

Witness Name: Humza Yousaf

Statement No.: 5

Exhibits: HY5

Dated: 04 March 2025

UK COVID-19 INQUIRY
WITNESS STATEMENT OF HUMZA YOUSAF

In relation to the issues raised by the Rule 9 request dated 2 December 2024 in connection with Module 7, I, Humza Yousaf, will say as follows:

Background

1. I am Humza Yousaf of the Scottish Parliament, Edinburgh, EH99 1SP.
2. My current role is serving as the Member of the Scottish Parliament for the Glasgow Pollok constituency.
3. Between 28 March 2023 and 7 May 2024, I was the First Minister of Scotland. I was the Leader of the Scottish National Party between 27 March 2023 and 6 May 2024. Following my resignation from both of those positions, I am not currently serving in the Scottish Government.
4. I have previously assisted the UK Covid-19 Inquiry (“the Inquiry”). I have previously provided four written statements [INQ000273956, INQ000273973, INQ000480774 and INQ000474454]. I also appeared at the Inquiry on 25 January 2024 and 19 November 2024 to provide oral evidence. Therefore, while this Module 7 written statement is self-standing, the reader may also wish to refer to my earlier statements and evidence for further information.
5. I have been asked to provide a written statement in respect of Module 7 of the Inquiry in response to a Rule 9 Request dated 02 December 2024 (“the Rule 9 Request”). References to exhibits in this statement are in the form

[HY5/number - INQ000000]. The Inquiry requested that, in this response to the Rule 9 Request, I replicate certain content from my own previous witness statements. The Inquiry also advised that I can and should reproduce relevant content from organisational statements provided to it by the Scottish Government.

A. INTRODUCTION

Role and responsibilities

6. Between 19 May 2021 and 28 March 2023, I served as Cabinet Secretary for Health and Social Care. I held primary responsibility for the Health and Social care Directorates and NHS Scotland. This included Primary Care, Allied Healthcare services, health care and social integration, carers and adult care, child and maternal mental health and medical records.
7. I also had lead responsibility for a number of public bodies including NHS Scotland, the Care Inspectorate, the Mental Welfare Commission for Scotland, the Scottish Social Services Council and Sport Scotland.
8. Between 28 June 2018 and 19 May 2021, I served as Cabinet Secretary for Justice. I held primary responsibility for a broad portfolio which included policing, fire and rescue services, the justice system, courts and sentencing, youth justice and legal aid.
9. I also had lead responsibility for a number of public bodies, including the Scottish Police Authority, the Scottish Fire and Rescue Service, Scottish Courts and Tribunals Service ("SCTS"), the Scottish Social Services Council and the Scottish Prison Service ("SPS").
10. Prior to this I served as Minister for Transport and the Islands from 18 May 2016 to 28 June 2018 and my main portfolio responsibilities were public transport, energy, connectivity and cross government co-ordination on islands.

11. I served as Minister for Europe and International Development from 21 November 2014 to 18 May 2016 and my main portfolio responsibilities were international development, fair trade and cross government co-ordination on the European Union. I held similar responsibilities from 06 September 2012 to 21 November 2014 as Minister for External Affairs and International Development.

12. As Cabinet Secretary for Health and Social Care I had lead responsibility for the oversight of Test and Protect in Scotland. For the most part, the foundations of the Test and Protect system were well-established by my predecessor, Jeane Freeman, and the team working alongside her. It was my lead responsibility to ensure the system: continued to operate well; was able to cope with the surges in demand; and was able to respond, in a bespoke manner if required, to large scale events we hosted such as COP 26 & the European Championship 2020 Fanzone (“the Euros Fanzone”). It was also my responsibility eventually to oversee the phased withdrawal of routine testing when the UK Government decided, unilaterally, to end funding for universal testing.

Decision making structures

Decision-making structures within the Scottish Government in response to the Covid-19 pandemic

13. The role of Ministers, Cabinet, Civil Servants and Special advisors in the Scottish Government's decision-making process is set out in the Scottish Ministerial Code, 3 provided [HY5/001 - INQ000131054], as is the basis of ‘collective responsibility’ in Cabinet decision-making.

14. There was no divergence that I am aware of from the Scottish Ministerial Code, or the roles described therein, during the pandemic. Further information is provided in Annex A of the Code [HY5/001 – INQ000131054] which outlines the Scottish Government decisions terminology and hierarchy, and also in the Module 2 DG Strategy and External Affairs corporate statement, provided 23 June 2023, which explains the process of decision-making during the pandemic.

15. The primary decision-making structure for core decision-making in Scotland during the pandemic was Scottish Cabinet. If a decision was to be made urgently, Scottish Cabinet would be called to make this decision. On occasion during the pandemic, due to the large membership of Cabinet, a smaller group of core Cabinet members would meet to consider more rapid advice. For example, if there was an update domestically on the evolution of the virus or if there was information about a new and emerging variant. These meetings were informally referred to as 'Gold Command' and attendance would depend on the issue in question. The Scottish Government Resilience Room (SGORR) was also regularly convened to provide situational updates, and were attended by appropriate Cabinet Secretaries and Ministers, and where necessary decisions were also taken and recorded.
16. As Cabinet Secretary for Justice, between January 2020 and May 2021, I was asked by the then First Minister to take responsibility for travel restrictions and exemptions associated with the pandemic response, on top of my responsibilities as Justice Secretary. On that basis, I attended regular calls and meetings with the Four Nations Cabinet Secretaries for Transport. These meetings focused on travel restrictions and exemptions.
17. Later, as Cabinet Secretary for Health and Social Care, from May 2021 to April 2022, I attended regular calls and meetings with the Four Nations Cabinet Secretaries for Health. These meetings were held weekly, and if they could not be held weekly, they were held fortnightly. A timeline which details attendance at these meeting is provided: [HY5/002 - INQ000147475].
18. I regularly attended SGORR meetings, where the strategic direction for the Scottish Government's response to the pandemic would be set. My dates of attendance are listed below:

<i>2020</i>	<i>2021</i>	<i>2022</i>
<i>17 February</i>	<i>29 September</i>	<i>05 January</i>
<i>25 February</i>	<i>06 October</i>	<i>26 January</i>
<i>02 March</i>	<i>21 October</i>	
<i>09 March</i>	<i>27 October</i>	
<i>16 March</i>	<i>31 October</i>	
<i>19 March</i>	<i>10 November</i>	
<i>23 March</i>	<i>17 November</i>	
<i>06 April</i>	<i>10 December</i>	
<i>09 April</i>	<i>15 December</i>	
<i>31 July</i>	<i>22 December</i>	
<i>1 September</i>	<i>30 December</i>	
<i>21 December</i>		
<i>23 December</i>		

19. I did not attend any COBR(M) meetings during the pandemic as invitations to these were generally only extended to the First Minister or the Cabinet Secretary for Health and Sport, a position held by Ms. Freeman when these meetings occurred in 2020.

20. The overarching principle which guided core political and administrative decision-making within the Scottish Government during the pandemic was protecting as many lives as possible and reducing harm as much as possible. This is reflected in the Covid-19 - A Framework for Decision Making [HY5/003 – INQ000182846] which stipulated that Scottish Government decisions-making should be safe, lawful, evidence-based, fair and ethical, clear, realistic and collective.

21. As Cabinet Secretary for Justice, I was responsible for a broad portfolio as outlined above. During the pandemic I was provided with advice, information and evidence from a wide range of experts, stakeholders, and advisory groups to inform key decisions. For example, Justice Analytical Services collected data

from a range of partner organisations, such as Police Scotland, to inform Scottish government policy making and published regular statistical reports.

22. Another pertinent example is the Independent Advisory Group (IAG) on Police Use of Temporary Powers, established in April 2020 by the former Chief Constable, which reviewed Police Scotland's use of new temporary police powers to tackle coronavirus. The IAG reported directly to the Scottish Police Authority and their findings were used to reflect and inform the Scottish Government's policy approach to the enforcement of Non-Pharmaceutical Interventions (NPIs).
23. I was in regular contact with the former Chief Constable and from March 2020 our regular meetings were extended to a bi-weekly frequency. These allowed the Chief Constable to update me on areas such as public compliance to NPIs, personal protective equipment ("PPE") supply for Police Officers, assaults on Officers, feedback on the issuing of Fixed Penalty Notices (FPNs) and providing assurance on Police Scotland's approach to engaging with the public around NPIs.
24. Further information has been outlined in the DG Education and Justice (Justice) statement, provided to the Inquiry on 23 June 2023.
25. As Cabinet Secretary for Health and Social Care, I was responsible for the health and social care portfolio, including NHS Scotland, as described above. I was provided with advice, information and evidence from a myriad of clinical and scientific experts, Scottish and intergovernmental advisory groups and stakeholders. I received advice from DG HSC and HSC Directors and officials, including the CMO, CNO, NCD, and Chief Scientific Officer Health (CSO) who were amongst advisers who attended meetings where advice was required. Officials from across HSCD provided a breadth of Ministerial submissions and advice across a wide range of key areas.
26. In my roles as Cabinet Secretary for Justice and as Cabinet Secretary for Health and Social Care, I worked closely with the then First Minister, Nicola

Sturgeon, with respect to decision-making. Decision-making during the pandemic was novel in many regards and required consultation with the former First Minister, especially in the early stages of the pandemic.

27. I was engaged in regular communications with the former First Minister, with the frequency of interaction increasing after my appointment as Cabinet Secretary for Health and Social Care in May 2021.
28. Between January 2020 and April 2022, I had a close working relationship with the then Deputy First Minister, John Swinney. I communicated with him frequently throughout this period. We were both part of Scottish Cabinet and we communicated in Scottish Cabinet meetings. The former Deputy First Minister chaired a regular Covid-19 Public Services Ministerial Group (CPSMG) which comprised of a number of Cabinet Secretaries to discuss the impact of Covid-19 and work across various portfolios. I attended this group both as Cabinet Secretary for Justice and as Cabinet Secretary for Health and Social Care. The former Deputy First Minister and I were also members of SGORR and communicated at those meetings.
29. I would communicate with both the former First Minister and the former Deputy First Minister using video call and phone calls, especially during the early stages of the pandemic, when there were restrictions on meeting face to face. When we were back in Parliament and lockdown restrictions had eased, it would be very common to have a quick face-to-face meeting with the former First Minister or the former Deputy First Minister. My preferred method of communication with both of them was face-to-face.
30. I also used WhatsApp to discuss matters with the former First Minister and the former Deputy First Minister. If any decisions were made these were recorded using the appropriate channels through our respective private offices.
31. In my role as Cabinet Secretary for Health and Social Care I worked closely with Kevin Stewart and Maree Todd, the Ministers for Mental Wellbeing and Social Care and Public Health, Women's Health and Social Care in reaching

key political and administrative decisions about the way in which the pandemic was managed in Scotland between May 2021 to April 2022.

32. Kevin Stewart, Maree Todd and I were involved in a weekly call with Special Adviser Davie Hutchison. Our offices were next to each other, and we would meet regularly when Covid restrictions eased. Kevin Stewart and I also had a regular call with various Scottish Social Care stakeholder groups, especially relating to recovery from the pandemic. I also had a regular weekly meeting, usually on a Thursday, with NHS Chief Executives and Chairs, as well as local Government representatives. This meeting would include discussion on a range of Covid-19 related issues, including the vaccine programme, pressures within NHS Scotland and recovery. Kevin and Maree would attend this meeting on occasion.
33. I primarily communicated with Kevin Stewart and Maree Todd using telephone calls, video calls, face-to-face meetings and WhatsApp messages. My methods of communicating with them depended on the stage of the pandemic. In the stages of the pandemic, when lockdown restrictions were in place, we could not meet face-to-face. When it was permitted, my preferred method of communication was face-to-face. In my experience, key decisions were not routinely made over WhatsApp.
34. In my role as Cabinet Secretary for Justice, I worked closely with my special advisers, Justice Ministers, the former First Minister and the former Deputy First Minister. I also worked closely with the Cabinet Secretary for Transport at the time, Michael Matheson.
35. In my role as Cabinet Secretary for Health and Social Care, I worked closely with my Junior Ministers, Kevin Stewart and Maree Todd, the former First Minister, the former Deputy First Minister, the Chief Medical Officer (CMO), the National Clinical Director (NCD) and other special advisors. When it was permitted, my preferred method of communication with these individuals was face-to-face.

36. The group of key decision-makers within the Scottish Government had good and effective personal and working relationships during the pandemic. There was a good understanding of the pressure everyone in the Scottish Government was working under. Key decision makers trusted each other, and understood the significant pressures we were all under, but in particular the former First Minister, who had rightly in my view, chosen to front up the communication of our response to the pandemic on a daily basis. The Scottish Government also had a good working and personal relationship with its advisors during the pandemic. These good relationships allowed the Scottish Government to make decisions with significant speed. Cabinet Secretaries and Ministers were well empowered within their portfolios, which worked well.
37. In relation to how decision-making could have been improved during the pandemic, I believe there were times when a decision made by the former First Minister or discussed within Gold Command was not cascaded to the rest of Cabinet or all Ministers due to the fast nature of decision-making during the pandemic. We did our best to explain the rationale of decision making but the feedback from some groups, in particular the hospitality industry, was that the rules were changing too often, with decisions made before guidance was available. On reflection, there may have been instances where we could have worked with industry on guidance before making a final decision on restrictions. I believe this could have been improved. Although not always easy with the speed at which the virus spread, making last minute changes to guidance or the lifting of restrictions caused much anger and frustration at times. One such occasion was on 17th May 2021 when a last minute change was announced by the First Minister that Glasgow would remain in Level Two and therefore hospitality businesses could not serve alcohol indoors and would have to close their doors to indoor diners by 8pm. I do not doubt that the First Minister's decision was driven by the data, however, many in the business community did not feel like the rationale for imposing such a decision was fully explained.
38. In relation to advisory structures, my experience is that the advice was always ready and available when needed.

39. In relation to information sharing between the Scottish Government and the UK government, I believe there was, in the main, good working relationships during the pandemic. However, there were times when the Scottish Government was not informed about decisions made by the UK government before these decisions were reported in the press. In my role as Cabinet Secretary for Justice, I would often hear from the press about travel restrictions on certain countries before the UK government would inform the Scottish Government about these restrictions in Four Nations calls. It would have been helpful for the Scottish Government to have sight of these decisions prior to them being reported in the press. We raised this issue with the UK Government during the course of the pandemic, however, I am afraid the situation did not improve.

Informal decision-making and communication

40. Key decisions about the Scottish Government response to Covid-19 were made in formal meetings and recorded. In my experience, it was very rare for a decision to be made at informal meetings. I do not recall any key decision being made at an informal meeting without it being appropriately recorded by either an official, special adviser or member of our respective private offices. I would on occasion have discussions with the former First Minister or the former Deputy First Minister during an ad hoc meeting, and a member of our private offices would be present to note any decisions made. If any decisions were made, or follow-up actions were agreed then members of our private offices and relevant ministers would record these decisions using the appropriate channels. If a member of my private office was not present at an informal meeting, I would inform my private office about the subject and contents of the meeting shortly after the conclusion of the meeting, who would record the content in the appropriate format.
41. I used the WhatsApp messaging application primarily for discussion of information and advice relating to Covid-19. I also used WhatsApp with my Private Office primarily for logistical purposes. I did not use any other messaging platform to communicate about the Scottish Government response to Covid-19 between January 2020 and April 2022. In my experience, key

decisions were not routinely made over WhatsApp, where they were they would have to comply with the necessary record management policy. In terms of the extent to which mobile messaging was used by other key decision makers across the Scottish Government, I cannot comment but the Inquiry has been provided with a corporate statement from DG Corporate which specifically deals with the use of mobile messaging in Scottish Government during the pandemic.

42. I do not recall any meeting between core decision-makers, including the First Minister and counterparts in the UK Government between January 2020 and April 2022, to which I would have expected to have been invited in my role as Cabinet Secretary for Justice and then for Health and Social Care to which I was not party.
43. Prior to significant meetings, such as Cabinet meetings, I would generally be provided with an agenda, a briefing and/or meeting papers, but this would depend on the format and nature of the meeting in question. These meetings would be recorded by officials present and the record circulated and retained on our corporate systems. The records would give an overview of the topics discussed and conclusions reached.
44. Discussions and decision-making in relation to significant decisions relating to the Scottish Government were made in a formal setting, in that they were recorded, a minute produced, and for the most part with officials present. In that regard, I do not believe there is a list of informal meetings which were significant in terms of the matters discussed.
45. I have no record of being a member of a WhatsApp Group called "Health 4 Nations". However, I was a member of a WhatsApp Group named "Health Ministers Forum" which included Matt Hancock, who was the Group Administrator, Robin Swann the Northern Irish Minister for Health and Eluned Morgan the Welsh Government's Health Secretary. I left the group on 01/07/21 shortly after Matt Hancock resigned from Government. As I became the Cabinet Secretary for Health and Social Care in Scotland in May 2021, I was only in this

WhatsApp group for a few weeks. A further four nations WhatsApp Group was set up by Eluned Morgan, and included me, Sajid Javid and Robin Swann, it was titled "Health Ministers UK". These WhatsApp group were used for information sharing as opposed to decision-making. I found WhatsApp a useful messaging app whereby Health Secretaries across the 4 Nations could share data about the spread of the virus in their localities and emerging trends and data in a timeous fashion.

46. I was a member of a number of WhatsApp groups with Scottish Government officials, these were mainly used to share information and logistics, and were also used during Parliamentary debates, to share necessary information. I also used WhatsApp to communicate with fellow Cabinet Secretaries on a wide range of subjects, including our response to the pandemic. I also had one-to-one WhatsApp communications with Ministers in the UK Government, other Devolved Administrations, and with oppositions MSPs, these communications were mainly used to share information about Covid-19.
47. I am unable to answer for other Ministers, or Scottish Government Officials, however my expectation is that all Ministers and Officials should comply with the relevant record management guidance. Where I have such WhatsApp messages over this timeframe, they are on a phone handset I no longer use, however, I have been able to recover these messages, which will be passed over the Inquiry in full. I am not aware of any key communication relating to formal or informal meetings that have not been retained on document management systems, with the exception of any communication which is required to be deleted after a specified time as per Scottish Government guidance. [HY5/004 -INQ000222963].
48. Aside from the Scottish Government Records Management Plan [HY5/005 – INQ000131067], there was no specific training offered in relation to the use of mobile devices during the pandemic response. However, all the records retention guidance was available on the Scottish Government intranet site and there was no change in the expectation that this guidance and the IT Code of Conduct should be adhered to during the pandemic. More information on

mobile messaging use during pandemic has been provided in the DG Corporate (Mobile Messaging) corporate statement, provided to the Inquiry on 29 August 2023.

49. With regards to whether there are any identifiable gaps in the use of the Scottish Government's Electronic Document & Records Management System, this was outside of the roles I held with Scottish Government between January 2020 and April 2022. I believe officials are better suited to comment on any identifiable gaps as it would be part of their role to use the Scottish Government's Electronic Document & Records Management System.
50. I believe informal communications were helpful in sharing information, scheduling meetings, and coordinating diaries especially Four Nations and UK-wide meetings. Outside of the regularly scheduled Four Nations call with other Health Secretaries, it was difficult to find availability to meet with them, and informal communications assisted in this. I would note anything of significance from informal communication of this nature with my private office.

Co working

Working with the UK Government

51. The Scottish Parliament was established in 1998 via the Scotland Act 1998, as amended most extensively by the Scotland Acts 2012 and 2016. This allows the Scottish parliament to make primary legislation on devolved matters, such as health and education. The UK and devolved governments have agreed a Memorandum of Understanding on devolution and supplementary concordats that establishes arrangements for liaison and dispute management. A full explanation of the devolution settlement has been provided in the DG Strategy and External Affairs corporate statement, provided 23 June 2023.
52. I understand that the Cabinet Office Briefing Room (COBR) is the principal mechanism within the UK Government used to coordinate intergovernmental actions in response to a UK wide crisis, or where events abroad have a

significant impact in the UK. During the pandemic, Scottish Ministers were invited to attend COBR(M) (which were Ministerial as opposed to Official) meetings and these invites were generally extended to the former First Minister and the then Cabinet Secretary for Health and Sport.

