time which was less useful in terms
4 of influencing people's way of approaching care.
5 **Q.** Coming, finally, please, to lessons learned and
6 recommendations. Looking back at both the things that
7 went well and the things that went less well in the
8 Scottish healthcare system response to the pandemic, are
9 there any key lessons learned or recommendations that
10 you would like to tell the Chair about that we haven't
11 already covered?
12 **A.** One of the things that I think was really evident in
13 terms of the response was just how flexible, agile and
14 committed the staff was over the whole course of the
15 pandemic. I think in retrospect we were too slow to
16 provide support for those staff, and that's something
17 which we could have looked at at a much earlier stage,
18 particularly psychological support, safe space for them
19 to debrief, in particular after what was quite harrowing
20 experiences for many of them, and that's something which
21 I would like to have seen more of.
22 I think that there's many lessons that we learned
23 along the way and that we adapted. I mean, the sheer --
24 the sheer scale of the response and the way that we were
25 able to deploy new ways of treating people so rapidly,

1 when you think the research in normal times takes
2 something so long to be applied consistently across
3 practice and yet sometimes within days people were
4 completely changing their approach to care, whether that
5 be through the use of greater use of anticoagulation or
6 through the greater use of proning, or introduction of
7 new agents such as dexamethasone. The speed at which
8 that was done was really quite incredible. And I think
9 if there's any learning from me, it's actually about how
10 you then replicate that in normal times to make sure the
11 breakthroughs, advances in therapy are consistently
12 replicated in that same way for the future.
13 And we innovated, we innovated, very, very quickly.
14 So platforms, again like I've mentioned, NHS Near Me and
15 the way that that was -- went from a fairly small-scale
16 project, nonetheless really useful, particularly for
17 patients in a rural environment, the digital platform
18 that was then used extensively right across Scotland,
19 and actually not only supported care at a difficult time
20 but perhaps even enhanced care because people were
21 suddenly able to attend with others, and perhaps were
22 enabled and supported to ask questions that they should
23 be asking about any aspect of their care. So NHS Near
24 Me, that type of innovation I think is something which
25 again we want to make sure that in the future we

1 don't(sic) embrace.
2 But the biggest risk for me just now in all of this
3 is that, given what we have done over the last
4 five years with the healthcare system, how we have
5 expanded, innovated, how we have valued it at times, is
6 that we lose sight of the fact that healthcare has to
7 continually evolve, and it's an expensive business, and
8 we must continue to make sure that we invest in our
9 healthcare system, our healthcare workers in a way that
10 allows us to keep pace with innovation and developments
11 that are necessary to make it a much more resilient and
12 sustainable service in the future.
13 **MS PRICE:** My Lady, those are my questions. Perhaps that is
14 an appropriate moment.
15 **LADY HALLETT:** It is, thank you very much.
16 We will come back at 3.20 pm for the last session
17 and I promise you we will finish today.
18 **(3.11 pm)**
19 **(A short break)**
20 **(3.25 pm)**
21 **LADY HALLETT:** Ms Mitchell, I think you are going first.
22 You have been asked questions by Ms Mitchell before,
23 Sir Gregor.
24 **Questions from MS MITCHELL KC**
25 **MS MITCHELL:** We have heard earlier in the evidence about

1 the complaints from healthcare professionals about lack
2 of PPE. I would like to ask you about the experience of
3 the Scottish Covid Bereaved, whom I represent, as
4 instructed by Aamer Anwar & Company.
5 We have heard that when visiting hospitals there was
6 insufficient PPE for them to use and on occasions they
7 were asked to use their own. Firstly, were you aware of
8 this difficulty?
9 **A.** I have to say to you that no, I was not aware of that
10 type of difficulty that people were experiencing.
11 **Q.** Earlier in your evidence you also spoke about chains of
12 communication and dialogues with clinical and medical
13 directors. Should you have been made aware of it?
14 **A.** It would probably have come up through a different route
15 if it was being escalated to Scottish Government, to be
16 honest. It would probably have come up to a route where
17 the responsibility for the provision of PPE and IPC lay
18 rather than through the channels of communication that
19 I had.
20 **MS MITCHELL:** But should you have been made aware of it?
21 **A.** I certainly would have liked to have been made aware of
22 it.
23 **MS MITCHELL:** And if you had been made aware of it, what
24 could you have done about it?
25 **A.** The most important thing that I could have done in that