53. During my roles as Cabinet Secretary for Justice and as Cabinet Secretary for Health and Social Care between January 2020 and April 2022, there was a clear understanding within the Scottish Government of our individual responsibilities for our respective portfolios. I believe this allocation within the Scottish Government was effective.
54. There was good coordination between myself and my UK counterparts in both roles during the specified time period. It is my view that these relationships worked well. In order to ensure proper coordination and communication on core decision-making amongst the Scottish Government and the UK Government, regular meetings took place between the Four Nations. I believe these regular meetings were helpful.
55. Between January 2020 and April 2022, in my roles as Cabinet Secretary for Justice and as Cabinet Secretary for Health and Social Care, I believe there was good communication between the Scottish Government and the UK Government for the most part. However, there were times during this period when this was not the case, and there was a lack of understanding within the Scottish Government about why certain decisions had been made by the UK Government. I can only speak about this in relation to the roles I held during this time period. I noted some frustration within the Scottish Government relating to public communication of decisions by the UK Government. In particular, I recall noting frustration within the Scottish Government in relation to not receiving communication about a decision made by the UK Government prior to its public announcement.
56. For example, if the UK Government had decided and announced, in relation to international travel restrictions, that a country was on the green list, the Scottish Government would often have to follow the decision made by the UK

Government, as international travellers could arrive in England and travel domestically to Scotland otherwise. This is also an example of decision-making by the UK Government which was driven by an England-only understanding of policy issues.

57. Another example of when I noted the Scottish Government did not understand the rationale for decisions made by the UK Government was just prior to the Christmas period of 2020. In mid-November the UK Government announced the decision to provide an amnesty to lockdown restrictions across the festive period across England. This would allow individuals to form new social 'bubbles' and travel to see family. There would be a focus on the period on each side of Christmas to drive down infection rates to mitigate the Christmas 'spike' in Covid-19 cases. At this point Scotland was still operating under a graduated levels system and the easing of restrictions in England would have cross-border consequences for Scotland in terms of virus transmission. This decision was contrary to advice which had been provided to the Scottish Government, and in my view, there was a lack of understanding within the Scottish Government as to why this decision had been made.
58. In relation to inter-governmental fora working during the pandemic, I believe the ones I directly interacted with worked well. For example, during my time as Cabinet Secretary for Health and Social Care, I believe the meetings between the Four Nations Cabinet Secretaries for Health worked well, in particular around the time of the rollout of the vaccine program, testing and surveillance. It was helpful to have knowledge of the situation, progress, emerging trends and case numbers across the Four Nations. In my role as Cabinet Secretary for Health and Social Care, I believe this was the most helpful forum for inter-governmental working.
59. The primary source of clinical information provided to me came from the CMO for Scotland, who was in regular contact with the 4 Nations' Chief Medical Officers. The information received from the Scientific Advisory Group for Emergencies (SAGE), the Joint Committee on Vaccination and Immunisation

(JCVI), Joint Biosecurity Centre (JBC) and the UK Health Security Agency (UKHSA) was useful as additional sources of information.

60. As well as the Four Nations meetings, I also attended the inter-governmental General Public Sector Ministerial Implementation Group (GPS MIG), which was one of four Ministerial Implementation Groups established by the UK to consider and oversee specific elements of the pandemic response. GPS MIG was chaired by the Chancellor of the Duchy of Lancaster (CDL) and was attended by the Deputy First Minister and other Scottish Government Ministers, depending on the agenda. I attended six of these meetings on the following dates:

- 31 March 2020;
- 03 April 2020;
- 04 May 2020;
- 05 May 2020;
- 12 May 2020; and
- 18 May 2020.

61. The topics discussed are outlined in the document provided: [HY5/006-INQ000131033]. As I do not believe it is relevant to me, I have no view on whether the Ministerial Implementation Groups (MIGs) should have remained in place after May 2020.

62. I also joined phone calls with the CDL, when required, although this was infrequent.

63. I believe the discussions in these inter-governmental meetings were helpful in informing the Scottish Government's core decision-making during the pandemic. There was a desire in the Scottish Government to have as much consistency as possible across the Four Nations. It was helpful to understand where and when there were differences across the Four Nations through these inter-governmental meetings, as well as remaining updated on issues of

criticality in areas where the UK Government retained the lead responsibility. For example, as the UK government was the one purchasing vaccines on behalf of all four nations, it was useful during these intergovernmental meetings to receive information on vaccine stock levels.

64. Intergovernmental advice was obtained and shared with decision makers through various channels. For example, reports and studies were produced directly from expert intergovernmental advisory groups, such as SAGE, and circulated accordingly to Scottish advisory groups, such as the Scottish Covid-19 Advisory Group (“C19AG”), who worked with Scottish Government officials to develop submissions and Cabinet papers for Ministers.
65. Cabinet meetings were the principal forum for strategic decision making and papers were circulated prior to the meetings to ensure that Ministers were provided with all the information required to make decisions on complex policy issues and that the interests of all relevant portfolios were reflected.
66. In my experience there wasn’t a risk of information overload or repetition for key decision-makers. I do not recall any practical difficulties that arose with multiple inter-governmental fora operating in parallel.
67. In June 2020, I was the Cabinet Secretary for Justice. My primary role in inter-governmental engagement was in relation to Four Nations meetings relating to travel. I would also have infrequent one-to-one discussions with the Secretary of State for Justice and also the Secretary of State for Transport. In addition, I would also have bilateral discussions with Cabinet Secretaries from the other Four Nations. Inter-governmental engagement generally worked well during this period.
68. I do not believe that the frequency of communication was the source of the challenge for inter-governmental engagement during this period. As mentioned before in this statement, it is my view that the challenges were related to the Scottish Government's lack of sight and understanding of the rationale behind decisions being made by the UK Government. I found it challenging that the UK

Government did not provide the Scottish Government information in sufficient time. This was frequently the case when making decisions around travel restrictions, that the Scottish Government was often provided information at the very last minute ahead of the meeting starting. At times, data was presented at a Four Nations meeting when decisions were required to be made. The Scottish Government would request data and information in advance of these decision-making Four Nations meetings, but this would frequently not be provided. My understanding is that these challenges were raised by the then First Minister and the then Deputy First Minister with their UK Government counterparts.

69. On occasion the UK Government took decisions which indirectly affected Scotland or raised cross-border issues without consulting the Scottish Government. I have mentioned previously in this statement about decisions the UK government made in relation to international travel restrictions and red and green list countries. Through my discussions with fellow Cabinet Secretaries, I believe that they also found themselves in a similar position on occasion.
70. Another example relates to rules around face coverings on public transport, which created cross-border issues. As restrictions eased in Summer 2021, the use of face coverings remained mandatory on public transport in Scotland while they were not mandatory in other parts of the UK. The Scottish Government had to quickly initiate a high-profile campaign to remind visitors to Scotland that a face covering was required after the border into Scotland had been crossed. I believe that I would have raised concerns about this with the UK Government in my role as Cabinet Secretary for Health and Social Care.
71. In respect Test and Protect, the decision by the UK Government to end universal testing on 01 April 2022 was made unilaterally by the UK Government and without consultation with the Scottish Government, or indeed any other Devolved Nations. This was an example of where intergovernmental working clearly failed, as we had no prior notice to the decision made – a decision that, while it was the UK Government's to make, would very clearly impact on Devolved Nations' testing regimes.

72. In my experience as Cabinet Secretary for Justice and as Cabinet Secretary for Health and Social Care between January 2020 and April 2022, I cannot recall a time when I did not receive an invite or agenda in time from the UK Government, though as previously mentioned, meeting papers were sometimes circulated at the last minute. It did appear at times during the pandemic that Devolved Administrations were not considered to be a priority by the UK Government, particularly in cases when the Devolved Administrations were not directly impacted but were indirectly impacted. While I am sympathetic in terms of the pace at which all governments were working during the pandemic, more could have been done to ensure that the Scottish Government and other Devolved Administrations received invites, agendas and papers in time.
73. My general experience is that there is not as good an understanding of the devolution settlement within the UK Government as there should be, especially at ministerial level. My experience is also that often UK civil servants have a better understanding of the devolution settlement than UK Government ministers.
74. International travel restrictions are example which illustrates how a lack of devolution capabilities hindered engagement between the UK government and the Scottish Government. For instance, I would be advised that I could make a different decision in relation to international travel restrictions for Scotland when this was not practically the case, considering that international travellers could fly into England first and then travel domestically to Scotland.
75. I cannot comment on whether there was any collective decision by ministers in the UK Government and the Devolved Administrations to coordinate the timing and content of public announcements as I was not part of these discussions. If an agreement existed, I believe the former First Minister would have followed any agreement on public announcements. At the beginning of the pandemic there was occasions where press briefing appeared indicating the UK Government was frustrated by the fact the Scottish Government was making announcement ahead of them.

76. With respect to when the Scottish Government adhered to a Four Nations approach to the management of the pandemic and when it did not, I can only speak for my experience through the roles I held between January 2020 and April 2022. In the early stages of the pandemic, as Cabinet Secretary for Justice, I believe there was an understanding that there should be coordination between the Four Nations, even though each required flexibility over its jurisdiction. In this early stage, there was an attempt to align the approach where we could and where appropriate and, while we were conscious of the geographic and demographic differences between Scotland and the rest of the UK, this alignment was in line with the advice at the time.
77. As understanding and information about the impact of Covid-19 and how to navigate it evolved, each of the Four Nations became more confident in navigating the differences of managing the pandemic. I am not aware that the Scottish Government at any point consciously planned to stop adopting a Four Nations approach. Decisions in the Scottish Government were made on an issue-by-issue basis.
78. The Scottish Government was continuously aware of the risks of potential divergence of approach with the UK Government in the management of the pandemic. For example, I recall the Scottish Government considering the risks to public health if rules were more relaxed in England and stricter in Scotland. I also recall the Scottish Government considering the risk to businesses operating cross-border in the case that restrictions were more relaxed in England. The Scottish Government took the view that communication was key in order to mitigate these risks. The First Minister provided a daily briefing to enable communication with the public. I believe the daily briefing was very effective.
79. In a Cabinet meeting on 10 May 2020, the then First Minister updated Ministers in relation to the UK's intention to ease lockdown and change messaging in a way that diverged from the more cautious approach taken by the Scottish Government. The Scottish Government maintained the more cautious approach

as the reproduction rate of the virus was still too high to justify any significant easing and scientific advice did not support easing at this point. It was therefore very important that public messaging continued to be clear and consistent in this regard. As for the working relationship between the Scottish Government and UK Government, I can only speak as to the roles I occupied during the course of the pandemic. In that regard, the former First Minister's public criticism of the UK Government's approach did not affect my relationship with UK Government counterparts.

80. As Cabinet Secretary for Justice, I had direct and regular contact with the Cabinet Secretaries for Transport for the Four Nations and spoke to them on regular Four Nations calls. I also had direct contact with the UK Government Secretary of State for Transport, Grant Shapps.
81. As Cabinet Secretary for Health and Social Care, I had direct and regular contact with the Cabinet Secretaries of Health across the Four Nations. These interactions were effective and useful in providing information across the Four Nations. The nature of the personal and working relationships with these individuals was good. Everyone approached these interactions with openness and professionalism, putting aside political differences to engage in the necessary discussions. I do not recall any personal relationships that made it more challenging to work together.
82. Between January 2020 and April 2022, I did not interact much with Alister Jack MP, the Secretary of State for Scotland and his office. We were both present in meetings chaired by the Chancellor of the Duchy of Lancaster, but that was the extent of my interaction with him. I do not have knowledge of the role he and his office played in UK Government's core decision-making, insofar as it related to the management of the pandemic in Scotland or inter-governmental workings between the Scottish Government and the UK Government.

Working with the other Devolved Administrations

83. In order to ensure proper coordination and communication on core decision-making amongst the Scottish Government and devolved administrations in Wales and Northern Ireland, the Four Nations Cabinet Secretaries for Health participated in regular Four Nations calls. This was the main method of communication with other Health Secretaries in the Devolved Administrations. These calls were helpful for the Scottish Government to understand when and why the other Devolved Administrations were taking steps in their management of the pandemic. Bilateral or trilateral calls between the Health Secretaries of the Devolved Administrations were not common.
84. I recall that bilateral discussions occurred between health officials of the Devolved Administrations. For example, if the position of the Scottish Government and the Welsh Government was aligned on a specific topic, there would often be a call between officials in advance of the regular Four Nations call in order to agree to raise an issue collectively. It was my experience that if the Devolved Administrations coordinated on specific issues, it was more likely to lead to a positive result in Four Nations calls.
85. I am aware that there were various forums in place for cooperation between the four nations throughout the pandemic. As I have set out earlier in this statement, this was reflected in the decisions taken and approach adopted, particularly early in the pandemic. With regards to the detailed areas of cooperation noted, I can only comment on those with which I was directly involved. As stated previously in this statement, as Cabinet Secretary for Justice I was involved in four nations calls surrounding international travel restrictions with my counterparts in the other three nations, in this case largely those with responsibility for transport. As Cabinet Secretary for Health and Social Care I was also involved in regular four nations calls with other Health Secretaries. As Cabinet Secretary for Health and Social Care between May 2021 and April 2022, I felt there was a good four nation approach to the Covid-19 response.
86. I am aware that representatives of devolved governments were invited to some COBR meetings. As I have said earlier, I did not attend COBR. However, I

understand that the Cabinet Secretary for Health and Sport, Ms Freeman, attended this in relation to Covid-19 on 24 January 2020, and subsequent meetings in January and February. The First Minister participated throughout March. The rhythm of COBR meetings intensified during March in preparation for national lockdowns across the UK.

87. Since these matters sat outside my portfolio responsibility at the time, I am not aware of why the Devolved Administrations were not included in Covid-O and Covid-S meetings as a matter of course and were included on an invite-only basis until September 2020. I am not aware of any consultation which took place with the Scottish Government about these changes in approach. I am not aware to what extent these changes in UK Government decision-making structures affected the effectiveness of the four nations approach to the Covid-19 response.
88. The Scottish Government corporate statements that have been provided to the inquiry explain how intergovernmental liaison arrangements expanded from health and resilience structures such as COBR to include a range of Covid-specific groups at both ministerial and official level as well as extensive day-to-day liaison. A future pandemic requiring government-wide responses would need similar close engagement between the governments and planning for that can build on the relationships and experience developed in relation to Covid as well-tested emergency mechanisms such as devolved governments' participation in COBR.
89. Function is more important than form, however. What is essential to success is a co-operative approach from all the governments from the outset that facilitates early and continuing engagement and information-sharing. A 'four nations' response does not require a uniform approach across the four nations with their widely different geographical, administrative and social circumstances, but it does require close liaison of the sort that – on most issues – characterised the four governments' approach to the pandemic. Since early 2022 the four governments have been operating a new, three tier, overarching system of high-level intergovernmental engagement centred on the Prime

Minister and Heads of Government Council that has replaced the Joint Ministerial Committee. However, that apparatus, and that it replaced, was not intended to bear the weight of, or replace, the vast range of formal and informal engagement between the four governments.

90. As set out in corporate statements the Scottish Government has already provided to the Inquiry, in general the UK Government did not seek to influence or persuade the Scottish Government to follow its approach for England, although on some occasions it did so on public health messaging as the UK Government believed pan-UK messaging would lead to less confusion. Where we could align, and it made sense to do so, including in relation to public messaging we did. More significantly, however, as is also set out in the corporate statements, the UK Government's decisions on funding, for example of the furlough scheme, aligned with its decisions for England rather than the requirements of Scottish restrictions and were therefore a practical constraint on Scottish decisions.
91. In relation to the regular meetings held by the Chancellor of the Duchy of Lancaster with the former First Ministers of Scotland and Wales and the First and deputy First Ministers of Northern Ireland, I understand that these meetings were regularly attended by the former First Minister, or if she was unable to do so, by an appropriate substitute.
92. I do not know why these meetings were chaired by Chancellor of the Duchy of Lancaster rather than the Prime Minister. As I have mentioned previously in this statement, as Cabinet Secretary for Health and Social Care, I used WhatsApp to communicate with other Health Secretaries across the UK, which included my membership of the "Health Ministers Forum" & "Health Ministers UK" WhatsApp groups. This use of WhatsApp was for information sharing as opposed to four nations decision-making.
93. I am not aware of why representatives of the Devolved Administrations were not present at initial meetings of SAGE and whether this had any impact on the Scottish Government's understanding of and initial response to the emergence

of the pandemic. During the course of the pandemic, Scottish government had regular access to papers produced by SAGE and the output of SAGE meetings. I believe that SAGE was a useful source of evidence and scientific consensus from which the CMO could develop advice for the Scottish Government, however, the drawback was that Scottish Ministers could not ask questions directly of SAGE. It was for this reason that the former First Minister arranged for the then-CMO, Dr Calderwood to set up the C19AG.

94. I understand from my preparation for this statement that the former First Minister met with the then Health Secretary, Matt Hancock, and Dido Harding on 14 September 2020 to discuss testing and contact tracing. This was outside my portfolio at the time. I am not aware of any further Scottish Government involvement with the three UK 'Tsars' appointed by the UK Government in April 2020 and whether this had any effect on the Scottish Government's pandemic response.
95. With reference to the fora I was involved with, I believe sufficient consideration was given during four nations decision-making to the impact of decisions, including NPIs, on 'at risk' and other vulnerable groups in light of existing inequalities, for example in the rollout of the vaccination programme.
96. I am not aware of the extent to which four nations decision-making about the response to Covid-19 considered the impact of Covid-19 restrictions for people living and working across internal borders. I was not involved in decision-making relating to this beyond considering policing of arterial routes during the operation of the levels system in late 2020 as Cabinet Secretary for Justice.
97. I was not directly involved with four nations discussion on the approach to Covid-19 restrictions over the festive period in December 2020, however I believe that there was ongoing discussion at official level for some time concerning the potential for a coordinated approach. I have set out above how, I was involved as a member of Cabinet in the decisions taken later in December about the adjustment to these plans required as a result of the emergence of the Alpha variant.

98. In terms of four nations decision-making seeking to learn lessons from the response to Covid-19 in other countries, I recall that the CMO and NCD would, during their regular Cabinet updates, on occasion use international examples of how the virus was being managed by other countries.
99. In my view, the Scottish Government was not involved in influencing core decision-making by the UK Government relating to the pandemic to the extent we would have liked. At times it seemed the Scottish Government was informed of decisions made by the UK Government without being provided an opportunity to contribute to decision-making. At times the Scottish Government would hear about decisions made by the UK Government via the media, for example, as I have mentioned previously in this statement in relation to travel restrictions.
100. In relation to the effectiveness of intergovernmental working, coordinated decision-making and communication between the UK Government and the Devolved Administrations throughout the pandemic, this would vary depending on the individual or group I was dealing with. For example, as Cabinet Secretary for Health and Social Care, my relationships with the Health Secretaries and Vaccine Ministers across the four nations were good and constructive. Regardless of the structures in place, I felt able to communicate with them directly if I needed to. If there were any obstacles, these could usually be addressed if Ministers were accessible to each other.
101. In my view, intergovernmental co-working around Test and Protect generally worked well. There were of course challenges, largely around funding, but as a whole in my view intergovernmental co-working worked well.
102. An example of that co-working is included in the Scottish Government Director General for Health and Social Care statement for Module 5 of the Inquiry [INQ000498141]: in relation to testing, in June 2021, Scottish Ministers agreed to loan the UK Government 10 million lateral flow tests which would be paid back within a month to cover a short-term shortfall. Similar loans were made to

UK Government in November 2021 (12 million) and December 2021 (2 million). Additionally, UK Government loaned 15 million tests to Scotland at short notice, and then at the next test procurement, Scotland agreed to purchase 15 million tests from UK Government in order to replenish the UK Government's stock. On this occasion it meant the net balance of tests owed by Scotland was 0.