1 circumstance would have been to engage both with
2 colleagues within Scottish Government but also with the
3 locations where people were experiencing particular
4 problems to make sure that adequate supplies were made
5 available to people.
6 **MS MITCHELL:** And just taking that point and moving on from
7 her Ladyship's questioning earlier, does that mean that
8 there is some lacuna or there should be some lacuna fix
9 to ensure that the CMO is getting decisions -- is
10 getting information from, as it were, the hospital floor
11 that you would be interested in? Is that something that
12 could be remedied in the next pandemic?
13 **A.** So in that specific example that you are giving, of
14 course I would have been interested in it. If you like,
15 the chain of governance that existed there would have
16 been through infection prevention and control policy
17 areas that have the levers as to try to address any
18 problems there are there. So that would -- as I say,
19 although I would have been interested in, that the Chief
20 Nursing Officer would have been probably equally if not
21 more interested in learning that there were issues with
22 that.
23 **MS MITCHELL:** Moving on in respect --
24 **LADY HALLETT:** Just before you do -- and it won't come out
25 of your time, Ms Mitchell, don't worry -- I'm just

1 getting the impression -- I mean, you are meant to be
2 advising the Scottish ministers, but because you have
3 all these different subgroups, specialised groups, there
4 are different chance of communication and it is not
5 coming to you. How can you advise Scottish ministers
6 properly on policy if this information isn't coming to
7 you?
8 **A.** I guess because I'm one of many advisers to Scottish
9 ministers, all with specific areas of remit around about
10 the advice that they provide. So the Chief Nursing
11 Officer, for instance, would provide specific advice to
12 Scottish ministers in relation to infection prevention
13 and control, and that usually wouldn't be an area that
14 the CMO would provide or be the prime focus of advice to
15 Scottish ministers.
16 **MS MITCHELL:** I'm obliged. When my lady looked at me
17 I actually thought she was meaning for me to move on!
18 **LADY HALLETT:** No, no, I was wondering if I could interrupt.
19 **MS MITCHELL:** That's why I didn't do that.
20 Moving then on to a further issue, again another
21 experience of the Scottish Covid Bereaved was that when
22 trying to visit loved ones, different health boards,
23 hospitals, wards even, took different decisions in
24 relation to visiting. The decisions weren't consistent,
25 including whether or not end-of-life visits would be

1 allowed. Were you aware of this inconsistent approach
2 being used?
3 A. I wasn't aware of the inconsistent approach but I was
4 very clear at all times that end-of-life visiting was
5 an incredibly important aspect of care that people were
6 able to provide and it was very important that people
7 could have time with loved ones at such an important
8 moment.
9 Again, I was -- it is possibly not correct to say
10 I wasn't completely unaware because there were one or
11 two instances I remember which were discussed and which
12 were then taken back to individual units or hospitals by
13 the person-centred team who looked after this to try to
14 make sure that they were adopting and interpreting the
15 policy correctly.
16 **MS MITCHELL:** Well, it is certainly the experience of the
17 Scottish Covid Bereaved that a number of people didn't
18 get to visit their loved ones before they died. And
19 these inconsistencies have caused much distress to the
20 members of Scottish Covid Bereaved, and no doubt others
21 not in the group, some of whom are finding out that
22 others were able to visit their loved ones, and they
23 blame themselves for not having, for example, pushed
24 hard enough or tried to escalate matters to get them to
25 be seen.

1 Ought a consistent approach to have been taken to
2 those visits and how can we ensure that happens in the
3 future?
4 A. The first thing to say is I'm very sorry to hear of that
5 experience that people had and I can only imagine the
6 impact that that has had on them not only at the time
7 but the enduring impact that it has had. And you are
8 absolutely right to say that there should have been
9 a much more consistent application of that approach
10 across the system.
11 **MS MITCHELL:** I wonder if I could now move on to DNACPRs.
12 We have heard -- one of my questions was, do you agree
13 that the blanket approach ought not to be used, and we
14 have heard in strong terms you say it shouldn't. Can
15 I check with you on that question, what do you actually
16 mean by "blanket approach"? What is it an approach of
17 or to?
18 A. What I will tell you should happen, rather than what
19 shouldn't happen, is that any discussion with any
20 person, or their family if the circumstances dictate
21 that, in relation to anticipatory care planning or
22 DNACPR should be individualised to that person. It
23 should be mindful of the circumstances which they find
24 themselves in.
25 And I really struggle to see how any approach to

1 proper anticipatory care planning or DNACPR can be
2 conducted if it is done in a blanket fashion, without
3 recognising the individuality and the preferences of
4 a person who is at the centre of it.
5 Q. Can I just check, do you mean a blanket approach in
6 relation to, for example, classes of people or a blanket
7 approach as in a one-time decision taken on DNACPR which
8 covers the future of that person's healthcare?
9 A. So I mean both, because one of the most important
10 aspects of anticipatory care planning -- and again I use
11 the broader term here, DNACPR being part of that -- is
12 the need to continually review that process that's been
13 done, to re-visit it. It is a dynamic process rather
14 than a once-and-done process.
15 Q. So you would agree that each decision should be taken
16 after consultation with the patient and, if possible,
17 their family?
18 A. Yes. And it should be revisited at an appropriate
19 timescale as well.
20 Q. Are you aware, as CMO, of any breaches of professional
21 codes of practice or ethical practice in Scotland in
22 relation to the use of DNACPRs?
23 A. I'm not aware of any of those breaches, and I've not
24 been made aware of any cases that have been taken by any
25 of the regulatory authorities against any clinicians in

1 relation to that.
2 Q. Again, I suppose following up on the first question,
3 should you be aware of or should someone be making you
4 aware of the answer to that question?
5 A. So, if those -- in Scotland we have a series of what we
6 call responsible officers, particularly -- and I can
7 only speak to the experience of medics here in the
8 system, doctors in the system, and the first point of
9 call should any of the regulatory authorities, in this
10 case the GMC, be taking action against any clinician
11 because of a breach of their professional
12 responsibilities, and in that case it would be to their
13 responsible officer on a health board level.
14 It wouldn't be escalated to the CMO unless there was
15 a suspension put in place for a particular practitioner
16 or -- I'm trying to think of any other circumstances
17 where it might be escalated to me in normal times.
18 Really it's only if someone was suspended or there was
19 such a pattern of an approach that the GMC felt it was
20 necessary to notify me over.
21 **MS MITCHELL:** I'm just over my time, so I'm obliged,
22 my Lady. Perhaps if there is such a review those
23 matters could be looked at.
24 **LADY HALLETT:** Thank you, Ms Mitchell. A special what in
25 place? You talked about:

1 "It wouldn't be escalated to the CMO unless there
2 was a ..."
3 Something or other.
4 "... in place ..."
5 And both I and the stenographer missed it.
6 **A.** Okay. So it wouldn't be escalated to me unless there
7 was a theme that emerged that was so important that the
8 GMC felt it had to be noted --
9 **LADY HALLETT:** A "special theme", was that the word?
10 **A.** Yes.
11 **LADY HALLETT:** Thank you.
12 Can I just go back, pursuing questions that
13 Ms Mitchell asked, to the point about revisiting
14 DNACPRs. You talked about them being time-limited. I
15 mean, I'm just a bit troubled by this idea that I might
16 go to see a GP on X day and agree care planning because
17 I'm feeling in a huge amount of pain and I'm feeling
18 pretty low, and I might say, you know, "I've had a good
19 life, that's it", but then I -- the pain might ease
20 a bit and -- I'm just a bit concerned about this idea
21 that I might say do not attempt to resuscitate me and it
22 gets transferred when my circumstances are changed.
23 So help me when it comes to when you talk about
24 "ought to be revisited within a certain time period",
25 what kind of circumstances are they?