Working with other sovereign nations

103. I cannot recall any specific discussions with other countries about Test and Protect in particular.
104. The Chief Medical Officer (Professor Sir Gregor Smith) and the then National Clinical Director (Professor Jason Leitch) would, during updates to Cabinet, take time to give us the international perspective on Covid-19. This did, from time to time, show differences in testing techniques from other countries. Whilst I do not recall having collaborated with other sovereign nations specifically on testing, our clinical advisors did continue to monitor the global picture in relation to testing, and this would at times look at differences in testing methodologies. I am not aware of instances where monitoring international testing regimes directly influenced our own testing programme.
105. I would also note that, as stated in the Scottish Government Director General for Health and Social Care statement for Module 2A of the Inquiry [INQ000215488, paragraph 66], the UK has a seat as a member state on international organisations such as the World Health Organisation ("WHO") and the World Health Assembly. Whilst Scotland is not a member state, information provided by these relevant international organisations was provided to the Health Protection Network and the CMO. The CMO received verbal updates from Professor Chris Whitty, CMO for England.

B. SYSTEM READINESS AND CAPACITY

Infrastructure and laboratory systems in Scotland

106. In January 2020, although I was in Cabinet, I was not the Cabinet Secretary for Health and Social Care so was not predominantly responsible for preparing the country and indeed the NHS for the pandemic. Scotland's preparedness for the development of a scalable and rapidly deployable Test and Protect system was a function of my predecessor, Jeane Freeman, in conjunction with the then First Minister, Nicola Sturgeon. Although there would have been Cabinet discussions about a Test and Protect system, I would not have been involved in the intricate detail of developing the system nor was I responsible for it. Those discussions would have taken place between the appropriate Ministers, such as the First Minister and the Cabinet Secretary for Health (who had responsibility for the creation and development of Test and Protect), alongside the appropriate Scottish Government officials and clinicians.
107. In my experience in Government, we had never dealt with a health emergency of this scale. Even when we had dealt with the spread of virial infections, it had never required a population testing system to be in place and associated preventative measures, such as isolation. As has been acknowledged by Governments across the UK, including the Scottish Government, the preparation for a global pandemic was based on an influenza-type virus, which would not have required the same type of testing infrastructure as we did require with a novel virus such as Covid-19. We, of course, had laboratories across Scotland with a skilled workforce in place who were responsible for infectious disease diagnostics. Testing and contact tracing were also used but mainly for limited outbreaks, and not on the scale of Covid 19 that required a whole population approach.
108. Again, I was not in role as Health Secretary during the development of Test and Protect so cannot comment further on the various phases of its initial development.
109. Despite the relatively limited testing infrastructure we had in place, particularly in comparison to what was required to deal with a global pandemic, it is my view that partners worked incredibly hard, and well, to set up testing infrastructure within weeks of the WHO declaring a public health emergency of

international concern on 30 January 2020. This initial infrastructure was then further developed and evolved as the weeks and months progressed.

Data collection, sharing and coordination between bodies

110. Given that, as stated above, I was not Cabinet Secretary for Health and Social Care at the outset of the Covid-19 pandemic, I am unable to comment in detail on data collection and sharing insofar as those practices were relevant to Scotland's preparedness to develop a test, trace and isolate system. I can, however, say that data collection, sharing and coordination between decision-making bodies was less of an issue during the time I took on the role as Cabinet Secretary for Health and Social Care. Test and Protect had been in place for over a year once I took up office, and any issues around data sharing that there may have been in the early days (which often related to GDPR issues and sharing of information between public bodies) had been largely resolved by this point.

111. There continued to be some discussions around GDPR, but I am unable to recall if they were specific to Test and Protect. We had various public bodies and agencies within Scotland who worked together on a daily basis, such as the NHS (who had responsibility for health care in Scottish prisons) and the SPS, and I recall as Cabinet Secretary for Justice being approached by SPS and told that due to GDPR data sharing was not as good as it should be between them and the NHS.

C. DEVELOPMENT OF POLICIES FOR TEST, TRACE AND ISOLATE

Responsibilities and decision-making in relation to Test and Protect

112. As Cabinet Secretary for Justice in the early part of the pandemic, I was responsible for ensuring that there was appropriate testing for various elements of the justice system such as the SPS. At that time there were around 8,000 prisoners in our care, ranging from young people in HMP YOI Polmont to very elderly men and women within a prison estate that was overcrowded. Our

prisons were beyond their operational capacity, so ensuring that we had a proper testing regime in place for that particular environment was an area which took up a significant amount of my time Cabinet Secretary for Justice in the early period of the pandemic.

113. My responsibilities extended right across the justice system, so I also had overarching responsibility for Test and Protect in relation to Police Scotland. The day-to-day operational responsibility lay with the then Chief Constable Ian Livingstone, so the engagement between Ian and I was frequent, and at times involved some frank exchanges. We worked well together, and ultimately both wanted to ensure that police officers, who were of course coming into contact with the public numerous times per day, were given the necessary protection, and assurances, required.

114. The key elements of the testing approach adopted by Police Scotland included the following:

- partnership with NHS Scotland:
 - Police Scotland worked closely with NHS Scotland to access Covid-19 testing for officers and staff;
 - a protocol was developed to ensure symptomatic officers and staff, or those identified as close contacts, could be tested promptly.
- dedicated testing facilities:
 - testing was arranged through a combination of NHS testing centres and bespoke arrangements for frontline officers;
 - mobile testing units were deployed in some instances to ensure accessibility for officers working in remote or rural locations.
- priority testing for key personnel:
 - officers and staff identified as critical to policing operations were prioritized for testing;
 - this included officers responding to emergencies, those in custody suites, and those in roles where close contact with the public was unavoidable.

- internal monitoring and reporting:
 - Police Scotland implemented systems to monitor Covid-19 cases within the workforce;
 - regular updates were provided to leadership teams to ensure operational resilience.
- support for self-isolation:
 - officers testing positive or identified as close contacts were required to follow self-isolation guidelines;
 - support measures were put in place, including access to health advice and welfare checks.
- bespoke guidance and PPE provision:
 - alongside testing, Police Scotland provided clear guidance on infection prevention measures, including the use of PPE for officers in high-risk roles.

115. I do not recall there being significant difficulties in relation to testing for police officers, however we were often pushed by the Scottish Police Federation, who represented front line police officers, to further prioritise police officers when it came to testing, particularly during surges of the virus or the emergence of a new variant, and prioritisation for vaccinations.

116. I also had responsibility for the SCTS. Whilst we were trying to tackle the backlog of cases in the courts system and keep the wheels of the justice system turning, we also had to ensure that appropriate testing was put in place, for example in relation to jurors who were asked to come on jury duty during the pandemic so that we could resume High Court cases. Testing was also required for witnesses, judges, counsel and lawyers, and appropriate Test and Protect measures were put in place as a result.

117. When I became Cabinet Secretary for Health and Social Care on 19 May 2021, I was given lead responsibility for the Test and Protect system in Scotland. It was my responsibility to ensure that right across all Scottish Government portfolios, and indeed across the country, we had a comprehensive and

functioning Test and Protect system that was ensuring we could identify cases of Covid-19 and make sure people were able to take appropriate precautionary measures to mitigate the spread of the virus. My role also involved ensuring that we had the appropriate funding for that system, which involved regular conversations between me and my counterpart in UK Government, and where appropriate with the Cabinet Secretary for Finance in the Scottish Government. It was also for me to make sure that we had appropriate testing capacity, particularly at times when there was a spike in cases. In essence, the overarching responsibility I had for Test and Protect did not change in relation to the responsibilities my predecessor had. However, my predecessor was clearly involved in the development and creation of the Test and Protect system in a way that I was not, given it was well established by the time I was appointed to my role as Health Secretary.

118. The Test and Protect system was quite well-established by the time I was appointed to the health portfolio. Maree Todd, who was the Minister for Public Health, Women's Health and Sport, had responsibility for testing as part of her role, although I retained overall responsibility as Cabinet Secretary.

119. When it came to particular NPIs being 'stood down' where necessary, we ensured that we had appropriate Test and Protect measures in place. That included at large-scale events, such as the Euros Fanzone.

120. I was provided with advice and information about Test and Protect by Scottish Government's clinical advisors including the CMO, the NCD, and the CNO, the latter often giving advice especially in relation to healthcare workers and social care workers. Clinical advisors were always available to me for advice when I was Cabinet Secretary for Justice: they would attend Cabinet, they had various Gold Command meetings some of which I attended, and they also made themselves available if I ever required them. We spoke over the telephone or via WhatsApp exchange if required. However, conversation with them was far more regular once I became Cabinet Secretary for Health and Social Care because from that point I had much broader responsibility for Test and Protect.

121. I also received advice from stakeholders 'on the ground', such as Scottish Care, and non-government stakeholders. Other sources of advice and feedback included trade unions and professional bodies, such as the Prison Officers' Association, the Scottish Police Federation, and the Royal College of Nurses. We would also receive advice, feedback and information about Test and Protect from UK bodies, such as SAGE, Public Health England (PHE) and Oxford University.

Responsibilities of Cabinet Secretaries and First Minister

122. I have been both a Cabinet Secretary and First Minister and so can speak from both perspectives. Cabinet Secretaries know clearly what responsibilities they have (they are clearly defined and are publicly available via the Scottish Government's website). Equally it is true that as First Minister you know that you ultimately have responsibility for everything that happens within Government; that becomes particularly pronounced during times of emergency, and the pandemic to this day is the biggest emergency the Scottish Government has had to deal with in the history of devolution. First Ministers naturally become the focal point during emergency situations facing the country, as people look for their leaders to lead. However, that doesn't mean that First Ministers do not delegate to their Cabinet Secretaries, and indeed when she was First Minister Nicola Sturgeon did delegate, but there were clearly areas across the breadth of the responsibilities of the pandemic that she took an interest in. Test and Protect was certainly one of those areas. It was not the case that there were certain responsibilities that were hers and certain responsibilities that were mine; my responsibilities were well-defined, but whenever the First Minister had a question or an interest or wanted further information on a particular matter, I would provide that to her and have conversations with her on those matters. Such conversations about Covid-19 generally and Test and Protect in particular were more regular when I was Cabinet Secretary for Health than when I held the Justice portfolio.

123. A Cabinet Secretary's responsibilities are very clear, and part of the job is to inform the First Minister whenever they have an interest, which Nicola Sturgeon did have in relation to Test and Protect.

124. As Cabinet Secretary for Health and Social Care, my other functions and responsibilities during the Covid-19 pandemic included:

- acute services;
- allied healthcare services;
- centre of excellence for rural and remote medicine and social care;
- community care;
- eHealth;
- health and social care integration;
- health improvement and protection;
- NHS estate;
- NHS performance;
- patient services and patient safety;
- person-centred care;
- primary care and GPs;
- quality and improvement;
- unscheduled care; and
- workforce, training, planning, and pay.

Points of contact

125. Trade unions and professional bodies were hugely important points of contact for the 'on the ground' feedback that they could provide from their members around what was happening in relation to the pandemic. I have mentioned earlier in this statement the advice received from clinical advisors, who were vitally important for their clinical expertise, and would add that we benefitted from the input of clinical advisors not only from within Scottish Government but also outside of government, such as the members of the C19AG.

126. Other scientific bodies, such as PHS (Public Health Scotland), SAGE (Scientific Advisory Group for Emergencies), UKHSA (UK Health Security Agency), JBC (Joint Biosecurity Council), were also important sources of advice, as were stakeholders such as bodies like Scottish Care, RCEM (Royal College of Emergency Medicine), The Health and Social Care Alliance Scotland, BEMIS (Black and Ethnic Minority Infrastructure Scotland), CEMVO (Council of Ethnic Minority Voluntary Organisations), CRER (Coalition for Racial Equality and Rights), GDA (Glasgow Disability Alliance), Inclusion Scotland alongside many others who represented particular sectors and demographics in Scotland. They were able to provide real-time feedback about the impact of the pandemic and of our decisions. It was also important that we engaged with bodies that represented those with learning disabilities, who were neurodiverse, and were living with mental health issues, to make sure that we were meeting their needs.

Chronology of Test and Protect decisions

127. A chronology of the main Scottish Government decisions, policies and strategies in relation to Test and Protect during the relevant period can be found in the following table:

Date	Title	Exhibit / INQ Number	Category: - Key Guidance - Core Decision - Key Policy / Strategy
28/02/2020	Testing expansion	<u>HY5/007 – INQ000571249</u>	Key Policy / Strategy
10/03/2020	Coronavirus: how contact tracing works	<u>HY5/008 – INQ000571320</u>	Key Guidance
13/03/2020	Move to delay phase	<u>HY5/009 – INQ000496466</u>	Key Policy / Strategy

Date	Title	Exhibit / INQ Number	Category: - Key Guidance - Core Decision - Key Policy / Strategy
15/03/2020	Surveillance testing expanded to GP practices to monitor the spread of Covid, covering up to 1.2 million people in Scotland	N/A	Core Decision
15/03/2020	Pause of locally led TTI strategy for the general public	N/A	Core Decision
15/03/2020	the First Minister announced all symptomatic residents in care homes would be tested, not just initial cases to establish the cause of an outbreak.	N/A	Core Decision
15/03/2020	Testing update	<u>HY5/010 – INQ000571250</u>	Key Policy / Strategy
24/03/2020	Testing expanded to NHS health and social care key workers	<u>HY5/011 - INQ000496422</u>	Key Policy / Strategy
25/03/2020	Creation of Covid-19 Advisory Group (C19AG)	N/A	Core Decision
05/04/2020	First UK PCR test site opened in Glasgow and online ordering enabled	N/A	Core Decision
14/04/2020	National Assistance Helpline (NAH) opened. A single point of contact for requests for support relating to self-isolation commences	N/A	Core Decision
23/04/2020	Framework for Decision Making published	N/A	Core Decision

Date	Title	Exhibit / INQ Number	Category: - Key Guidance - Core Decision - Key Policy / Strategy
23/04/2020	Coronavirus (Covid-19): residential childcare	<u>HY5/012 – INQ000571272</u>	Key Guidance
25/04/2020	Coronavirus (Covid-19): prioritisation matrix for key workers to be tested	<u>HY5/013 – INQ000571319</u>	Key Guidance
25/04/2020	Coronavirus (Covid-19): getting tested in Scotland	<u>HY5/014 – INQ000571344</u>	Key Guidance
25/04/2020	Proposal for rapid introduction of a sustainable contact tracing system	N/A	Core Decision
27/04/2020	Testing to enable Health and Social Care workers to return to work	<u>HY5/015 – INQ000574386</u>	Key Guidance
01/05/2020	Testing eligibility expanded	N/A	Core Decision
01/05/2020	Testing expansion	<u>HY5/016 – INQ000571251</u>	Key Policy / Strategy
04/05/2020	National Contact Tracing Centre (NCTC) established	N/A	Core Decision
04/05/2020	Coronavirus (Covid-19) :Test, Trace Isolate Support Strategy	<u>HY5/017 - INQ000571343</u>	Key Policy & Strategy
05/05/2020	Four phased Scottish approach to Covid-19 Contact Tracing set out	N/A	Core Decision
18/05/2020	Testing eligibility expanded to children over five with symptoms	N/A	Core Decision
18/05/2020	Testing expansion	<u>HY5/018 – INQ000571252</u>	Key Policy / Strategy

Date	Title	Exhibit / INQ Number	Category: - Key Guidance - Core Decision - Key Policy / Strategy
26/05/2020	Coronavirus (Covid-19): Test and Protect – summary	<u>HY5/019- INQ000571253</u>	Key Guidance
26/05/2020	Coronavirus (Covid-19): Test and Protect - advice for employers	<u>HY5/019- INQ000571253</u>	Key Guidance
26/05/2020	Coronavirus (Covid-19): Test and Protect	<u>HY5/019- INQ000571253</u>	Key Guidance
26/05/2020	Test and Protect established	<u>HY5/019- INQ000571253</u>	Key Policy / Strategy
31/05/2020	SG data protection announcement. Contact tracing data used by NHS Scotland safe and secure	N/A	Core Decision
07/06/2020	Coronavirus (Covid-19): international travel and quarantine	<u>HY5/020 – INQ000571273</u>	Key Guidance
22/06/2020	Coronavirus (Covid-19): Test and Protect information leaflet	<u>HY5/021 – INQ000571322</u>	Key Guidance
23/06/2020	Weekly PCR testing offered for healthcare workers	N/A	Core Decision
02/07/2020	Coronavirus (Covid-19): guidance for use of FIT testing for patients with colorectal symptoms	<u>HY5/022 – INQ000571274</u>	Key Guidance
14/07/2020	Coronavirus (Covid-19) Test and Protect: multi-sector guidance on collection of customer and	<u>HY5/023- INQ000571275</u>	Key Guidance

Date	Title	Exhibit / INQ Number	Category: - Key Guidance - Core Decision - Key Policy / Strategy
	visitor contact details – July 2020		
15/07/2020	Coronavirus (Covid-19): guidance on food and other essentials for local authorities	<u>HY5/024 – INQ000574173</u>	Key Guidance
17/07/2020	Coronavirus (Covid-19): Test and Protect information leaflet	<u>HY5/025 – INQ000571276</u>	Key Guidance
21/07/2020	Testing eligibility expanded to those under five years of age	<u>HY5/026 - INQ000326379</u>	Key Guidance
30/07/2020	Coronavirus (Covid-19): self-isolation advice	<u>HY5/027 – INQ000571277</u>	Key Guidance
31/07/2020	SG announced development of 'Protect Scotland' App to support Test and Protect system	N/A	Core Decision
14/08/2020	Mandatory customer data collection for hospitality sector	N/A	Core Decision
14/08/2020	Coronavirus (Covid-19): Mandatory customer data collection	<u>HY5/028 – INQ000571278</u>	Key Guidance
14/08/2020	Mandatory customer data collection requirements introduced for hospitality sector	<u>HY5/028 – INQ000571278</u>	Key Policy / Strategy
17/08/2020	Testing Strategy	<u>HY5/029 - INQ000147448</u>	Key Policy / Strategy
25/08/2020	Testing capacity and access expansion	<u>HY5/030 – INQ000571254</u>	Key Policy / Strategy

Date	Title	Exhibit / INQ Number	Category: - Key Guidance - Core Decision - Key Policy / Strategy
25/08/2020	SG announced the increase of capacity and accessibility of testing, with 11 walk-through test sites to be set up	N/A	Core Decision
11/09/2020	Contact tracing case prioritisation to respond to increasing demands	N/A	Core Decision
20/09/2020	Decision not to replicate UKG self-isolation legal requirements	N/A	Core Decision
02/10/2020	SG announced antibody survey for education staff	N/A	Core Decision
09/10/2020	Contact tracing calls for people requested to self-isolate as of 12/10/2020	N/A	Core Decision
13/10/2020	SISG commenced	N/A	Core Decision
19/10/2020	Continuation of National Assistance Helpline (NAH) and Local Self-Isolation Assistance Service (LSIAS)	N/A	Core Decision
22/10/2020	Clinical and scientific review of testing strategy	<u>HY5/031</u> - INQ000571280	Key Policy / Strategy
23/10/2020	Coronavirus (Covid-19): review of testing strategy - October 2020	<u>HY5/031</u> - INQ000571280	Key Guidance
23/10/2020	Strategic Framework	<u>HY5/032</u> - INQ000339830	Key Policy / Strategy

Date	Title	Exhibit / INQ Number	Category: - Key Guidance - Core Decision - Key Policy / Strategy
27/10/2020	Covid-19 Asymptomatic weekly testing guidance for employers and staff on the importance of weekly Asymptomatic testing.	<u>HY5/033</u> – <u>INQ000571323</u>	Key Guidance
11/11/2020	Student testing scheme	N/A	Core Decision
12/11/2020	Coronavirus (Covid-19): self-isolation factsheet	<u>HY5/034</u> – <u>INQ000571281</u>	Key Guidance
25/11/2020	Testing expansion for hospital patients, Health and Social Care staff, and communities in Level 4 areas	N/A	Core Decision
25/11/2020	Testing expansion	<u>HY5/035</u> – <u>INQ000571282</u>	Key Policy / Strategy
02/12/2020	Scotland's first Community Asymptomatic Test (CAT) site opened in Johnstone, Renfrewshire	<u>HY5/036</u> – <u>INQ000571283</u>	Core Decision
06/12/2020	SG announced LFD testing of designated visitors to be trialled in 14 care homes	N/A	Core Decision
06/12/2020	LFD test trial in care homes	<u>HY5/037</u> – <u>INQ000571256</u>	Key Policy / Strategy
09/12/2020	Interim Guidance for patient facing Healthcare workers	<u>HY5/038</u> – <u>INQ000574387</u>	Key Guidance
13/12/2020	Coronavirus (Covid-19): adult care home LFD testing	<u>HY5/039</u> – <u>INQ000571284</u>	Key Guidance