1 **A.** So we have to be very clear about the circumstances, and
2 if we go back to the document that was shown by counsel
3 in terms of the guidance to the circumstances when the
4 DNACPR conversation might be appropriate for someone,
5 and generally that's when it's evident that actually the
6 process of CPR would ultimately be futile in terms of
7 achieving its aim of resuscitation someone whose heart
8 has stopped. Okay?
9 The circumstances that you're describing there for
10 me wouldn't warrant a DNACPR conversation. It would
11 warrant certainly an ACP to be formed about the
12 preferences for your care, but we're not in a situation
13 that you've described there whereby approaching CPR
14 would actually be kind of a futile response to your
15 circumstances.
16 **LADY HALLETT:** So basically every decision ought to be
17 a clinical decision. So whatever the patient has agreed
18 with the GP, when the patient gets to hospital it ought
19 to be a clinical decision by the hospital doctors, after
20 consultation with the patient and their family if
21 possible?
22 **A.** That should be the case in every aspect of care. Every
23 aspect of care should have an element of what we call
24 sheer decision-making in it.
25 **LADY HALLETT:** You can't have any transfer of agreement

1 to --
2 **A.** That is the purpose of ACPs, is to be able to express
3 within the ACP what certain preferences are so that that
4 can then be picked up by the hospital clinician, and it
5 act as a really good starting point with the
6 conversations with people about the care that they're
7 going to receive.
8 **LADY HALLETT:** But it was only a preference expressed at
9 that time which will still remain a clinical decision on
10 the day --
11 **A.** And shared decision-making must be the method by which
12 we are undertake that decision-making.
13 **LADY HALLETT:** Thank you.
14 Mr Dayle, where are you? There you are. Can you
15 see Mr Dayle over there?
16 **Questions from MR DAYLE**
17 **MR DAYLE:** I ask questions on behalf of the Covid-19
18 Airborne Transmission Alliance, or CATA, and I have
19 a few questions.
20 There was a step-down from FFP3 to FRSM which
21 occurred in mid-March 2020. CATA considers this to have
22 been driven by lack of resources, a shortage of FFP3s
23 for healthcare workers.
24 Do you agree that the moral and ethical position
25 should have been to inform healthcare workers of the

1 shortage and assure them that the appropriate protective
2 equipment would be provided as soon as possible?
3 **A.** I'm not aware that there was such a critical shortage
4 that they weren't available for the appropriate
5 circumstances that had been identified by the expert
6 groups who were examining this just now. So I'm not
7 sure I understand the whole nature of your question.
8 **Q.** Assuming that that proposition is a -- or CATA's
9 contention is factually accurate, would you agree that
10 it would have been the appropriate route to take, that
11 is to inform healthcare workers of the shortage and
12 assure them that the appropriate protective equipment
13 would be provided as soon as possible?
14 **A.** We appear to be talking about a hypothetical situation
15 here, and I guess my -- the point I would make in
16 response there is that communication and dialogue is
17 really important with people as to the reasons why any
18 particular route is being taken and, in the
19 circumstances, again I back to my point, is that the
20 level of PPE which had been identified by the expert
21 groups, that was identified on the basis of the evidence
22 that was available to them and wasn't dictated by supply
23 chains at that point.
24 **Q.** Very well. My next question, do you accept that
25 a significant number of healthcare workers might have

1 lost trust in organisations or institutions that are
2 supposed to keep them safe in terms of guidance and so
3 on?
4 A. I think that there was a very marked response from
5 clinicians at that point in time and as a result of
6 their experience, and many of them felt let down by the
7 organisations they were working for. I think that's
8 evident from the survey which we have already examined
9 earlier on today and some of the feedback which was
10 certainly evident through the BME membership.
11 The reasons for that I think are complex and deal
12 with a range of things from supply issues, which were
13 evident in some places, through the personal risk that
14 people thought that they were personally experiencing as
15 a result of them working in a very hostile environment,
16 I have to say, at times in terms of their busyness and
17 overloaded with various considerations as they tried to
18 kind of treat cases, but also just because of the
19 conflicting information, which was very evident at that
20 point in time, and I think that conflicting information,
21 some of which had unfortunately no basis, led to
22 a reduction in trust in people.
23 Q. Are you concerned that this loss of trust as it exists
24 might have implications for future pandemics when
25 healthcare workers weigh up the risks to themselves and

1 their families if they do go out to work?
2 A. I think there's lots of learning we need to take from
3 this last pandemic, and the purpose of this Inquiry is
4 to try to distill as much of that as possible so that we
5 can learn from it and implement that in the future.
6 I think much of that, as stated towards the end of my
7 own evidence, was about how we value our workforce and
8 how we support them to do the jobs that they want to do.
9 And it is becoming increasingly evident for many, many
10 reasons that the number of people choosing careers in
11 healthcare is falling.
12 Now, as I say, the reasons for that are very, very
13 complex, but there's never been a more important time to
14 make sure that our workforce does feel valued and is
15 given the proper equipment and capacity within the teams
16 to do the jobs that they come to work to do.
17 Q. This is a reflective question. Do you believe today
18 that the approach that was taken then was consistent
19 with the precautionary principle?
20 A. I believe that the approach that was taken at that point
21 in time was consistent with the precautionary principle
22 on the basis of the evidence that was available at that
23 time.
24 Q. In what you referred to as the second meeting with our
25 Dr Gillian Higgins in April 13, 2022, and this was in

1 her capacity as founder of Med Supply Drive UK, which is
2 a charity set up to address issues of appropriate RPE
3 for healthcare workers, during this meeting Dr Higgins
4 suggested a range of manufacturers and universities that
5 might help, and this is referenced just for the record
6 at paragraph 62 of her statement, and I should point
7 out, by the way, that she states there -- she declared
8 a complete absence of any commercial interest in the
9 potential sources of reusable respirators.
10 So healthcare workers, at the time of your meeting
11 in 2022, they were being permitted to request RPE. But
12 the meeting, it was clarified, the point of it was
13 really to allay anxieties and concerns about safety,
14 rather than an acceptance of the scientific evidence on
15 airborne route of transmission.
16 In light of the expert witness evidence provided to
17 the Inquiry to date, what is your understanding now of
18 the route of transmission of Covid-19? That is, do you
19 accept the airborne route of transmission of Covid-19?
20 A. So I think we've already gone over this in the evidence
21 that I've given today is that there are a variety of
22 ways that Covid is now known to transmit. Through
23 droplet, absolute short and through longer range
24 aerosol, all of these, there's a much greater degree of
25 evidence now for those routes of transmission than there

1 was. There's less evidence and less thought about the
2 kind of spread through fomite routes that were thought
3 to be more important in the early stages of the
4 pandemic. But it's my view and, as I've stated earlier
5 on today, I have held the view for a long time that
6 aerosol transmission has certainly played a role.
7 Q. And, finally, do you support a change in the current
8 guidance in the national IPC manual, given the evidence
9 the Inquiry has heard about airborne transmission?
10 A. I am confident that the IPC cell will continue to keep
11 all available evidence under review and based on that
12 evidence will make the best recommendations for what
13 protective equipment should be used and how IPC should
14 be approached.
15 MR DAYLE: Thank you.
16 LADY HALLETT: Thank you very much, Mr Dayle.
17 Mr Wagner.
18 **Questions from MR WAGNER**
19 MR WAGNER: Good afternoon, hello. My name is Adam Wagner
20 and I ask questions on behalf of the Clinically
21 Vulnerable Families.
22 I want to ask you, first, please, about the
23 recommendation in relation to face coverings for the
24 general public and the fact that FFP2 and FFP3 masks
25 were not specifically recommended.

1 I want to ask you about one subsection of the
2 public, which is hospital patients. Do you accept that
3 the risk of being infected with Covid-19 in hospital was
4 at times high?
5 A. The evidence would certainly suggest from nosocomial
6 data that there was -- there were points in time when
7 there was a high risk of infection within hospital.
8 Q. And do you accept the evidence from Professor Beggs --
9 if I refer to Professor Beggs, do you know of that
10 evidence that's been given to the Inquiry?
11 A. Could you expand on that?
12 Q. Professor Beggs has given evidence about the -- about
13 the routes of transmission, particularly for the
14 Inquiry, and also he's given some evidence as an expert
15 on FFP2 and FFP3 masks, and one of the things he says,
16 and I'll check whether you agree with this or not, is
17 that FFP2 and 3 masks offer good protection to the
18 wearers of the masks from inhaling infectious aerosols
19 as compared to surgical masks or face coverings that
20 don't?
21 A. So there is certainly evidence that FFP3 masks give the
22 wearer more protection against inhaling aerosols. That
23 also comes unfortunately with the downside of wearing
24 those masks as well, which is often overlooked, and
25 that's the length of time to which people can generally