Date	Title	Exhibit / INQ Number	Category: - Key Guidance - Core Decision - Key Policy / Strategy
14/12/2020	Coronavirus (Covid-19): discretionary SISG guidance	<u>HY5/040–</u> <u>INQ000571285</u>	Key Guidance
14/12/2020	Isolation period changes from 14 to 10 days	N/A	Core Decision
15/12/2020	Coronavirus (Covid-19) point of care and rapid testing - clinical management: governance policy	<u>HY5/041 –</u> <u>INQ000571286</u>	Key Guidance
23/12/2020	Community testing in areas with high coronavirus prevalence from January 2021.	N/A	Core Decision
05/01/2021	Small scale test sites would be available for rural areas as part of a testing pilot	N/A	Core Decision
08/01/2021	Coronavirus (Covid-19): adult care home testing guidance for visiting professionals	<u>HY5/041a –</u> <u>INQ000571287</u> and <u>HY5/042 –</u> <u>INQ000581883</u>	Key Guidance
15/01/2021	Coronavirus (Covid-19): social care and community-based testing guidance	<u>HY5/043 –</u> <u>INQ000571288</u>	Key Guidance
15/01/2021	Testing access expansion	<u>HY5/043 –</u> <u>INQ000571288</u>	Key Policy / Strategy
18/01/2021	Targeted community testing formally commenced, following pilots in Johnstone, Renfrewshire	N/A	Core Decision
19/01/2021	NAH and LSIAS continuation to 31/03/2021	N/A	Core Decision

Date	Title	Exhibit / INQ Number	Category: - Key Guidance - Core Decision - Key Policy / Strategy
02/02/2021	Expansion of testing	N/A	Core Decision
08/02/2021	Expansion of testing to close contacts of positive cases	N/A	Core Decision
08/02/2021	Expansion of testing	<u>HY5/044 – INQ000571289</u>	Key Policy / Strategy
15/02/2021	Mental health support	N/A	Core Decision
17/02/2021	Coronavirus (Covid-19): Scottish Welfare Fund statutory guidance	<u>HY5/045 - INQ000571345</u>	Key Guidance
17/02/2021	Coronavirus (Covid-19): Self-isolation support discretionary payment - regulations	<u>HY5/045a – INQ000571314</u>	Key Guidance
17/02/2021	Expansion of testing	N/A	Core Decision
22/02/2021	Coronavirus (Covid-19) - employee testing programmes: guidance for employers	<u>HY5/046 – INQ000571290 and HY5/047 – INQ000581889</u>	Key Guidance
23/02/2021	Strategic Framework	<u>HY5/048 - INQ000343997</u>	Key Policy / Strategy
26/02/2021	Expansion of testing	N/A	Core Decisions
26/02/2021	Testing access expansion	<u>HY5/049– INQ000571258</u>	Key Policy / Strategy
05/03/2021	Testing access expansion	<u>HY5/050 – INQ000571259</u>	Key Policy / Strategy

Date	Title	Exhibit / INQ Number	Category: - Key Guidance - Core Decision - Key Policy / Strategy
11/03/2021	Decision not to create an offence relating to employers and self-isolation rules	N/A	Core Decision
12/03/2021	Community testing in Scotland: local Coronavirus testing information	<u>HY5/051 – INQ000571291</u>	Key Guidance
17/03/2021	NAH and LSIAS continuation to 30/06/2021	N/A	Core Decision
17/03/2021	Coronavirus (Covid 19) - Testing Strategy: Update March 2021	<u>HY5/052 - INQ000351878</u>	Key Policy / Strategy
30/03/2021	Coronavirus (Covid-19): disposal of waste from Lateral Flow Device Testing - FAQs	<u>HY5/053 – INQ000571292</u>	Key Guidance
20/04/2021	Coronavirus (Covid-19): Test and Protect - collection of customer and visitor contact details: guidance – April 2021 update	<u>HY5/054 – INQ000571293</u>	Key Guidance
22/04/2021	Coronavirus (Covid-19): social care testing overview March 2021	<u>HY5/055 – INQ000574174</u>	Key Guidance
25/04/2021	SG announced free lateral flow test kits to be available for anyone without symptoms from 26/04/2021	N/A	Core Decision
25/04/2021	Testing capacity and access expansion	<u>HY5/056 – INQ000571260</u>	Key Policy / Strategy

Date	Title	Exhibit / INQ Number	Category: - Key Guidance - Core Decision - Key Policy / Strategy
26/04/2021	Coronavirus (Covid-19): Mandatory customer data collection		Key Guidance
09/06/2021	Rapid testing kits rollout to community pharmacies	N/A	Core Decision
17/06/2021	Strategic Framework	<u>HY5/057</u> - INQ000235137	Key Policy / Strategy
21/06/2021	Coronavirus (Covid-19): social care and community-based testing overview	<u>HY5/058</u> – INQ000571294	Key Guidance
22/06/2021	NCTC to prioritise cases by risk	N/A	Core Decision
24/06/2021	Coronavirus (Covid-19): uploading LFD testing results and bar code scanners	<u>HY5/059</u> – INQ000571295	Key Guidance
08/07/2021	Coronavirus (Covid-19): Advisory Sub-Group on Universities and Colleges: addendum to advice on the beyond level 0 scenario	<u>HY5/060</u> – INQ000571296	Key Guidance
22/07/2021	Coronavirus (Covid-19): living with dementia in care homes	<u>HY5/060a</u> – INQ000571297	Key Guidance
23/07/2021	Self-isolation changes for those in critical infrastructure roles	N/A	Core Decision
09/08/2021	Reduced isolation for vaccinated close contacts	N/A	Core Decision

Date	Title	Exhibit / INQ Number	Category: - Key Guidance - Core Decision - Key Policy / Strategy
11/08/2021	Testing access expansion	<u>HY5/061</u> – INQ000571261	Key Policy / Strategy
16/08/2021	Guidance on twice weekly asymptomatic testing of Healthcare workers.	<u>HY5/062</u> – INQ000571324	Key Guidance
26/08/2021	Coronavirus (Covid-19): Reopening of offices handbook	<u>HY5/063</u> – INQ000571298	Key Guidance
28/08/2021	Introduction of triage call for index cases for people who had not completed the online tracing form (CO3)	N/A	Core Decision
17/09/2021	Coronavirus (Covid-19): COP26 Contact Tracing Approach	<u>HY5/064</u> – <u>INQ000571299</u>	Key Guidance
16/11/2021	Strategic Framework	<u>HY5/065</u> INQ000353777	Key Policy / Strategy
23/11/2021	Certification scheme - changes to venue attendance	N/A	Core Decision
27/11/2021	Travel restrictions due to Omicron variant	N/A	Core Decision
29/11/2021	Essential workers priority for PCR test site slots	N/A	Core Decision
06/12/2021	Domestic certification scheme to include negative Covid-19 test as alternative to proof of vaccination	N/A	Core Decision
11/12/2021	Move to SMS messaging close contacts of suspected Omicron	<u>HY5/066</u> – <u>INQ000571181</u>	Key Policy / Strategy

Date	Title	Exhibit / INQ Number	Category: - Key Guidance - Core Decision - Key Policy / Strategy
	cases over the 8th and 9th December		
16/12/2021	Coronavirus (Covid-19): Customer data collection	<u>HY5/067– INQ000571302</u>	Key Guidance
20/12/2021	Contact Tracing System moves to 'Focus' model and sector-based exemptions	N/A	Core Decision
29/12/2021	Prioritising Test and Protect for those at highest risk	<u>HY5/068 – INQ000571301</u>	Key Policy / Strategy
03/01/2022	Advice for schools. All secondary pupils to take at-home tests before returning to school to limit Omicron spread	N/A	Core Decision
05/01/2022	Changes to self-isolation and testing regarding LFD and PCR requirements	N/A	Core Decision
24/01/2022	Changes to vaccinated and non-vaccinated arrivals	N/A	Core Decision
15/03/2022	Test and Protect Transition Plan	<u>HY5/069 - INQ000235186</u>	Key Policy / Strategy
21/03/2022	Changes to contact tracing. Customer data collection legislation and guidance withdrawn. Check in Scotland (CIS) App and Webpage switched off.	N/A	Core Decision

Date	Title	Exhibit / INQ Number	Category: - Key Guidance - Core Decision - Key Policy / Strategy
30/03/2022	Changes to testing. People without symptoms no longer required to take tests. Test sites to close on 30/04/2022	N/A	Core Decision
28/04/2022	Ending of contact tracing, some testing	N/A	Core Decision
29/04/2022	Managing Health and Social Care Staff with symptoms of a respiratory infection, or a positive Covid-19 test, as part of the Test and Protect transition plan	<u>HY5/070</u> – INQ000571325	Key guidance
01/05/2022	Ending of contact tracing, some testing	N/A	Core Decision
01/05/2022	Ceasing of routine contact tracing in health and social care settings and cessation of population wide contact tracing	<u>HY5/071</u> – <u>INQ000571303</u>	Key Policy / Strategy

Working with other members of the Scottish Government

128. As First Minister, Nicola Sturgeon took a key leadership role in terms of our response to the Covid-19 pandemic. She was the face of our response, as per her daily briefings, and she was also immersed in the detail of the pandemic, across many, if not all, portfolio areas. Therefore, whilst we as a Cabinet took a collective decision on many aspects of the pandemic, she was the ultimate decision-maker. Cabinet often delegated to her, and the Deputy First Minister, the final decision, where that was appropriate.

129. Whilst I was Cabinet Secretary for Justice, I would speak with the First Minister if there were particular issues I wanted to raise or indeed that she wanted further information about. I do not recall regularly discussing Test and Protect with the First Minister in that capacity, because we had a system that, in my view, was working across the justice system, in the constraints within which we were operating. When intervention was required, discussions were usually between me and Jeane Freeman or clinical advisors if I needed particular clinical advice.
130. Interaction with the First Minister became more frequent when I became Cabinet Secretary for Health: we would have discussions usually on a weekly basis, and multiple times per week when required, for example when there were spikes in cases or when we were trying to achieve a particular vaccine target. By the time I was appointed as Cabinet Secretary for Health and Social Care, Test and Protect was quite well established, so discussions with the First Minister about that particular issue were typically in relation to large-scale events taking place that required their own bespoke testing regime to be put in place, such as the Euros Fanzone and COP 26, to make sure she was comfortable with the testing infrastructure being proposed. Other matters, such as significant changes to the Test and Protect system such as the unilateral decision by UK Government to withdraw funding for Test and Protect, would also be brought to the First Minister's attention.
131. Given that John Swinney, who was at that time Deputy First Minister, had responsibility for coordinating the Scottish Government Covid response across portfolios, discussions with him were fairly regular – at least weekly during the early days of the pandemic, if not more. During those discussions I would give him updates about Test and Protect if I thought a particular issue needed addressing, or to flag certain matters to other Cabinet Secretaries during a regular cross-governmental meeting that Mr Swinney chaired in his role as Deputy First Minister.

132. As Cabinet Secretary for Justice I did not work closely with Kevin Stewart, but when I became Cabinet Secretary for Health he was appointed as Minister for Mental Health and Social Care, which sat under my portfolio remit, so he and I would have fairly regular discussions about testing and other issues given his responsibilities for social care. Although, as noted earlier in this statement, the Test and Protect system was well-established by then, including within the social care sector, he and I would have discussions about testing for example when there were spikes in cases and we wanted to ensure testing in the social care system was sufficiently robust, or we noticed that the vaccination rate was lower among health and social care workers than it had previously been. We also discussed the withdrawal of funding for Test and Protect, and worked with others in the social care landscape in Scotland to make sure that there was appropriate testing in place for social care workers and residents. This could be a challenge given the fragmented nature of the social care landscape in Scotland, with a number of different providers, both public and private, spread across 32 local authorities and 31 health and social care partnerships.
133. Kevin Stewart and I would have had conversations about supporting people living with mental health issues, but I do not recall him flagging any concerns in that regard that were specific to Test and Protect. By that time, we had established systems in place already, including for facilities such as Leverndale Hospital that care for patients with acute mental health challenges.
134. As Minister for Public Health, Women's Health and Sport, Marie Todd was delegated responsibility around certain aspects of Test and Protect, so again I worked closely with her again as Cabinet Secretary for Health and Social Care. She, Kevin Stewart and I met weekly and had a weekly call, and we'd speak more often than that if required. Our offices were quite literally next door to each other, so if necessary we would pop in and have a conversation where required.
135. Whilst I was Justice Secretary, I would speak to Jeane Freeman in her capacity as Health Secretary if issues arose that I thought required her awareness and sometimes even attention. For example, early in the pandemic it was clear to

me a lot of prisoners who were asymptomatic were testing positive. I flagged the high number of asymptomatic positive tests to Jeane Freeman and National Clinical Director Jason Leitch at the time. I recall that further mobile testing units were also sent to other prisons within the Scottish estate as a result of this. This aided our understanding of asymptomatic spread, particularly in confined environments like prisons. I do not recall if any specific changes were made to guidance within prisons at this time. We would also speak on other health-related matters within the justice portfolio when and where required.

136. I would also speak to Kate Forbes in her capacity at the time as Cabinet Secretary for Finance. We would speak fairly regularly about finances, more so when I was Health Secretary than when I was Justice Secretary. We would not initially have spoken much about Test and Protect finances as that was funded by UK Government, but there would have been more discussions with her when UK Government withdrew funding for testing. Scottish Government extended the transition period for slightly longer than UK Government did, and that required us to ensure that we had the necessary financial basis. Nicola Sturgeon would have been involved in those discussions, too.

Advisory bodies

137. A wide range of advisory groups were used throughout the pandemic, some of which were in place prior to January 2020 and some which were stood up specifically in response to pandemic.
138. As stated earlier in the statement, SAGE was the initial intergovernmental source of information in the early pandemic. During the course of the pandemic, the Scottish Government had regular access to papers produced by SAGE and the output of SAGE meetings. I did not attend any SAGE meetings and it was not usual for Ministers attend. However, officials and advisers were sometimes invited to attend as observers and could draw on the discussion and evidence presented in formulating advice to Scottish Ministers. The CMO Scotland and Deputy Chief Medical Officer (DCMO) were members of SAGE.

139. The JCVI and Joint Biosecurity Centre (JBC) were also useful sources of advice and information.
140. The CMO was the primary source of clinical information provided to me, often in conjunction with advice from the NCD. The CMO was in regular contact with the Four Nations' Chief Medical Officers and also the C19AG.
141. C19AG was established in March 2020 and met to consider the scientific and technical concepts and processes that were key to understanding the evolving Covid-19 situation and potential impacts in Scotland. This included applying the advice that was received from SAGE and other sources but did not have any involvement in advice relating to political, social or economic aspects. The Chief Scientific Advisor (CSA) for Scotland was a member of C19AG and two of its subgroups and this was her primary mechanism for providing the Scottish Government with advice. The four C19AG subgroups specifically considered issues and provided advice relating to their particular areas:
- Advisory Sub-Group on Public Health Threat Assessment;
 - Advisory Sub-Group on Education and Children's Issues;
 - Advisory Sub-Group on Universities and Colleges; and
 - Nosocomial Review Group.
142. In terms of how these structures and bodies changed or developed between January 2020 and April 2022, the Scottish Government would have limited insight into the reasons behind changes to the UK Convened Groups. C19AG evolved depending on demand and the phase of the pandemic.
143. It is important to note that over the course of the pandemic the clinical understanding of the virus improved, as did the volume and reliability of the data and subsequent modelling. As a government, we would be kept abreast of the latest clinical and scientific understanding by the Chief Medical Officer during his weekly update to Cabinet. Clearly, if there were significant

developments, such as the emergence of a concerning new variant, the CMO would alert the First Minister and I immediately.

C19AG and SAGE

144. In March 2020, as Cabinet Secretary for Justice, knowledge of the timing and rationale for the formation of the C19AG was outside the scope of my responsibilities. As such, I cannot comment on why its first meeting was not earlier, how and by whom the membership of the C19AG was arrived at.
145. I have described above my understanding of how far SAGE provided advice to the Scottish Government. In my role as Cabinet Secretary for Justice, I had limited insight into whether these groups and their sub-groups were appropriate for dealing with a pandemic of this nature, or whether the system by which scientific advice was provided to the Scottish Government in the period before the formation of the C19AG was effective between January 2020 and February 2020.
146. I did not attend any SAGE meetings. I attended the C19AG on one occasion, in my role as Cabinet Secretary for Health and Social Care, on 5 August 2021, where I discussed a number of issues including the balance of easing restrictions whilst supporting the continued compliance with NPIs where recommended and the uncertain trajectory of the pandemic.
147. The advice that I received from the CSA for Scotland, the CMO for Scotland, the DCMO's for Scotland and the NCD was transparent, clear and readily available throughout the pandemic. A full outline of the CSA, CMO, DCMO and NCD's roles during the pandemic has been provided in the Module 2/2A DG Health and Social Care (CMO/CSO/NCD) and DG Economy (CSA) statements provided to the Inquiry on 23 June 2023.
148. I also felt able to challenge their advice properly, however it was more often the case that I and other Cabinet Ministers would probe the advice further in order to gain a better understanding, given not a single Cabinet Secretary or indeed

the former First Minister had clinical expertise. I believe that the former First Minister and other core decision makers in the Scottish Government challenged the scientific advice provided to them when necessary. I understand that a broad range of expertise was available from within broader advisory structures to complement clinical advice, however in my role as Cabinet Secretary for Justice I was not close to the composition of all these groups.

149. In relation to receiving ethical advice in connection with core decisions taken by the Scottish Government, I and the Scottish Government as a whole was informed by engaging with the third sector, people and groups affected by measures and restrictions, particularly mindful of those who were deemed highly vulnerable. As Cabinet Secretary for Health and Social Care, I had discussions with groups of carers and their families in relation to the impact of imposing or lifting lockdown measures and restrictions. Any specific advice obtained from ethical advisors on the ministerial code including Dame Elish Angiolini and James Hamilton would have been provided to the former First Minister.

150. In relation to whether scientific and expert advisory structures available to the Scottish Government were sufficiently representative of various competing interests relating to the management of the pandemic in Scotland, I believe the views of the various competing interests were sufficiently represented. There were occasions where interested parties were critical about their voice being heard or represented within decision making processes, when that became apparent, we tried, as a government, to engage with such groups as best we could.

151. I did not have any concerns regarding the adequacy or sufficiency of scientific advice, or other expert advice on which the Scottish Government's response to Covid-19 were based. I believe core decision makers were able to understand and interrogate medical and scientific information to an extent when making decisions relating to the management of the pandemic in Scotland. A large inhibiting factor was that many of us within Scottish Government did not have clinical, medical, or scientific expertise. We would ask for explanations from the

CMO for Scotland and for further detail at times from the CMO and other clinical and scientific advisors to further aid our understanding. The CMO was typically able to answer any question we had in Government, however, if he did not have the information or explanation to hand then he would provide a written note or brief in due course. Having the CMO and NCD at Cabinet weekly was extremely helpful. There was plenty of opportunity for Cabinet Secretaries to ask for further clinical explanations from the CMO if required. I found both the CMO, Gregor Smith, and the NCD, Jason Leitch, to be very approachable and responsive, even in my time before becoming Health Secretary.

152. I felt confident that the individuals and bodies making recommendations to the Scottish Government during the pandemic relating to medical and scientific information, advice and data modelling were giving good, relevant and sufficient information. In terms of whether these individuals and bodies were subject to any external assessment or peer review, this is outside my knowledge. I believe these individuals and bodies are better placed to comment on this.

153. I cannot recall a specific instance when conflicting medical and scientific information, advice, and data modelling was communicated by advisers to key decision makers within the Scottish Government. I do recall times when there were gaps in the data, scientific information or advice, particularly in relation to a new variant. For example, when information emerged about a new Covid-19 variant, Omicron, in late November 2021, advisors were understandably unsure about the extent of immune-escape or severity of Omicron. The scientific research was still in the early stages in South Africa (where Omicron was first identified) and while it was quickly established that it had a high transmission rate, other factors such as how it would impact those who had the booster vaccine was unknown. The lack of scientific understanding was communicated to Cabinet at the time, both from the CMO and in papers provided to Cabinet and taken into account when making decisions. It was not my experience that the Scottish Government received conflicting medical or scientific advice. In the age of social media, there was always a variety of interpretations of data, and if there was anything of note that we wanted clinical or scientific advisors to explore further that was never met with any resistance.

154. In the overall consideration of the balance of the Four Harms, clinical advice on measures to suppress the virus was not followed in isolation. For example, in November 2021 I recall the Scottish Government being provided with advice that if the virus was to be suppressed in its entirety, current restrictions should be continued rather than planning for an easing of restrictions over the festive period. The Scottish Government considered this against the impact on people's mental and physical health, the economy, and financial implications alongside other considerations. While the overarching and primary source of advice for the Scottish Government was medical, it was considered with other factors in mind. My understanding is that decision makers weighed medical and scientific advice with other considerations when making key strategic decisions in response to the pandemic through its "four harms" approach. As set out in the Scottish Government Covid-19 Framework For Decision Making – Assessing the Four Harms of the Crisis (December 2020), provided [HY5/072 - INQ000131028].
155. Key decision makers within the Scottish Government had access to information, advice and feedback from patient groups or other representative groups about the patient experience within the healthcare system during the pandemic. For example, we considered feedback from these groups on lockdown measures and other measures in place to tackle the virus. There was particular focus on receiving feedback from patients or groups representing those who were most vulnerable, such as input from carers and disabled persons groups.
156. I cannot recall any decisions in relation to which medical and scientific information, advice or data modelling was not sought but which ought to have been sought. The CMO and NCD were present at virtually every Cabinet meeting during the height of the Covid pandemic offering advice that helped inform decisions that had to be made.

Funding

157. The UK Government was responsible for some significant areas of funding and budgeting which affected the management of the pandemic in Scotland. This included funding related to the furlough scheme, testing and vaccination. For instance, in early 2022 the UK unilaterally announced it would stop population testing for Covid-19 in England from April 2022, in most circumstances. This significantly reduced the available consequential funding for the Scottish Government and constrained the Scottish Government's ability to decide on the length and nature of transition of the Test and Protect scheme. While the Scottish government did continue to fund testing in Scotland for a short period, the lack of budgetary capacity or required borrowing powers meant that the Scottish government had little choice but to also transition away from mass population testing. I raised these concerns publicly and with the UK Government. The lack of funding from the UK Government had a direct impact on our ability to continue access to universal testing for longer, as we simply could not afford to fund the scheme within the devolved settlement. I also raised concerns publicly with the UK Government that we had not seen the scientific advice behind their decision to withdraw the universal testing offer, and made it clear that their decision would force our hand to phase out the universal offer sooner than we would have liked.

158. In terms of the Scottish Government funding its pandemic response, one of the difficulties included the extremely high cost involved in responding to a pandemic. The Scottish Government is a devolved government with limited borrowing and taxation powers and requires the UK Government to provide funding. When UK funding was withdrawn for certain programmes, and the Scottish Government was required to provide vaccinations and testing for the Scottish public, it was impossible to fund particular measures if the requisite funding was not provided by the UK Government. The cost of the testing and vaccination programme alone was very high. The Scottish Government's primary concern was protection of public health and how it could protect the Scottish public from harm, however clearly available funding was a consideration we had to take into account.

D. TESTING

159. As stated in my statement for Module 2A of the Inquiry, paragraphs 173 & 215, on moving from the contain to delay phase, again, this advice was given by SAGE and applied to the whole of the UK. This shift had been anticipated and was discussed in Cabinet on 10 March. The CMO wrote to all Health Boards on 15 March 2020 to advise them on the implications of moving to the delay phase.
160. While these measures were not within my portfolio at the time, I understand that the locally led Test, Trace and Isolate' intervention was paused for the general public as all symptomatic people were advised to stay at home for seven days, regardless of travel and contact. Testing of the general public stopped but was maintained in hospitals for admissions with suspected Covid-19 and all ICU-admissions with upper respiratory conditions. This was for the purposes of clinical care and diagnostics and followed advice from the four UK CMOs.
161. Regarding the announcement made by the Scottish Government on 12 March to cancel indoor and outdoor events of 500 people or more, effective from 16 March, while I was not directly involved, my recollection is that while clinical advice at the time was that cancelling large events would not significantly reduce the transmission of the virus, this decision was made to ensure the resilience of emergency services.

Overview

162. I was not Cabinet Secretary for Health and Social Care during the initial phase of the pandemic during which the planning and roll-out of Scotland's testing programme was being developed and initially evolving and being deployed, so cannot comment meaningfully on how Scottish Government worked with local authorities, health boards and other healthcare bodies at that time. A chronology of key decisions made in relation to testing has been provided earlier in this statement.

163. When I became Cabinet Secretary for Health and Social Care, there was already an established Test and Protect system that seemed to work well with local authorities, health boards and other healthcare bodies. Certainly, I cannot recall many significant issues being flagged by local authorities, health boards and other healthcare bodies around the Test and Protect system during my time as Cabinet Secretary for Health and Social Care. As far as I recall, we worked well with local authorities and other bodies in relation to Test and Protect.
164. Where possible we tried to ensure a Four Nations approach in relation to testing, and for the most part there was alignment. There were good reasons for taking a Four Nations approach, for example: the creation of a supply chain for PCR test distribution and analysis; and later, for lateral flow test procurement and distribution. There was also certain nuances which differentiated our testing regime in comparison to the UK Government's. For example, in Scotland, mobile testing was carried out by the Scottish Ambulance Service, but it is my understanding that in England a third-party contractor was used.
165. We would also potentially have differences when it came to access to testing sites due to our unique remote, rural and island geography.
166. In a number of the UK Government bodies, which were essential to advising Ministers in relation to testing, Devolved Nations were usually not at the main decision-making table. For example: as noted in the Scottish Government Director General for Health and Social Care statement for Module 5 [INQ000498141], when part of UK Government's Department of Health and Social Care and PHE merged into UKHSA, top-level decisions were considered at UKHSA's Executive Committee – including for the testing programme. Devolved Governments were not represented at this forum, but in essence relegated to the UK-DA Board that was established to sit alongside the Executive Committee. Given the decisions made by the Executive Committee would have impacts on the populations of those living in devolved nations, I would have thought it appropriate that Devolved Administrations were represented on the main body as opposed to a sub-group.

167. For the most part, there was a Four Nations approach to testing. Not just in regard to the procurement of testing, but also the fundamentals of a Test and Protect system. There were nuances around prioritisation, and ultimately there was a difference regarding the ending of routine, population-wide testing, with Scotland and Wales opting for a slightly longer transition period than the UK Government. This was based on the clinical advice we were receiving at the time of the importance of the universal testing offer, and its efficacy in identifying cases and helping to contain the spread of the virus, particularly as we were still dealing with significant waves of the virus.

Capacity

168. I had no specific role in decision-making in relation to the development of testing capacity in Scotland. This work was part of the then Health Secretary Jeane Freeman's government brief and was an interest of the then First Minister, Nicola Sturgeon. I was, however, aware of good Four Nations working around the development of the Lighthouse Laboratories and increasing testing capacity. During my meetings with Lighthouse Laboratory staff and senior officials, including during a visit to the laboratory, they were keen to stress to me that the Four Nations working was critical to the success of the Lighthouse Laboratory. As referenced by the University itself, establishing the laboratory was a collective effort between Glasgow University, University of Dundee, BioAscent, the Beatson Institute and the UK Government, who funded the laboratory. At times information about testing and scaling-up of capacity was brought to Cabinet, but I would not be intimately involved in the discussions.

169. The following timeline of key events related to testing in Scotland was previously produced included in the Scottish Government Director General for Health and Social Care statement for module 5 paragraph 366 [INQ000498141]. The first decision / step in which I would have been involved was that announced on 09 June 2021:

- **24 February 2020:** the first two people were tested for Covid in Scotland. Both individuals tested negative;
- **15 March 2020:** surveillance testing was expanded to GP practices to monitor the spread of Covid in the community, covering up to 1.2 million people in Scotland;
- **15 March 2020:** SG updated health boards on the pause to the locally-led test, trace, isolate strategy for the general public. All symptomatic people are advised to stay at home for seven days regardless of travel or contact. Testing of the general public stops but is maintained in hospitals for admissions with suspected Covid, and all ICU admissions with upper respiratory-related conditions, for the purposes of clinical care and diagnostics;
- **15 March 2020:** the First Minister announces all symptomatic patients in care homes will be tested, not just initial cases to establish the cause of an outbreak;
- **24 March 2020:** SG publishes guidance for NHS health boards in Scotland to prioritise testing to enable health and social care staff to get back to work;
- **25 March 2020:** SG announces the creation of its C19-AG to supplement UK-wide SAGE;
- **05 April 2020:** the first UK PCR site (Glasgow drive-through regional test site) opened for testing on 5 April 2020. Online ordering also opened for those eligible;
- **23 April 2020:** SG publishes the Framework for Decision Making which includes setting out the role of testing, contact tracing and supporting self-isolation as part of transitioning out of lockdown;
- **01 May 2020:** testing eligibility was expanded in line with additional capacity;
- **04 May 2020:** the test, trace, isolate, support strategy was published;
- **18 May 2020:** testing eligibility was extended to those over five with symptoms;
- **28 May 2020:** Test and Protect was established and those with Covid symptoms were encouraged to book a test and self-isolate if positive;
- **23 June 2020:** health and social care staff were offered weekly PCR testing;

- **21 July 2020:** testing was expanded to under 5s;
- **17 August 2020:** Scotland’s Covid-19 Testing Strategy was published;
- **25 August 2020:** increasing capacity and accessibility of testing was announced, with 11 walk-through test sites to be set up;
- **26 August 2020:** NHS Scotland procures 300 point of care testing machines and 500,000 tests;
- **02 October 2020:** SG announces an antibody survey for education staff;
- **23 October 2020:** SG publishes its Strategic Framework;
- **11 November 2020:** SG announces a Covid-19 student testing scheme to support the safe return of students ahead of the winter break;
- **25 November 2020:** SG announces an expansion in testing for hospital patients, health and social care staff, and communities in Level 4 areas;
- **02 December 2020:** SG announces the opening of Scotland’s first Community Asymptomatic Test (CAT) site in Johnstone, Renfrewshire. The trial lasted to 9 December 2020;
- **06 December 2020:** SG announces lateral flow testing of designated visitors will be trialled in 14 care homes in North Ayrshire, Fife, Argyll and Bute, Inverclyde, and Aberdeenshire;
- **23 December 2020:** SG announces community testing in areas with high coronavirus prevalence from January 2021;
- **05 January 2021:** SG announces a new way of testing, small-scale test sites, coronavirus testing will be available from two fire stations in Thurso and Lochgilphead between 6 and 29 January, as part of a trial to increase testing access in remote and rural areas;
- **02 February 2021:** SG announces expansion of testing in order to try to drive down rates of Covid-19 in Scotland. The expansion includes routine testing for patient-facing primary care workers, regular testing offered to support the return of schools and nurseries, an expansion of targeted community testing, routine testing for certain workplaces and tests offered to all close contacts of people who have tested positive for Covid-19;
- **17 February 2021:** SG announces an expansion of testing to include anyone who is identified as a close contact of somebody who has tested positive for Covid-19, from 18 February 2021;

- **18 January 2021:** targeted community testing formally commences, following pilots in Johnstone, Renfrewshire;
- **23 February 2021:** SG publishes its Strategic Framework update;
- **26 February 2021:** SG announces access to testing is now available from 21 fire stations across Highland and Argyll & Bute, completing the rollout of small-scale test sites in rural and remote areas of NHS Highland;
- **17 March 2021:** SG published an updated testing strategy, including a £13 million investment in 2021/22 to establish Scotland’s own genomic sequencing service to track new Covid-19 variants and manage future outbreaks;
- **25 April 2021:** SG announces free lateral flow test kits to be available for anyone without symptoms from Monday 26 April;
- **09 June 2021:** SG announces rapid test kits to be rolled out to community pharmacies from 9 June;
- **17 June 2021:** SG publishes its Strategic Framework update;
- **22 August 2021:** UKG launches UK-wide antibody surveillance programme for the general public for the first time. Home antibody tests available for up to 8,000 people a day across the UK who opt in to the service through NHS Test and Trace;
- **22 September 2021:** SG announces more than 10 million Covid-19 PCR tests have now been carried out in Scotland over the past 19 months since testing got underway;
- **16 November 2021:** SG publishes its Strategic Framework update;
- **23 November 2021:** SG announces that from 6 December, people attending venues covered by Scotland’s Covid-19 certification scheme are to be given the option of providing a recent negative lateral flow test for the virus, as an alternative to proof of vaccination;
- **27 November 2021:** SG imposes new travel restrictions as a result of the omicron variant – fully vaccinated arrivals will need to take a PCR test within two days of arrival and to self-isolate until a negative result is received;
- **06 December 2021:** SG announces that from Monday 6 December, the domestic Covid certification scheme will include provision for a negative test for Covid-19, as an alternative to proof of vaccination;

- **29 November 2021:** SG announces that priority for PCR test site slots will be given to essential workers, those at highest risk and anyone eligible for new Covid treatments. A self-isolation exemption scheme is also available for essential workers;
- **03 January 2022:** SG advises all secondary pupils to take at-home Covid-19 tests before they return to school to limit the spread of Omicron;
- **05 January 2022:** SG announces changes to self-isolation and testing. From 6 January, new cases can end self-isolation if they do not have a fever and test negative on a LFD on Day 6 and again at least 24 hours later. Anyone who tests positive on a LFD will no longer be asked to take a PCR test to confirm the result;
- **24 January 2022:** fully vaccinated arrivals into Scotland will no longer be required to possess a negative test result from 4am on 11 February. Non-vaccinated arrivals will still be required to take pre-departure tests and a PCR test on or before day two – but the requirement for isolation will end – and they will no longer have to take a day eight test;
- **22 February 2022:** Scotland’s updated Strategic Framework is published;
- **15 March 2022:** SG’s Test & Protect transition plan is published. People without Covid-19 symptoms will no longer be asked to take regular lateral flow tests from 18 April. From this date, free lateral flow devices (LFDs) will no longer be available except for any purpose for which testing continues to be advised. People with symptoms should continue to isolate and get a PCR test until the end of April;
- **30 March 2022:** SG announces that from 18 April most people without symptoms will not be required to take tests. Lateral flow devices for twice weekly testing will no longer be available. PCR tests for people with Covid-19 symptoms will be available until 30 April, when test sites will close;
- **28 April 2022:** SG announces public health advice will change to a ‘stay at home’ message from 1 May All contact tracing will end. Testing for the general population will end on 30 April, with test sites closing. Testing will remain available to certain groups. NHS Scotland will be taken out of emergency footing at the end of 30 April;

- **25 September 2022:** SG announces that health and social care workers will no longer be required to test for Covid-19 every week as asymptomatic testing is paused by 28 September.

Strategies and targets

170. There are a number of key findings of the effectiveness of the testing system that can be found, in particular in Scotland’s asymptomatic testing programme evaluation (November 2020 – June 2021) {CIRD to Exhibit} which indicates that, although overall positivity rates among asymptomatic individuals were low, asymptomatic testing did successfully identify otherwise undetected Covid-19 cases. The study also has a number of other key findings, including the efficacy of multiple test routes being made available and accessible to the general public. The evaluation helpfully also details the variables that were present during the pandemic in relation to testing, such as adherence to follow up procedures.

171. Although the Canna Model was an analytical study of Test and Trace in England [HY5/073- INQ000571764], many of the findings could be relevant to Scotland, given the similarities in our approach to testing, identifying cases and isolation measures. One of the most striking key findings, which speaks to the efficacy of the Test and Protect system across the UK, is that from June 2020 to April 2021, testing, contact tracing and self-isolation directly prevented between 1.2 million and 2 million Covid-19 infections. This does not take into account the impact of onward chains of transmission which could be significantly higher.

UK Lighthouse Laboratory Network

172. As previously referenced, the testing infrastructure (both NHS and Lighthouse Laboratory), was well established by the time I took on the role as Cabinet Secretary for Health and Social Care.

173. Scotland received a population share of the UK Lighthouse Laboratory capacity which operated effectively as a single UK-wide system. That capacity continued

as the infrastructure evolved during the early days of the pandemic response. There were occasions when demand in some parts of the UK would put pressure on the capacity of the Lighthouse Laboratories, which could result in delays in processing times. However, this was a UK-wide problem, and there were occasions when surges in Scotland would place that demand on the system. During the limited occasions this happened, during my time as Cabinet Secretary for Health and Social Care, I found the contingency arrangements we had in place, involving four nations engagement, worked well. I do not recall any challenges in this regard.

174. There were discussions with the UK Government, as the primary funder of the Lighthouse Laboratory, about whether or not the University of Glasgow (“UoG”) Lighthouse Laboratory would be made permanent with funding from UK Government, with a view to both future pandemics and being able to do other things once we got out of the emergency phase of the Covid-19 pandemic. Those discussions were largely between UoG and UK Government but I did at times raise the point during meetings with UK Government, particularly during our Four Nations health conversations.
175. The Lighthouse Laboratory network did, in my view, consistently meet Scotland’s requirements for testing capacity. However, as noted above, there were occasions when surges in demand across the UK would put pressure on the network. Any delays were generally fairly minimal and short-lived.
176. The Glasgow Lighthouse Laboratory was operational from 21 April 2020.
177. The Glasgow Lighthouse Laboratory, established at the UoG’s Queen Elizabeth University Hospital campus, operated alongside NHS Scotland’s existing diagnostic and reference laboratories, expanding testing capacity rather than replacing local health board services.
178. The Lighthouse Laboratories were designed for mass processing of Covid-19 tests using PCR technology. They were separate from diagnostic laboratories, which handled routine and urgent clinical testing.

179. Samples collected from home test kits ordered through the UK Government booking portal, and at UK Government test sites (walk-through local test sites, mobile testing units, and drive-through regional test sites) were transported to Lighthouse Laboratories for processing, complementing NHS Scotland sample processing.
180. PCR test results from the Lighthouse Laboratory Network fed into PHS' case management system, allowing monitoring and analysis of Covid-19 case data and supporting real-time surveillance and public health decision-making.
181. The Glasgow Lighthouse Laboratory contributed to genomic sequencing efforts, helping track virus variants by providing samples to sequencing facilities such as the MRC-University of Glasgow Centre for Virus Research.
182. There were 'surge' periods during the pandemic when we saw rapid rises in the number of cases, and there would be times where technology would fail as can happen, particularly given the equipment was effectively running twenty-four hours per day, seven days per week. I do seem to recall an instance of a failure of a piece of kit in a Lighthouse Laboratory, which had an impact on not only Scotland but the whole of the UK. As I recall we were able to find capacity in other Lighthouse Laboratories in the UK, as well as utilising NHS Laboratory capacity while the necessary repairs were being carried out, which was a good example of Four Nations working.
183. In relation to whether the demands of the Four Nations were met equally, I can only speak from a Scottish perspective. It seemed to me that we had a good system in place, and questions of one nation being significantly prioritised over another were very rarely, if ever, raised during my time as Cabinet Secretary for Health and Social Care. As stated above, the system was operating as a UK-wide system, so demands in one part of the country could lead to a surge in the system, which would potentially mean a slight delay in processing times. This was accepted given the benefits of a Four Nations approach.