1 wear them comfortably, and also some of the skin
2 problems that people suffer as well as a consequence.
3 But I think it's generally accepted that FFP3 masks give
4 more protection than the other masks, such as fluid
5 resistant surgical masks.
6 Q. Well, bearing those two points in mind, the high risk of
7 Covid-19 in hospitals at times and the fact that FFP3
8 masks give higher protection against aerosol
9 transmission, do you now think it would have made sense
10 to recommend FFP2 masks -- sorry, FFP3 masks for at
11 least some hospital patients?
12 A. That would have been something which could have been
13 risk assessed in local circumstances, but it would have
14 been an onerous undertaking. I think -- guess we should
15 remember that masks, the personal protect evidence
16 equipment, were only part of a range of protections
17 which were in place, each one layered on top of each
18 other which gave protection to both patients and staff
19 within hospitals, and the consistent application and
20 implementation of all measures of that -- under that
21 hierarchy of controls was certainly one of the most
22 important aspects in the kind of research findings as to
23 how you provided effective protection within hospitals.
24 So it may not have added a huge amount of additional
25 protection and could have added something at a cost to

1 the individual wearer, particularly if asked to wear
2 them for long periods of time within a hospital bed.
3 Q. But it may -- would you agree, it added some protection,
4 particularly for vulnerable patients?
5 A. It may or it may not. That's yet to be determined,
6 I think.
7 Q. What about in July 2020? And I just want to ask you,
8 you gave evidence earlier about clinically extremely
9 vulnerable people being given advice as to shielding,
10 and once the shielding programme was ending. Should
11 they have been advised about the potential benefits of
12 wearing higher-grade masks like FFP3 to help them more
13 safely return to the community?
14 A. My own view in this is that with the benefit of
15 hindsight, given the fear and apprehension that many
16 people experienced at that point in time, then it's
17 something that could certainly have been considered as
18 to whether the provision of those masks -- type of masks
19 would have given them greater confidence to re-establish
20 themselves in society.
21 Q. You say it could have been considered, should it have
22 been considered?
23 A. Again, we go back to whether it would have given, in the
24 real world, an additional amount of benefit which would
25 have actually protected the patient. Particularly with

1 those kind of higher grade of masks where fit testing is
2 necessary as well. Sometimes, if not worn properly, if
3 not applied properly, it can give a false level of
4 reassurance that actually could be detrimental.
5 Q. But that can be overstated, can't it, because it is
6 a 10/15-minute fit test and then it's done?
7 A. If people are able to apply it and use it consistently.
8 Q. I want to ask you about the Chief Medical Officer's
9 technical reports which you were shown earlier. It says
10 in the IPC section that feasibility of implementation
11 was one factor in choosing to recommend that the public
12 wear face coverings rather than particular masks.
13 Once the supply chain pressures eased for the higher
14 grade masks, do you think recommendations about mask
15 wearing should have changed for the general public?
16 A. My own personal view is no.
17 Q. Do you want to expand on that?
18 A. Again, I go back to the acceptability of -- for the
19 general public of particular approaches, and to mandate
20 particularly high levels of mask wearing for the general
21 public I think would have been -- the biggest risk with
22 that would have been to ensure that more people didn't
23 follow the guidance in relation to -- when you are
24 wearing particularly the highest grade of mask for
25 prolonged periods of time, it can be quite an unpleasant

1 experience, and I think there were points of time in the
2 pandemic where you could begin to see that even wearing
3 the lower grade masks was something which many members
4 of the public found difficult.
5 Q. What about the public guidance -- and I'm talking about
6 guidance not mandates here -- explaining relative
7 benefits of one kind of mask over another? Do you not
8 think that would have at least allowed people to make
9 their own decisions about whether, on the one hand,
10 there is the possible discomfort of wearing the mask,
11 the 15-minute fit test, and on the other there is
12 the risks to them, particularly for vulnerable people,
13 of getting Covid. Do you not think it would have been
14 better to have put that in the hands of the public
15 rather than just saying face coverings are fine?
16 A. At this stage, it is difficult to give you an answer to
17 that, I have to be honest, because it would have been
18 interesting to know to what level many members of the
19 public wanted to protect themselves. Many of these
20 masks were freely available to purchase and the FFP3
21 masks were more difficult to come by and, as I say, had
22 to be preceded by fit testing to make sure that they
23 were appropriately used as well.
24 I don't know where the public's mind lay in all of
25 this. It is something that could have been explored but

1 unfortunately it wasn't.
2 Q. I want to ask you about the implementation of the
3 shielding policy. I appreciate you explained before
4 that you weren't as involved in the earlier stages of
5 shielding as you were in the slightly later stages.
6 I think it is right to say that the UK chief medical
7 officers were tasked with identifying which people
8 should be classified as clinically extremely vulnerable
9 and therefore go on to the shielding lists.
10 Now, in England, there was then a division where
11 I think NHS Digital were tasked with tracking the people
12 down once the groups were identified as a cohort, and
13 they had some difficulties accessing that data and there
14 is a national audit report, for example, that says it
15 took three weeks from when a decision was made to expand
16 the shielding list initially to getting those names on
17 the list, getting the letters out.
18 Do you know whether any of those kinds of issues
19 were replicated in Scotland?
20 A. I recall that there was huge efforts made both within
21 the digital teams, who worked primarily in the
22 organisation, the NHS organisation, the NSS, but also
23 working with clinicians, particularly in general
24 practice, to make sure that the correct coding was in
25 place for patients who might need to shield. Without

1 that clinical coding in the digital electronic record,
2 it was very difficult to identify patients. And it has
3 to be said that in not all instances was that coding
4 leading to the identification of people who either
5 should be shielding or sometimes it led to the
6 identification of people who actually didn't require to
7 shield, although that was less -- seldom a problem.
8 The way we tried to overcome that in Scotland was to
9 give flexibility for clinical teams to add people to the
10 list themselves, if they felt that their patient was at
11 sufficient risk, but there was a period of time of
12 intense activity to make sure that data sharing
13 arrangements were in place to be able to identify them.
14 Q. Did you or your office give any advice when developing
15 and maintaining the shielding programme about how many
16 of the people who fell into the clinically extremely
17 vulnerable cohorts lived with other people and
18 particularly with other people who weren't shielding?
19 A. We didn't give specific advice, nor were we asked to
20 give specific advice in relation to that but it was
21 a consideration that I remember being discussed on many
22 occasions about the impacts not only in the clinically
23 extremely vulnerable people but also in their families
24 and family life as well.
25 Q. So when designing or amending the shielding programme,

1 did you consider and take into account the feasibility
2 and the real-world challenges of individuals who were
3 asked to shield who lived with other non-shielding
4 people, for example, with children who had to go to
5 school every day?
6 A. Those things were discussed frequently. I remember
7 conversations about the difficulties taking place.
8 Q. And was it ever considered whether the focus should be
9 changed or amended so that you weren't just advising the
10 shielding people but you were advising almost like
11 a separate cohort, the non-shielding individuals who
12 lived with them how to manage that dynamic?
13 A. It was -- if the question is, was it ever considered to
14 expand it to those who were living in the same household
15 as well, then, no, it wasn't considered in those terms,
16 but certainly there was consideration about actually
17 what advice could be given to support people living in
18 those households to live as easily as possible, given
19 the huge undertaking.
20 It was less of a problem at the beginning of the
21 process of shielding because of the national response on
22 all of us essentially being confined to our houses, but
23 it became more evident as the response went on and as
24 people started to enter society again, and at that point
25 we became aware of some apprehensions that existed