184. In my view, the Lighthouse Laboratory network was a very effective part of Scotland's Test and Protect system.
185. Whilst I was Cabinet Secretary for Health and Social Care, there were very few times that concerns related to testing were raised with me. We experienced challenges in relation to withdrawing NPIs, large-scale events, and funding for Test and Protect, but they did not hinder the effectiveness of the Lighthouse Laboratory network. There was one point at which machinery and equipment in the Lighthouse Laboratory network and NHS laboratories were working at a pace they were not designed for, and were running effectively twenty-four hours per day, seven days per week. Maintenance of the machines was therefore incredibly important and, as noted earlier in this statement, there were times when the technology would fail. Such instances had implications, but to my recollection those issues were quickly resolved. I do not recall who would have had the contract for maintenance of the equipment.

Testing technologies

186. I had no specific role, in the early days of the pandemic, in decision-making relating to the technologies of tests that would be used in Scotland because at the outset of the pandemic I was serving as Cabinet Secretary for Justice and testing was not one of my responsibilities, other than ensuring appropriate testing infrastructure was available to allow the justice system of Scotland to function appropriately. Decisions relating to the technologies of tests that would be used in Scotland were taken by the then-Health Secretary and the First Minister.
187. Testing technologies became more relevant for me when the UK Government decided to withdraw testing for funding, by which time I was Health Secretary. I had to make a decision, with the First Minister, about what the Scottish Government should do in relation to PCR testing and LFD testing.
188. During my time as Health Secretary, we began to significantly resume elective care. Antimicrobial Resistance Healthcare Associated Infection ("ARHAI")

Scotland's Hospital Testing for Covid-19 table [HY5/074 - INQ000411022], published on 01 April 2022, confirmed that all elective surgical patients must be tested prior to admission, and that fully vaccinated patients could use rapid diagnostic tests (including point-of-care testing) or LFDs whilst patients who were not fully vaccinated would require a PCR test. This was informed by clinical advice that I received at the time. ARHA guidance would be informed by clinical advice, in particular from nursing colleagues such as the Chief Nursing Officer.

189. Wastewater testing was well established by the time I became Health Secretary, and was an important source of real-time information. We were receiving population-wide and country-wide data, which was helpful as it could indicate if there was an increase in infection in a particular part of the country before PCR testing would indicate a surge in cases. Wastewater testing was a very important data source that we would receive weekly or even more frequently, and I would look at it often. My recollection is that Scottish Water would collect wastewater samples from across the country, and those samples were analysed and the data presented in a regular brief to me and other relevant ministers such as the First Minister. As referenced above, wastewater sampling could be useful in helping to detect a possible surge in cases that was not yet showing through PCR results.
190. Whilst I was Cabinet Secretary for Justice, I was responsible for ensuring that there was appropriate testing in place for different sectors of the justice system. That required a basic understanding of the effectiveness of PCR tests and LFD tests, and what the pros and cons were of each of the various different types of testing. As I recall, those of us who were in Government were given briefings, from our clinical advisors, in relation to PCR testing and LFD testing and the efficacy of those technologies in the early days of the pandemic. I do not recall the exact briefing we would have received in this regard. That advice would likely have informed decisions about different testing being used in different scenarios and circumstances, such as the use of LFD tests in relation to resuming elective care as described earlier in this statement.

Supply of tests

191. Decisions about when to first make PCR tests for Covid-19 available in Scotland, and the processes / stages of the PCR test roll-out were not for me, but for my predecessor as Health Secretary. I did not have any significant role in this decision making in the early days of our pandemic response.
192. At times, when I was Health Secretary, there were a few rare occasions when decisions around prioritisation would have to be made. For example, in light of the Omicron variant, from December 2021 to January 2022 a large increase in case numbers meant there was high demand for tests. Testing availability was prioritised for those at highest risk [HY5/068 - INQ000571301].
193. Essential workers were prioritised for PCR testing, especially during surge periods. Early in the pandemic, when I was Justice Secretary, there were discussions about who should be considered essential workers for PCR prioritisation. Prison staff, probation staff, court and tribunal staff, those in the fire and rescue service, and police including support staff were all classed as essential workers. By the time I became Health Secretary, priority groups were already well-established and well-understood. As I recall, very little changed in this regard but at times of extreme surge, such as during the Omicron variant, we had to revert back to prioritising testing for essential workers.
194. PCR samples were collected primarily through test sites across Scotland operated by the UK Government. These sites included walk-through local test sites, drive-through regional test sites and three mobile testing units.
195. My understanding is that the Scottish Government planned the locations of walk-through local test sites in areas of high deprivation, low car ownership and high population density, and initially high student population, to increase testing uptake and access for the communities that most needed better access. However, the process by which decisions were reached on testing site locations would have taken place before my time as Cabinet Secretary for Health and

Social Care. Drive-through regional test sites were planned in areas of highest additional population coverage within a 30-minute drive.

196. In addition to the three mobile testing units operated by UK Government service management providers, 39 mobile testing units operated by the Scottish Ambulance Service also collected PCR tests. These were used flexibly to support access to testing for those with symptoms, and targeted community testing to support asymptomatic testing in areas of high prevalence.
197. Additionally, some local health boards and local authorities collected PCR samples as part of their community testing sites.
198. PCR home testing kits were also made available via the UK Government testing portal, allowing individuals to self-swab and return samples via courier or priority post boxes.
199. PCR testing was prioritised for those with symptoms, close contacts of confirmed cases, and those in high-risk environments, including care homes, hospitals, and key workers. NHS Scotland laboratories processed PCR tests for hospital inpatients, emergency admissions, and those requiring pre-op screening.
200. As described earlier in this statement, funding for testing was ultimately withdrawn by UK Government – a decision that was made unilaterally by the UK Government in early 2022. A number of months before the official announcement about withdrawal of funding was made, there were briefings in the press regarding the issue of funding being withdrawn for universal testing. I raised this with Sajid Javid, who at the time was UK Government's Health Secretary, and was assured that this wasn't the case. When the decision was made by UK Government, it was made without discussion with the Scottish Government or the other Devolved Administrations. As a result there were discussions to be had within Scottish Government, between me, the First Minister and the Finance Secretary, around what we would be able to fund in order to ensure a longer transition period, which we deemed to be essential. As

a result we also had internal discussions about who would be included within PCR testing, availability of PCR testing, availability of LFD testing, who would no longer be eligible for testing, and what settings to prioritise for testing. Given the very limited funding we had, the transitional phase was relatively short and we decided to take a phased approach to ending universal access to testing. This transition had a number of different phases that were detailed in the Coronavirus Covid 19: Test and Protect – [HY5/069 – INQ000235186]. The plan would have been a collective effort with initial discussions between me, the First Minister, and Finance Secretary, with appropriate Scottish Government officials and clinical advisors. The First Minister made it clear that she wanted to ensure a longer transition to end testing, based on the fact that we were still experiencing spikes of the virus and the testing regime was working well to help us identify positive cases and take the requisite action. Officials, including colleagues from finance, provided advice to relevant Ministers and we signed-off a transitional phase; officials used this sign-off to develop the Coronavirus Covid 19: Test and Protect – transitional plan. The various phases of the plan are, as per the publication, summarised below:

- **Step 1: From Mid-April – (for most people) if you are well, with no symptoms, you will no longer be advised to test twice weekly**
 - Advice to the general public to routinely test if asymptomatic will cease and access to lateral flow tests for that purpose will stop.
 - Routine asymptomatic testing in workplaces will cease (with the exception of health and social care settings).
 - Routine asymptomatic testing in education settings – schools, early learning and childcare, and universities – will cease at the end of the current term.
 - PCR tests will remain in place for anyone with symptoms with tests accessible at test sites and by post.
 - Contact tracing and support for isolation continues.
 - Positive cases will continue to be advised to isolate (though can continue to shorten their isolation period if negative on lateral flow tests on day 6 and day 7).

- Fully vaccinated close contacts will continue to be advised to test daily for 7 days.
 - Anyone visiting a care home or hospital will be asked to do a lateral flow test in advance.
- **Step 2: From End April - Transition to steady state - move from population symptomatic testing to testing for clinical care, surveillance and outbreak response**
- Move from population level symptomatic testing to targeted testing for clinical care.
 - Groups eligible for testing to support clinical care will access tests through the home order channel.
 - General public will no longer be advised to seek a test if symptomatic – at this stage we will move instead to general public health guidance to stay at home if unwell.
 - Test sites will close at the end of April.
 - Population level contact tracing, isolation and support will end and we will stop using the Protect Scotland proximity contact tracing app (but retain it for future use if required).
 - Surveillance and contingency infrastructure for outbreak response will remain in place.
 - Ongoing routine asymptomatic testing in health and social care workforces will continue – with this kept under regular clinical review.
 - Anyone visiting a care home or hospital will still be advised to do a lateral flow test in advance - though this will be kept under regular clinical review.
- **Testing Steady State**
- At the end of the transition period (from beginning of May) we will move to a new steady state for Test and Protect. This will be built around six pillars and be supported by ongoing investment in testing as part of the required health measures for the effective ongoing management of COVID-19.
 - *Testing for clinical care*

- As with all diseases, the effective clinical care of a person with COVID-19 will sometimes require testing to confirm or rule out diagnosis. Those who are eligible for anti-viral treatments now, and for those future treatments in development, will continue to be able to access testing – in the community and in hospital settings. In addition, testing may continue to be recommended in advance of certain other clinical procedures – such as pre-operative testing – in order to improve patient outcomes. Testing like this if advised as part of your clinical care will always be free at the point of need – as with all of our NHS.
- Evidence on which groups of people can benefit from, and are therefore eligible for, antiviral treatment continues to build and to be reviewed. We will always ensure testing is available to help people get the treatment they need. The current route for people across the UK to access testing for the purpose of accessing antiviral treatment is the home order channel for both LFD and for follow up PCR. This route will remain the key route for access for those in the community, with tests for those in hospital arranged by clinicians in the usual way and processed in our NHS Scotland laboratories.
- *Testing to protect those in highest risk settings*
 - Some regular asymptomatic testing – for example in health and social care workforces – will continue to be in place, alongside a range of other infection prevention and control measures such as PPE, in order to reduce the risk of the spread of infection in settings where the clinical risks of transmission are high.
 - Precise advice for different workforce groups within the broad category of health and social care will continue to evolve, based on clinical advice. For many groups, the advice will be to continue to test twice weekly with LFD tests. In general in social care, the priority will continue to be testing in long stay settings for elderly people such as residential care homes. There will also be a continuing priority in health care worker testing to support testing for hospital based staff to reduce the risk of infection spread in our hospitals.

- Similarly, there will be continued access for testing to support care home and hospital visiting, subject to regular clinical review and advice.
- *Surveillance*
 - Not all surveillance requires testing – much of the long running respiratory surveillance systems in Scotland, both in the community and in hospitals, relies on a range of measures including data from GP systems and NHS24, monitoring trends at a population level in the reporting of certain symptoms, and monitoring disease severity and patient outcomes in hospital settings.
 - However, testing will remain a critical part of enhancing this existing surveillance, to best adapt to the additional requirements of effectively monitoring COVID-19 trends and new variants. This includes ongoing random sample PCR testing through the ONS Community Infection Study, wastewater testing, and genomic sequencing to investigate variants of interest and concern when they arise. A proportion of regular testing carried out for clinical care purposes – for example, hospital based PCR testing, will also routinely be sequenced, enabling a further layer of surveillance for any emerging signals of new variants of concern.
- *Outbreak response*
 - At times, in particular as part of the investigation of potential new variants, testing will be part of the regular Health Protection led response to outbreaks of respiratory disease – which will include COVID-19 outbreaks – in settings. Public Health Scotland are leading on the key guidance to local Health Protection teams on investigating new variants of concern – the Variants and Mutations Plan – which includes clear processes on testing and contact tracing as part of outbreak investigation and response.
- *Contingency*
 - The ability to respond in the event of new variants requires contingency to be maintained across Test and Protect capabilities. This includes a core contingency of LFD stocks, Mobile Testing Units, PCR testing capacity and the ability to rapidly sequence

positive tests, and enhanced Health Protection teams in local Health Boards with retained skills in complex outbreak investigation and support from PHS experts in epidemiology.

- Sufficient LFD stocks will be held in contingency in Scotland to enable a rapid increase in the intensity of targeted testing if required in the event of a new variant of concern. This contingency would assist in adding to layers of protection that may need to be enhanced, in particular around high risk closed settings. Contingency stocks will be sufficient to enable two months of additional enhanced testing, which also enables time to procure additional testing if required. In addition, to support the investigation of new variants, a contingency fleet of ten Mobile Testing Units will be maintained, and ongoing access to a reduced UK wide network of PCR testing will be retained.
- We will also keep the daily case rates, hospital data and other key indicators under close review over the transition period and retain the option – subject to clinical advice – of being able extending symptomatic testing beyond the end of April (using lateral flow tests) if the pandemic circumstances require this.
- *Legacy*
 - In the two years since the pandemic started Scotland has invested significantly in diagnostics and in wider health protection measures to support the Covid response. There will continue to be activity to build on this testing legacy to support wider population health goals.

201. In the period from March to June 2020, I was Justice Secretary. As such, decisions about eligibility for and prioritisation of PCR testing during that period were largely not for me to make. My decisions were focussed on the justice system and ensuring that those within the system who I felt should be designated as essentials workers were so designated.

202. I was also responsible for ensuring there were appropriate testing regimes in place in the prison system, which is a unique environment that was very

conducive to the spread of viral infection given the capacity issues that exist in prisons and the fact that prisoners have to be kept in relatively confined spaces.

203. In my role as Health Secretary in particular, I worked with local councils, health boards and those involved in civil contingencies such as Ready Scotland on a regular basis. I usually worked with them through regular meetings; I met at least weekly with health boards and local councils, and when there were civil contingencies issues stemming from Covid-19 that we had to deal with the necessary conversations would take place via SGORR. Discussion with those bodies specifically about the planning, policy-making and roll-out of testing would have taken place before my time as Health Secretary. I did, however, have conversations with local stakeholders about the phasing out of universal testing, how that would be implemented, and the transition period.
204. I found engagement with those partners to be effective. Conversations took place and there was a trusting relationship, to the point that where there were issues we knew that local councils or regional health boards would have the confidence to raise them with officials, or where necessary directly with Ministers. In relation to the roll-out of testing I certainly never got the impression that anybody was holding back from telling us about any challenges that they were experiencing in regards to any element of our response to the pandemic, including the Test and Protect system.
205. Most of the concerns raised with me from local government were usually in relation to funding. They had, with some due cause, concerns that decisions made by the Scottish Government would add to their financial burden. At some times we were able to offer additional funding, but at other times that simply wasn't possible due to our own budgetary constraints. This would ultimately be a judgement and decision for the Finance Secretary to make, while weighing up a number of other budgetary pressures.
206. There were regular discussions about testing between Scottish Government and the other devolved nations, although by the time I became Health Secretary they didn't particularly focus on eligibility because by that time

eligibility was well-established. As mentioned earlier in this statement, I participated in discussions about the UoG Lighthouse Laboratory and whether or not there would be appropriate investment to make that a permanent laboratory and whether the UK Government would fund it as such. There was a period whilst I was Health Secretary when discussions were ongoing between UK Government and UoG about contracts to ensure that the funding of the UoG Lighthouse Laboratory would continue. The decision not to stop funding entirely but to significantly reduce the funding was, again, made by the UK Government and not in consultation with me. Concerns were raised by the trade union UNITE about significant job losses that would accompany UK Government reneging on their commitment. I raised this issue with UK Government at the time. A lot of the discussions and challenges about the Four Nations approach were related to funding rather than eligibility and prioritisation.

207. As described earlier in this statement, the main topic about which I had discussions with counterparts from the other nations was funding and the UK Government's unilateral decision to withdraw funding for testing.

208. While decisions about eligibility and prioritisation were made before the time I was Health Secretary, my understanding is that there was little in the way of significant differences in regards to eligibility and prioritisation for testing across the four nations. Scotland's unique remote, rural and island geography did at times require a difference in approach to testing in some parts of the country, but again these were relatively minor differences.

Sector testing

209. A chronology setting out the main Scottish Government decisions, policies and strategies in relation to Test and Protect during the relevant period, including in relation to sector testing, is provided earlier in this statement.

Testing of healthcare and social care staff

210. I took on the role as Cabinet Secretary for Health and Social Care in May 2021. The Test and Protect system was well established at this point. However, relatively minor changes were made during my time as Health Secretary, which usually related to surges of the virus, emergence of a new variant or unilateral decisions made by the UK Government such as the end of population-wide testing. Some changes could be 'signed off' by senior clinicians and they would often be flagged to me should I wish to provide any comment, such as the decision to move the healthcare workers testing programme to a 'business as usual' approach in June 2021.
211. I led the Scottish Government's response, alongside the First Minister, to the emergence of the Omicron variant. For all intents and purposes, the First Minister was the Minister within Government who took lead responsibility for our response to Covid. This leadership from the front was demonstrated by the fact she held hundreds of daily briefings during the period in scope of this Inquiry. However, in terms of the day-to-day operational responsibility for the response to the Omicron variant, I was the Cabinet Secretary charged with that task. For example, ensuring we gave a booster vaccine to as many eligible adults by the end of the calendar year as possible was my operational responsibility, but the First Minister would regularly check-in on progress, and also reiterate, during her daily briefings, the need for the general public to get vaccinated. As news of Omicron first emerged, our understanding of its transmissibility, impact and immune escape was very limited. However, early data was showing that Omicron had a high rate of transmissibility. As such we increased the frequency of testing for healthcare workers from twice-weekly to daily testing.

Testing in the justice system

212. Schedule 4 of the Coronavirus (Scotland) Act 2020 [HY5/075 - INQ000571767] relates to Justice matters. I was involved in developing and ensuring passage through the Scottish Parliament of that legislation, and was the main decision-maker in the Scottish Government for these provisions.

213. The legislation focussed on a number of key areas, including:

- the Courts and Tribunal Service;
- Community Payback Orders;
- The parole board;
- Legal Aid provisions; and
- release of prisoners.

214. The issue which garnered most attention was one that ultimately we decided not to proceed with, largely given the scale of the opposition to it from opposition political parties, but also from a number of legal stakeholders. This was the provision to make accommodation for juryless trials in some instances.

215. The issue in the legislation that gained the most attention in Parliament was that of prisoner release. The Coronavirus (Scotland) Act 2020 allowed for certain categories of prisoners (with specific exclusions listed) to be released earlier than their previous release date, if there were sufficient concerns in relation to the health, safety and welfare of prisoners. In total, 348 prisoners were released early in this regard.

216. As Justice Secretary I had conversations with the then-Health Secretary around who I believed should be prioritised in relation to, for example, PCR testing, and was pleased that there was agreement between Jeane Freeman and I about who in the justice system should be prioritised if necessary. I am pleased that under the category of Essential Workers, prisons, probation, courts and tribunals staff, judiciary, police and support staff, fire and rescue service employees including support staff, National Crime Agency staff, those maintaining border security, British Transport Police were all prioritised for PCR testing.

217. As the pandemic progressed, attention turned towards balancing the risks to public health with the operation of justice. Operational delivery partners, like the SCTS, took decisions based on an assessment of these risks and the available

mitigations (such as the availability PPE, testing regimes and advice on distancing and room capacity) to inform the court programme and operations. These decisions and reviews were linked to advice from the Scottish Government more generally and the state of the pandemic as the country entered the levels system and localised outbreaks and hot spots were managed with local restrictions.

218. As I recall, LFD tests were primarily used in helping us when it came to restarting the justice system and to address the backlog of cases that were building up as a result of the pandemic.

Prisons and YOIs

219. The response to the pandemic in prisons, including testing, was led by the SPS, in partnership with the Scottish Government, NHS, PHS and other partners. In early 2020, while I was Justice Secretary, SPS established a National Coronavirus Response Group with PHS. This group implemented a national pandemic plan across the prison estate, keeping plans under consistent review with health partners. The National Prison Care Network played a crucial role in working with local NHS partners and SPS to facilitate national co-ordination, develop consistent approaches and co-ordinate communications between partners.