1 within households about actually family members going
2 back out into society and risking coming into contact
3 with Covid as well.
4 **MR WAGNER:** Thank you, those are my questions.
5 **LADY HALLETT:** Thank you very much Mr Wagner.
6 And, lastly, I think we have Ms Hannett.
7 By all means look at Ms Hannett when she asks the
8 question but she won't consider it a discourtesy if you
9 then turn to me to make sure your voice is in the
10 microphone.
11 **Questions from MS HANNETT KC**
12 **MS HANNETT:** Thank you, my Lady.
13 Professor Smith, I appear on behalf of the Long
14 Covid groups. I have a small number of questions for
15 you on the approach to Long Covid in Scotland.
16 Starting off that in your evidence this morning you
17 described Long Covid services in Scotland as being ad
18 hoc and as being dependent on the particular health
19 board. The experience of the members of the Long Covid
20 groups has meant this has been a profound difficulty for
21 some of them in accessing treatment. So, for example,
22 a healthcare worker member has found that in the absence
23 of specific Long Covid clinics in Scotland she was
24 unable to access the care she needed and had to pay for
25 the services required.

1 Similarly the expert report of Professor Brightling
2 and Dr Evans on Long Covid says that the small number of
3 boards that set up dedicated Long Covid services were
4 unable to meet the demand for them.
5 In the light of all of that, do you accept that the
6 variation in Long Covid services within Scotland meant
7 that very many patients had difficulty in accessing
8 suitable care?
9 **A.** Apologies for turning away from you as I answer --
10 **Q.** Not at all.
11 **A.** -- but, yes, I do accept that many patients do had
12 problems accessing the care that we would have wanted to
13 be able to provide them with Long Covid. And more than
14 that, I think that some of those problems are enduring
15 and they still need to be fully addressed with greater
16 long-term understanding of what services have the
17 biggest impact for people who suffer Long Covid and how
18 we can figure those in a way that they are easily
19 accessible at the right time to maintain people in
20 employment, and that we continue to learn and research
21 this area so that perhaps in the future there will be
22 different options for treatment as well.
23 **Q.** Thank you, Professor Smith. In your evidence this
24 morning you also said that you were not able to assist
25 the Inquiry with whether the Long Covid services had

1 improved after September 2021 as there is an absence of
2 data.
3 Are you able to assist the Inquiry as to why there
4 is an absence of data on the efficacy of Long Covid
5 services in Scotland?
6 **A.** I'm afraid I'm not, no.
7 **Q.** And, finally, third, what recommendation would you ask
8 the Inquiry to make now to ensure equitable access to
9 Long Covid healthcare to adults across the four nations
10 and in particular in Scotland?
11 **A.** One of the most important things that we can do when
12 considering Covid is the fact that across services in
13 the healthcare sector we've essentially absorbed
14 activity that's associated with a high volume infectious
15 disease, and that continues to be the case even to this
16 day, is that we will continue to see a high volume of
17 cases as a consequence of Covid with all the sequelae,
18 whether that would be Long Covid or whatever as
19 a consequence of that.
20 And we need to make sure that rather than just
21 expecting healthcare services to, forgive the term, but
22 consume their own smoke in terms of how they respond to
23 that, is that sufficient additional resources are made
24 available to make sure that we are able to provide the
25 care that clinicians want to provide to care in every

1 circumstance.
2 **MS HANNETT:** Thank you, Professor Smith.
3 Thank you, my Lady, that is all from me.
4 **LADY HALLETT:** Thank you very much. I think that completes
5 the questions now from the core participants.
6 Thank you very much for your help, Sir Gregor. I'm
7 sorry, as I said to your colleague yesterday, I can't
8 give you an undertaking I'm not going to impose upon you
9 again. We do understand the demands we make upon you
10 and your office when we do ask you to assist the
11 Inquiry, but I'm very grateful for your help in
12 preparing the statement obviously, and today I hope it
13 hasn't been too bad a day for you.
14 **A.** Thank you.
15 **LADY HALLETT:** Thank you. Tomorrow at 10 o'clock, please.
16 **(4.05 pm)**
17 **(The hearing adjourned until tomorrow at 10 o'clock)**
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