220. Following national policies, anyone in custody displaying symptoms was asked to self-isolate. Similarly, prison staff displaying symptoms were advised to follow the national advice and self-isolate. Clinically-led protocols for the management and care of those who had contact with or was suspected of contracting Covid-19 were in place. SPS also aimed to ensure all new admissions to custody self-isolated for seven days before moving into the main prison population.

221. From September 2020, everyone in prison who displayed symptoms of Covid-19 was tested to determine whether or not they had the virus, consistent with the wider community. All health board areas provided testing of those in

custody when symptomatic in order to prioritise treatment and ensure that prisoners were only required to self-isolate when it was absolutely necessary. All prison staff were able to access the drive-through testing sites in Glasgow, Edinburgh, Aberdeen and Inverness.

222. SPS' 'Test and Protect in a Custodial Setting Guidance' was published in September 2020 [HY5/093 – INQ000475011], and was reviewed in line with Scottish Government developments. This guidance was reviewed on a regular basis.
223. With implementing 'Test & Protect' in the prison setting this did result in high numbers of individuals being isolated when an outbreak occurred, which may have reduced the spread of Covid-19. However, this also resulted in individuals potentially being in and out of isolation frequently.
224. In October 2020, it was agreed that a mobile testing unit would be deployed to HMP Barlinnie to get better control of the situation, to understand how the virus was spreading within the prison, and to support future planning for management of any cases. Tests were initially offered to all staff and individuals in E Hall and part of D Hall as these were the areas most affected. There was considerable uptake of these voluntary tests. The opportunity to be tested was extended to B and C Halls, although there were not the areas of initial infection.
225. In November 2020, in response to the second wave, the Clinical Advisory Group for Prisons ("CPAG") was established to ensure the prison service was provided with strategic national clinical and public health advice in response to Covid-19. In July 2021, the first prison specific guidance was published by Public Health Scotland, co-produced by PHS, ARHAI Scotland, SPS and NHS National Prison Care Network Chair.
226. In spring 2021, the Prison and GEOAMEY Testing Board was established under the remit of the National Testing Programme Board. Following recommendations from CPAG, it oversaw six asymptomatic testing pathways

between June 2021 and November 2021 (although at this point I was no longer Justice Secretary):

- SPS staff PCR pathway offering weekly PCR testing at SPS sites;
- private prison staff LFD pathway (this was a separate pathway due to legal barriers to PCR testing in private prisons);
- admissions testing PCR / LFD pathway enabling testing on day one and day seven or eight of admission;
- prisoner LFD pathway broadly in line with the 'universal' public offer in community;
- staff LFD pathway allowing staff to access twice-weekly LFD testing in addition to weekly PCR testing; and
- prisoner visitor LFD pathway which provided LFD tests to prison visitor centres.

227. Testing of individuals in SPS' care was the responsibility of NHS Scotland. However, in Spring 2022, SPS staff were tasked with observing LFD tests taken by prisoners to allow for early release from isolation following a negative test result, which involved implementing a process of recording.

228. Testing and isolation of close contacts / households ended in July 2022 as part of SPS' Transition Plan which meant that large numbers of prisoners who were previously designated as close contacts no longer had to isolate. Testing to end isolation early also ceased in July 2022, however symptomatic testing continued until September 2023 before a pause was agreed. Identifying cases, while having a limited availability of tests, was still important in a higher-risk environment, like our overcrowded prison estate. As a result, while restrictions were already lifting in the community, and in line with revised Public Health Scotland prison-specific guidance, SPS continued to isolate those symptomatic prisoners who were testing positive for at least five days. Those who were symptomatic, but refused testing, were also isolated.

229. In early 2023, Ministers made the decision to pause asymptomatic admission and transfer testing in prisons.
230. In July 2023, testing across healthcare, social care and prison settings was reverted to the pre-pandemic approach to infection testing per the National Infection Prevention and Control Manual.
231. As stated earlier in this statement, police officers and staff, and fire and rescue workers were prioritised for PCR testing. I do not recall Scottish Social Services Council staff being prioritised for testing.

Justice Directorate engagement

232. The main forum for engagement on the Covid-19 response between Scottish Government and key justice stakeholders was the Justice Board Coronavirus (Covid-19) Sub-Group (“the Sub-Group”). The Sub-Group collectively discussed the operational challenges and response to the pandemic as a whole and did not focus on Test and Protect matters specifically.
233. The Sub-Group was established on 02 March 2020 in response to the Covid-19 outbreak. Its purpose was to oversee and manage the collective justice system response to the virus outbreak. Recognising the dynamic and at times urgent nature of the response to the outbreak, the Sub-Group was tasked with:
- sharing the preparedness of each organisation, including their business continuity planning;
 - establishing the preparedness of the justice system as a whole;
 - seeking to build a common understanding of the implications and potential impacts of the virus on the justice system;
 - providing a forum for member organisations to collaborate and share information and updates;
 - working together to address the challenges and risks the virus poses to the justice system;

- engaging where appropriate with Scottish Government resilience colleagues to obtain their views and to keep them informed of the justice system response; and
- reporting to the Justice Board following each meeting of the Sub-Group, including where appropriate making system-level recommendations.

234. The Scottish Government chaired and provided secretariat to the Sub-Group, whose membership was as follows:

Organisation	Member
SG (Chair)	Willie Cowan
SCTS	Noel Rehfisch
COPFS	Robert Green
SPS	Stephen Coyle
Police Scotland	Roddy Irvine Garry McEwan
SFRS	John Dickie
SCRA	Paul Mulvanny (sub is Susan Deery)
SPA	Darren Paterson
SLAB	Rachel Anderson (sub is Colin McKinnell)
Community Justice Scotland	Bill Fitzpatrick

235. The Sub-Group met regularly, including weekly throughout 2020. The last meeting of the group was in September 2022.

236. Senior justice leaders met on a regular basis through the Justice Board and Criminal Justice Board forums. These meetings covered an array of topics, not always explicit to Covid-19 or Test & Protect.

237. The Justice Directorate, through the Safer Communities and Justice Directorate (SCJD) Covid-19 Hub, provided daily briefings for Justice Ministers that provided updates from justice partners on a range of Covid-19 matters / known and emerging issues.

238. Where required clinical experts were invited to present to the Sub-Group members.

239. From my recollection there was good engagement between the Justice Directorate and PHS when and where required.
240. The NHS in Scotland is responsible for providing healthcare in prisons, so there would have been very regular discussions between Justice Directorate and the NHS in relation to the health of prisoners and those within our care, including young offenders. There were also discussions between Jeane Freeman and me in relation to prisoner healthcare at the time she was Health Secretary and I was Justice Secretary.
241. There was significant engagement, input and cooperation between the Justice Directorate and the Crown Office and Procurator Fiscal Service in relation to restarting the justice system and addressing courts backlog. I would have regular discussions with the Lord President, Lord Justice Clerk, the Chief Executive of SCTS, Lord Advocate, Solicitor General and other senior officials within both the SCTS and COPFS in relation to ensuring the justice system could continue to hear cases during the course of the pandemic. As you would imagine, some of those conversations would include the appropriate testing regime in place.
242. There was official engagement between the Justice Directorate and the private sector operators in the justice system, such as Serco and G4S, in relation to ensuring that they were aligned with our testing regime.
243. There was likely engagement between Justice Directorate and the Border Policing Command when we were making decisions about those arriving into the country from red and amber list countries, the testing regimes that were in place for people to come out of isolation, and Covid-19 hotels, etc. However, the vast majority of engagement with Border Policing Command would have taken place via Police Scotland in relation to the day-to-day operational challenges.

244. In my view, the collaboration in relation to testing between the bodies described above and the Justice Directorate was very good. The relationships between government officials, and colleagues within various justice bodies was already well established, and for the most part worked very well. Everyone had a shared goal: we wanted to ensure the wheels of justice continued to turn, despite the challenges Covid-19 presented. While the design of the testing regime was ultimately for Government, and specifically for the Health Secretary and First Minister to decide upon, feedback could be provided by partners which could be shared with Cabinet by the appropriate Cabinet Secretary.
245. Early in pandemic, the Cabinet Secretary for Health and I issued a joint letter to NHS Board Chief Executives and Integration Joint Boards relating to the treatment of prisoners with Covid-19, and I made a statement to Parliament setting out how the prison service was responding to the emergency situation. Issues around Test and Protect would have been in contemplation at that time.
246. As I recall, I was very worried about the overcrowded environment within prisons. We had already seen in some parts of Europe, specifically Italy, very concerning images and concerning data about the spread of the virus in prison environments. It was vital that I did what I could to try and alleviate the pressures and ensure we had an appropriate testing regime to identify positive cases and isolate them. These issues were being dealt with before we had a vaccine, so we were working with a virus that was making people very unwell and at its worst killing people. The virus impacted prisoners, but also prison staff and their families.
247. I wanted to try to make sure that those in our care were able to in some way have visits with their families with appropriate testing regimes in place, because one of the key factors in rehabilitation and reducing reoffending is prisoners wanting to reform for the sake of their family and in particular their children. That was not possible in the early days of pandemic, so we introduced mobile telephones that prisoners could use to keep in touch with their families, with appropriate safeguards so that they could not be readily abused.

248. While I do not recall the details of the exact briefing at the time, I am certain that I would have been provided with advice in relation to how we could facilitate visits, and what testing regime should be put in place to help mitigate any risks of the spread of the virus.

249. I have already stated my concerns around asymptomatic testing in prisons, the mobile testing unit I requested, and the fact the results were flagged with both the Health Secretary and National Clinical Director at the time.

Testing, borders and international travel

250. As stated in my statement for Module 2A of the Inquiry, paragraph 310, due to the success of the vaccination programme at the time and the need to simplify the traffic light system for international travellers, on 18 September 2021 the Scottish Government announced that the green and amber lists would merge. Unlike England, Scotland announced that there would be no changes to the rules regarding Covid tests for returning travellers as we felt there was no public health justification for doing so, and that testing remained an important source of surveillance information in terms of emerging variants. It is fair to say that I am not sure that we fully understood the UK Government rationale for changing the testing rules for returning travellers in England. The Scottish Government issued a press release on 17 September 2021 describing these changes [HY5/076 - INQ000571768].

251. The rationale for maintaining Covid-19 tests for returning travellers would have been based on the clinical advice received at the time.

252. The decision to move away from a red-amber-green risk rating system was made on a Four Nations basis and reflected the successful global rollout of vaccination programmes at this stage in the pandemic, shifting from assessing the risk of arrivals from given countries to assessing the risk of individual travellers based on their vaccination status (where the traveller could demonstrate vaccination with a specified vaccine product, through a form of certification recognised in the relevant regulations).

253. Removing the green and amber country lists and recognising vaccine certification from additional countries continued a process already in place, as travellers from, for example, the EU and USA were already treated in effect as 'green' arrivals on entry from an 'amber' country if they were able to demonstrate their vaccination status. The 'red' list remained in place for the highest risk countries where there was evidence of a variant of concern, with enhanced restrictions including the requirement for managed isolation. Those changes were to come into effect from 04 October 2021.
254. At the same time as announcing list changes, the UK Government announced their intention to, in the near future, change the testing requirements for fully vaccinated travellers arriving in England – to remove the requirement for pre-departure testing, and to lower the diagnostic standards required for the 'day two' test specified in the regulations so as to permit LFD testing in addition to PCR tests. This announcement was made unilaterally by the UK Government without Four Nations agreement and without prior consultation.
255. While I do not recall the detailed advice, I do recall that clinical and policy officials reflected concern to Scottish Ministers about the adequacy of these new testing requirements at limiting the risk of importation of new variants.
256. Pre-departure testing was the first testing requirement implemented in the international travel regulations, in January 2021. It provided a screening effect by removing a proportion of Covid-19-positive travellers from the cohort of international arrivals in the UK. The day two test was introduced in February 2021, along with a day eight test requirement (which had already been lifted for 'green' arrivals but remained for 'amber' and 'red'). This was required to be, in practice, a PCR test (although some higher-end lateral flow devices met the standard specified in the regulations); for individuals in managed isolation, positive tests were prioritised for genomic sequencing to monitor for variants of concern. Mass-market LFD tests (including those freely available from the NHS) did not meet the diagnostic standard in the regulations at that time, and did not capture a sample that could be sequenced.

257. The UK Government would later announce on 15 October 2021, again unilaterally without prior consultation or notification on a Four Nations basis, that the change on testing requirements would come into effect in England on 24 October 2021. The Scottish Government ultimately decided to align with the testing requirement changes, as did Wales and Northern Ireland. The change to day two testing came into effect in Scotland on 31 October.

258. The First Minister, in a statement on 21 September 2020 [HY5/087 – INQ000475046], described the balance of considerations Ministers faced:

“The UK Government has also announced that for people travelling to and from England, it intends to change the requirements on taking tests before and after international travel. Scotland – like Wales and Northern Ireland – has not yet taken a final decision on this, though we will do so within the next couple of days.

We do have real concerns about easing the requirements on tests. That’s because we still need to guard against new variants of the virus being imported into the country, and also have a way of identifying quickly if a new variant does enter the country. Testing – both before someone’s departure to travel to Scotland, and soon after their arrival – can help us to do that. Without that, we will have much less ability to pick up the presence of new variants.

We also believe that the PCR tests – and other highly sensitive tests – currently required for testing, are more effective at guarding against the risk of new variants than alternative tests. They are more likely to identify positive tests than most lateral flow tests – although lateral flow tests are valuable – and PCR tests also make it easier for new variants to be sequenced and identified.

However, on the other hand in terms of this consideration, we also fully understand and agree with the desirability wherever possible of

adopting a Four Nations approach to travel restrictions. And we have to recognise the reality, however difficult this may be for us, that if Scotland adopts more stringent requirements than England, then people living in Scotland, who want to go abroad, may decide to fly from airports based in England. In those circumstances, we would potentially face the economic cost of stricter travel rules, without gaining enough public health benefit to justify that cost.

So we must weigh up the public health risks of making this change – and I will be discussing this further with the Chief Medical Officer – with the pragmatic considerations I have just frankly set out and the understandable concerns of the travel industry. It's not an easy decision and will have implications either way.”

259. The lack of prior Four Nations discussion or notification by UK Government of proposed changes to testing requirements is recorded in contemporary advice to Ministers.
260. A written ministerial statement from Welsh Government on 17 September 2021 [HY5/077- INQ000571769] presented a similar position to that of Scottish Government: agreement on country changes being reached on Four Nations basis, but considering their position in response to UK Government's announcement on testing.
261. A press release from Northern Ireland Department of Health on 18 September 2021 [HY5/078- INQ000571770] was similar: there was agreement on country changes, but testing changes were still to be discussed.
262. We generally tried to maintain a Four Nations approach for lots of reasons, because pragmatically it made sense to do so. As Justice Secretary, I was Scottish Government's delegated Minister to attend calls with UK Government about red list countries.

263. It's fair to say that a Four Nations approach to decisions about international travellers and red lists, etc. was largely maintained, but this was not always the case. If the UK Government took a decision not to include a country in the red list, it was difficult for any other nation to include it because there was no way of preventing people from travelling into an English port and then coming to Scotland. We would not only lose the health protection impact of the red list, but our travel sector would also be negatively impacted. As such, there was a 'double whammy' of negative impacts if a country was not on the UK red list, but was on ours. Although Scottish Government had autonomy in this regard, if UK Government wanted to take a country off their red list then it would be difficult for us to depart from that.
264. There were some instances when we kept a country, for example Spain, on our red list despite UK Government having taken them off theirs, because we absolutely felt that the data required us to do that. In this specific instance, the UK Government did, after a few days, put Spain back on their red list.
265. I do not recall any occasions when Scottish Government wanted to take a country off the red list and persuaded the other governments to take the same approach. My recollection is that we and the other Devolved Administrations were more likely to be trying to put countries on the red list than have them taken off, in part due to concerns that there was a desire to reopen the tourism and travel sector far quicker than we felt could be done safely.
266. Consideration of potential screening measures, such as temperature testing at airports, for international travellers and arrivals sat within the transport portfolio rather than the justice portfolio. As such, any discussions about screening at airports, etc. would likely have involved the Transport Secretary rather than me. However, as I recall there was discussion about whether more than temperature testing could have been done, however, there was, at the time, a lack of data in relation to its effectiveness. A further option that I understand was explored was the use of digital health tools, for example an app that travellers would use to confirm that they didn't have Covid-19 symptoms. Other

countries used that approach, but ultimately we didn't have digital infrastructure to do so.

267. The restrictions and requirements that were put in place on travellers were:

- providing information on travel history prior to arrival in UK (June 2020);
- self-isolation on return to UK (June 2020);
- providing a negative test result prior to departure for UK (January 2021);
- requirement to enter UK at specified ports (February 2021);
- refusal of entry to UK for red-list travellers without right to reside (February 2021). (This was a reserved power implemented by Border Force using existing immigration law; all other measures implemented in devolved regulations.);
- requirement to enter managed isolation for high-risk arrivals (February 2021); and
- requirement to take day two and day eight tests after arrival (February 2021).

268. Some of these requirements were reduced or removed depending on a risk assessment, either of countries the traveller has recently travelled through, or of the vaccination status of the traveller; or because of exemptions specified in the regulations, e.g. for national security and state affairs, critical national infrastructure, essential supply chains for food and medicine, etc..

Testing in care homes

269. A chronology of key decisions in relation to testing has been provided earlier in this statement, and decisions in relation to testing in care homes during my time as Cabinet Secretary for Health and Social Care can be seen from that chronology.

270. In the early days of pandemic my involvement in decisions made regarding testing in care homes was very limited. Those decisions were for the Health

Secretary and the First Minister to make. There were Cabinet discussions about the issue, but the detail and development of policy was for the Cabinet Secretary and the First Minister, who took a very active involvement.

271. It was clear to those of us in Cabinet, from clinical advice provided by the CMO and NCD, that older people were more susceptible to the worst impacts of the virus. As such, serious and detailed consideration was given to the question of what testing in care homes should look like, and our position on that evolved over time as data changed. For example, we moved from routinely testing symptomatic people to routinely testing asymptomatic people upon discharge from hospital.

272. When I became Health Secretary and assumed overall responsibility for social care, the testing protocols in place in care homes, and across the social care landscape, were well-established. Those included testing upon discharge from hospital, testing of care home staff, and testing residents. Although those protocols were well-established by that point, that is not to say there were not changes and updates to guidance during my time as Health Secretary. For example, when Omicron became a variant of interest and then became widespread we were still unsure about its severity, transmissibility, and ability to evade the vaccine. As such, additional guidance and advice was sent to care homes. In summary, that guidance said that we expected adult care home staff to take a daily LFD test on workdays and all other social care staff to take a daily LFD test, particularly on days when they were working with vulnerable or potentially vulnerable people. The guidance also advised that all social care staff should consider taking LFD tests on non-working days if they were socialising.

273. During my time as Health Secretary, the key critical decision to be made in relation to Test and Protect was off the back of the announcement by UK Government that they would withdraw funding for universal testing. I had discussions with the Finance Secretary and the First Minister, and with Cabinet, about what we wanted to do, what we could afford to do, and what our plans were. A transition plan was put in place which provided for a slightly longer

transition than the UK Government had put in place for England. That allowed for a longer lead time to phase out universal testing and then begin to plan further phases of testing and withdrawal, given there was only a limited amount we could do due to UK Government's unilateral decision.

274. The decision to maintain routine testing for those being discharged from hospital into care homes after the transition away from mass population testing in 2022 would have been part of the discussions I would have had with clinical advisers including the CMO, CNO, and NCD. Such decisions were always based on the higher risk to the elderly population in the care home environment.
275. The care home environment and in particular the adult care home environment is, by its nature in terms of who is cared for therein, particularly high risk. We wanted to make sure that we minimised the risk as much as possible because of the vulnerability of the people residing in care homes. Whilst routine testing had to be phased out for the rest of the population due largely to the UK Government's funding decision, maintaining testing for those discharged from hospital for as long as possible was important due to the significant risk that Covid-19 posed for those in care homes. We were always more risk-averse in relation to the care home environment than we were in relation to the general population as a whole.
276. Scottish Care previously expressed the view that "the lack of testing in care homes where there were no known Covid-19 positive individuals resulted in failure to adopt a preventative approach to the potential spread of the virus in an area where there was known to be high community transmission." As previously stated in my statement for Module 2A of the Inquiry [INQ000273956], paragraph 360, in response I would again refer to the fact that in the early stages of the pandemic we did not have the scientific understanding about the virus and its transmission that we have now. If a different approach had been taken earlier then it may have had a different impact on the spread of the virus, but I reiterate that we could only work with the clinical advice that was available to us at the time.

277. I have also made reference in previous statements, including in my Module 2A statement, paragraphs 359-360, and am happy to reiterate again, that we could have potentially introduced such testing earlier than we did, given some of the international evidence about asymptomatic transmission that was emerging. As I recall, there was a period early in the pandemic when we were being pushed by some members of the opposition to consider testing for all patients discharged from hospital to care homes.

Scaling back of testing

278. I have described earlier in this statement the impact of the UK Government's decision to end universal testing for Covid-19 from April 2022.

279. I have also discussed this issue in previous statements. In my statement for Module 2A [INQ000273956], paragraph 82, I explained that the UK Government was responsible for some significant areas of funding and budgeting which affected the management of the pandemic in Scotland. This included funding related to the furlough scheme, testing and vaccination. For instance, in early 2022 the UK unilaterally announced it would stop population testing for Covid-19 in England from April 2022, in most circumstances. This significantly reduced the available consequential funding for the Scottish Government and constrained the Scottish Government's ability to decide on the length and nature of transition of the Test and Protect scheme. While the Scottish government did continue to fund testing in Scotland for a short period, the lack of budgetary capacity or required borrowing powers meant that the Scottish government had little choice but to also transition away from mass population testing. I raised these concerns publicly and with the UK Government.

280. In my statement for Module 3 [INQ000480774], paragraphs 27-32, I explained that although I generally had a good working relationship with Ministers in the UK Government, there were, naturally, some challenges. These challenges could have a material impact on our ability to respond to the virus such as on

testing. For example, the UK Government would far too often make decisions unilaterally that would have a direct impact on healthcare systems in Scotland and their ability to respond to Covid-19. One instance of this is when the UK Government decided to scale back the Test and Protect scheme without first consulting the Scottish Government. Funding for Test and Protect came from the UK Government, so while the Scottish Government was able to fund the scheme in Scotland for a few extra weeks from its own budget, it ultimately ceased earlier than the Scottish Government would have liked. Similarly, the UK Government decided unilaterally to withdraw support for businesses. Another impact of these challenges that existed between both governments was the mistrust that was created between the two governments as a result of these tensions.

281. I continued in my Module 3 statement, paragraph 44, to explain that there were instances when I read stories in a national newspaper that looked, on the face of it, like UK Government briefing about an imminent change to its approach in a particular area. I recognised that if a change in approach was indeed coming then it would have a knock-on effect in Scotland, usually in respect of funding but indirectly on the Scottish healthcare system's ability to respond to the pandemic. However, it was not possible to know for sure where newspapers obtained such stories, as the UK Government had not consulted the Scottish Government about the proposed change. One such example involved a story in The Times newspaper, which suggested the UK Government was imminently proposing to withdraw access to free lateral flow tests [HY5/079 - INQ000480777].

E. TEST AND PROTECT

Overview

282. As stated in my statement for Module 2A of the Inquiry, the rationale behind the Test and Protect scheme, launched on 26 May 2020, was to identify individuals with Covid-19 in order to take preventative measures to limit the spread of the virus. I am not aware of why it was not launched until that date, but I

understood from Cabinet discussions that the scheme was contingent upon a reliable diagnostic test being developed and available at scale and the testing infrastructure being put in place, both of which required time. The initial development of Test and Protect (assumed to cover the period up to the end of May 2020) was first shaped by the UK Influenza Pandemic Strategy 2011. The UK Government, in collaboration with the Scottish Government, Welsh Government and Northern Irish Executive, developed the UK Influenza Preparedness Strategy 2011, which aimed to reduce the impact of a potential influenza pandemic on the population. This strategy provided a general framework for responding to pandemics. As health is devolved in Scotland, the Scottish Government developed its own strategy to respond to Covid-19.

283. The establishment of Test and Protect is noted in the chronology that can be found earlier in this statement.
284. The purpose of Scotland's Test and Protect system was, in simple terms, to ensure appropriate access to testing was available in order to help identify cases of Covid-19 and help people, particularly in the early days of the pandemic, to appropriately isolate or take other preventative measures in order to prevent the further spread of the virus. All of this was to stop harm to our people, institutions and country, as per the Four Harms approach.
285. As described earlier in this statement, my role in relation to Test and Protect in its infancy involved being part of Cabinet discussions as opposed to leading the creation and development of Test and Protect. In those early days, decisions about the system and its roll-out would have been made by Jeane Freeman and Nicola Sturgeon in light of clinical advice. When I became Cabinet Secretary for Health and Social Care, the lead responsibility for Test and Protect transferred to me. While the system was well established at that point, it continued to evolve and new guidance was issued. Key developments usually centred around a variant of concern such as Omicron being identified, or the need for putting in place appropriate testing infrastructure for large-scale events such as COP26 and the Euros Fanzone. It was during my time as Health Secretary that the decision was made by UK Government to withdraw funding

for universal testing, which impacted our plans and meant that I had to make a decision, in consultation with the Finance Secretary and of course First Minister on phasing out universal routine testing, and the accompanying transition period.

286. Test and Protect was delivered by a range of partners, both at the national and local level. The programme itself was a collaborative effort between the Scottish Government, local health boards, National Services Scotland, PHS and local authorities. Ultimately, Scottish Government Ministers, primarily the Cabinet Secretary for Health, had lead responsibility within Government for the Test and Protect system.
287. A number of different fora existed in order for partners to come together and discuss the Test and Protect system, such as the Test and Protect Steering Group, Test and Protect Oversight and Assurance Board, and Testing Transition Board.
288. Test and Protect's integration with Scotland's domestic testing capacity was already established by the time I became Health Secretary. It was during my time in that role that we introduced the Covid-19 certification scheme, whereby in the absence of a vaccine people could present a negative LFD test result. That development had to be incorporated into the wider Test and Protect scheme.
289. Test and Protect's methods of data collection and data sharing were already established by the time I became Health Secretary and I do not recall any significant developments or changes in this regard.
290. The Scottish Government's Future Pandemic Preparedness programme is ensuring appropriate learnings are identified from our response to the pandemic. This will better equip us for when the next, and future, pandemics are identified.

291. Each Cabinet Secretary and Minister of the Scottish Government has a collective responsibility to learn the lessons identified in their specific portfolio areas, in relation to the Covid-19 pandemic. The Inquiry (and the Scottish Covid Inquiry) will help identify those lessons, including in the Test and Protect system, which will be hugely helpful in planning for a future Test and Protect system.
292. Communication with other devolved nations in relation to the development of their tracing apps, including discussions on app interoperability and data sharing, would have taken place before I held the Health portfolio.

Working with other bodies

293. As I understand it, there was regular engagement with key stakeholders and key partners, including local resilience partners, in relation to the planning and roll-out of Test and Protect. I would not have been involved in these early discussions as they would have been led by the then Health Secretary, Jeane Freeman. Ultimately the Scottish Government made decisions about policy-making and roll-out of Test and Protect, but there was regular discussion between the relevant Ministers and key partners. I know from the time when I was Justice Secretary that there were regular discussions between me and, for example, the SPS and Police Scotland in relation to testing policy and particular intricacies and nuances that we had to factor in when it came to testing in prisons or amongst police officers and staff. That was my experience as Justice Secretary, and I am quite confident that a similar approach would have been taken by other Ministers and their key partners.
294. Some partners, such as Scottish Care, suggested that we could have begun testing asymptomatic patients discharged from hospital into care homes earlier than we did. We ultimately did adopt that approach, but there were certainly calls for us to do so before we introduced that measure. I was not Health Secretary or First Minister at the time, but we would have been guided by the scientific and clinical advice that we were receiving at the time. Nonetheless, it was right for partners to ask such questions.

295. The effectiveness of cooperation between the Scottish Government, health bodies and local authorities in relation to the implementation of Test and Protect is, in my view, demonstrated by our record. Some key Test and Protect achievements towards the end of the relevant period (as at 22 April 2022) were:

- increasing test site access and bringing 99% of Scotland’s population within a 30 minute drive, and more than a third of the population within a 30 minute walk, of a fixed site;
- collecting nearly six million PCR samples at test sites for onward processing at laboratories;
- more than 27 million lateral flow test results being reported, and more than 800,000 positive lateral flow test results being identified;
- more than 16 million PCR results were processed at laboratories, and the median PCR turnaround time was 22.5 hours;
- contributing to uploading over two million sequences on the global data sharing initiative GISAID, making the UK number two globally for sequences uploaded; and
- contact tracing more than two million unique contacts and asking them to self-isolate, and offering self-isolation support to a quarter of a million people.

296. This list of achievements is drawn from a number of sources, but was not published in a single document or paper. The achievements were however listed as part of a thank you letter that was issued by the First Minister and I (on 22 April 2022) to recognise the efforts of test site staff and volunteers during the pandemic [HY5/094 – INQ000475012]. Further achievements are drawn from the 21 December 2022 letter I wrote to members of the Test and Protect Transition Board.

297. The Four Nations approach that was taken in relation to testing and test, trace and isolate schemes worked quite well. An example would be the sharing and loaning of tests when one nation was running low. For the Scottish

Government, that worked both ways: we provided the UK Government with tests, and at times they provided us with tests. Similarly, the nations cooperated if there were testing equipment failures, for example if there were failures in England and that required some tests to be processed in Scotland or vice versa, we were able to have that discussion and have the resilience in place to cope. Cooperation of that nature worked well and, in my opinion, was effective.

298. As described in the Scottish Government Director General for Health and Social Care statement for Module 5 [INQ000498141], paragraph 410, there was a memorandum of understanding in place relating to testing and laboratories that allowed devolved nations access to Four Nation / UK Government procurement frameworks and contracts, which were likely to have been less cost-effective and more time-consuming to establish separately. The validation and assessment of new technology was conducted on a Four Nations basis, where the validation was carried out by PHE Porton Down and the results and analysis shared with devolved governments. Colleagues in NSS's National Laboratories Programme also undertook comparator validation on LFDs for reassurance. Devolved governments and their Ministers could also request to opt out of a significant procurement in a particular technology and receive equivalent funding calculation according to the Barnett Formula, or an alternative technology.

299. As described earlier in this statement, we were ultimately reliant on UK Government for funding for testing: they decided how much funding we would receive for testing, and when that ended.

300. As described in the Scottish Government Director General for Health and Social Care statement for Module 5 [INQ000498141], paragraph 412, the governance which existed within UK Government departments was not designed to facilitate decision-making on an equal basis for the Four Nations, particularly in areas such as health, where decision-making is devolved. Particularly in the early set up of services, but also through the peak of the pandemic response, decisions were routinely made within UK Government governance structures, with Scotland being informed of the

decisions taken and therefore largely becoming 'recipients' of the decisions made by UK Government. This way of operating was of lower impact in areas where policy in each nation was fully aligned, but became problematic where policies differed or where timescales for implementation differed. An example of this would relate to the timing of school terms, which differ particularly in the start of summer holidays and therefore meant a differing timescale for return to school testing because Scottish schools return earlier in late summer than schools in England. This required a different, and earlier timescale for return to school testing. Similarly on decisions on the level of funding available for Covid services such as testing, these have remained decisions taken by the UK Government, rather than being decisions taken on a Four Nations basis.

301. I do not recall why the name "Test and Protect" was chosen for the system in Scotland, and that decision predated my time as Health Secretary. My inclination is that it was chosen because it was easily understood: people should test, and then take protective measures if necessary. The UK Government's "Test, Trace and Isolate" branding seemed less easy to understand.. I do not think the name was chosen deliberately to be purposely different to the one used by UK Government. The Welsh and Northern Irish systems' names had elements in common with both ours and that of the UK Government. The decision was, I suspect, simply about branding the system so that it was well understood by the population.

302. The roll-out and implementation of systems did not differ significantly between the Four Nations. There were nuanced differences, with each administration deciding who were essential workers and who would be prioritised for testing, but overall there was a significant amount of alignment in relation to roll-out and implementation.

303. In my statement for Module 2A, paragraph 180, I stated, "I recall there was discussion at the time about whether Scotland could have implemented the Test and Protect scheme sooner". That recollection was mainly in relation to international travel: there were already international examples of testing and screening taking place in international airports across the world. They varied

but included temperature checks and thermal cameras, etc. There was a question about whether or not we could have implemented more of that into our international airports sooner. However, although I was involved in some discussions about international travel, I was not involved in all such discussions as I was not Transport Secretary.

304. I think the lesson learned on Test and Protect would have been that we could have discussed more with international partners and could have used our diplomatic, consular network here in Scotland better to understand what was being done in other countries, and potentially adopting those approaches.
305. As described earlier in this statement, there were also questions about whether we could have introduced earlier asymptomatic testing for those discharged from hospitals into care homes.
306. In my Module 3 statement, paragraph 35, I said, “The Scottish Government and the UK Government did have different approaches to ‘lockdown’ and other non-pharmaceutical interventions, which would then in turn have an impact on healthcare systems [...] Differences in relation to testing would also have an impact on our healthcare systems.” This was simply in reference to the testing and self-isolation requirements for healthcare workers in Scotland and England at different points during the pandemic.
307. In my statement for Module 2A, paragraph 467, I stated, “Notwithstanding the obvious pressures on testing supplies during the height of a pandemic, where possible a precautionary approach should be taken, particularly in the early days, it is better to over-test than under-test.” I do not recall the clinical advice that was given in the early days, but I do remember a very strong statement made globally by the then-head of the WHO: leader “Test, test, and test.” We were being encouraged at a global level from the likes of WHO to test as much as we possibly could, and there was a general view from WHO that there could be very little harm in over-testing.

308. In terms of whether there were opportunities to over-test that were not taken up in Scotland, I have discussed earlier in this statement the question of testing asymptomatic patients being discharged from hospitals to care homes. Thinking about the prison service: we had a very confined and over-occupied environment, and while of course we were always going to be restricted by the availability of testing kits and laboratory capacity, I made the case that there was a need to test – including those who were asymptomatic – more regularly in our prisons. I requested and received some mobile testing units at our prisons, including HMP Barlinnie, because I was quite alarmed at the scale of asymptomatic individuals who were testing positive.

F. TRACING

309. In my module 2A statement, paragraph 152, I stated that, “As our understanding of the testing and tracing [of infected persons] evolved over time, our position changed and evolved in terms of who we should be testing and tracing.” My comments earlier in this statement about asymptomatic testing demonstrate how our understanding evolved. Our initial understanding was that the spread of the Covid-19 virus would be from those who were symptomatic to others, but as clinical and scientific data improved we came to know about the dangers of asymptomatic spread of the virus and therefore that asymptomatic testing was required at population level. Our understanding of the symptoms of the virus also evolved over time, so as our understanding of the various symptoms began to expand that had an impact on testing.

310. As the Cabinet Secretary with lead responsibility for Test and Protect, I also had responsibility for the contact tracing element. Again, this was well established as a result of the good work done by my predecessor. I was responsible for ensuring that the system was working efficiently, that we were identifying cases of Covid-19 – including of course asymptomatic cases where possible – and ensuring the general public knew the preventative measures they needed to adopt should they test positive, or end up being identified as a close contact of someone who tested positive. I cannot recall any significant issues with the

tracing element of Test and Protect during my time as Cabinet Secretary for Health and Social Care.

G. ISOLATION

311. My decision-making role in relation to the evolution of the guidance on isolating in relation to Test and Protect, what drove and informed those changes, whether any international comparisons were considered, and the impact on groups that may be disproportionately impacted by isolation requirements was very limited. Those issues were considered during the establishment of Test and Protect and during its development. By the time I became Health Secretary, the system was well-established as was our guidance on isolation. Guidance did change during my time as Health Secretary, and that was based on factors such as scientific advice and new variants emerging.
312. The impact on guidance of virological and epidemiological data depended on the variant. When Omicron emerged, for example, and we tried to understand its epidemiology and characteristics, we were unsure about its level of immunity to the vaccine but we did know it was transmitting at a significant rate and speed, which influenced our decisions around testing and vaccines. Some of the key decisions made at the time I was Health Secretary around testing and the Omicron variant are included in the chronology provided earlier in this statement.
313. As I recall some international comparisons were looked at by the NCD and CMO, but they were referred to more in relation to the spread of the virus than in terms of Test and Protect.
314. Ensuring our communications, including those regarding Test and Protect, were accessible and relevant to the broad diversity of our society was important. There are a number of steps we took in this regard; in summary some of these interventions included:

- We had regular and consistent engagement with faith and belief stakeholders, particularly given the unique environments for worship, the rituals involved, and the risks that were posed in relation to the spread of the virus.
- We were aware that our communications had to be inclusive and not assume that everyone had access to, or could easily navigate, digital resources. We ensured that important information was communicated via the First Minister’s daily briefing, and we also used stakeholder representative groups who had their own networks to ensure information was appropriately disseminated.
- Inclusive communications were also available for those who had a visual or hearing impairment, such as the use of BSL interpreters during daily briefings, audio versions of key strategic documents, and braille versions of important health advice also being made available.
- The Expert Reference Group on Covid-19 and Ethnicity (‘ERG’) was asked to provide advice and recommendations by the Scottish Government in relation to data, evidence, risk and systemic issues. Two subgroups of the ERG were formed: one to review health data and evidence, and the other to examine systemic issues and risk. The work of both groups was underpinned by evidence of the risks that migrant and minority ethnic communities face in contracting COVID-19. Ministers accepted the recommendations of the Expert Reference Group on Covid-19 and Ethnicity including those for health in November 2020. These included the specific recommendation (recommendation 3) with regard to Test and Protect and future health measures:

“There must be Minority Ethnic participation at all levels of the COVID response. It is also important to ensure that communication with individuals from minority ethnic communities by Test and Protect teams is effective and that Test and Protect teams have incorporated processes and expertise which reflect the diversity of the communities they serve and the intersectional framing of their experiences.”

Further, as other health policies, such as shielding and vaccinations, are being developed the Scottish Government must ensure that the needs of minority ethnic communities are considered and acted upon. There is a risk of undermining the broader zero COVID-19 community transmission approach if this is not done.”

315. There were regular meetings between officials and Ministers within the Scottish Government with our stakeholder groups, many of whom represented minority groups, those with a protected characteristic and those in our society who had additional communication needs.
316. As I have referenced in paragraph 313 above, we were also very cognisant of ensuring that information was available for those who were less digitally literate, in particular with a focus on the elderly population [HY5/040 – INQ000571285]. Health messaging, including in relation to Test and Protect, was made available in a variety of formats; including a number of different languages, Braille, easy-read and was communicated during daily briefings held by the First Minister during which there were British Sign Language (“BSL”) interpreters present.



提前做好计划

在家里准备好一些物品是个好主意，以防你需要自我隔离。这些物品应该包括：

- 家庭储备的药物
- 基本食品供应
- 你认识的人的联系方式，以便他或她把你所需物品送到你家（他或她应该把物品放在你家大门外面）和你复购。



经济上的支持

如果你需要自我隔离，你的雇主应该帮助你，你可能会获得法定病假工具。如果你的收入低，并且 Test & Protect 要求你进行自我隔离，你也可以获得500英镑的自我隔离支持补助金 (Self-isolation Support Grant)，即使你无法获得公共资源，你仍有可能被接受从而获得支持。欲了解更多信息，请拨打全国援助热线 (National Assistance Helpline) 0800 111 4000 或者 0800 111 4114。



重要的支持机构联系方式

如果你在自我隔离期间没有任何人可以帮你买食物或买药，请拨打全国援助热线 0800 111 4000 或在 0800 111 4114 (周一至周五，上午9点至下午5点)。
如果你担心你的心理健康，请访问 clearyourhead.scot
如果你和你孩子的心理健康，请访问 parentclub.scot
如果你正遭受家庭暴力，请拨打 0800 027 1234 或访问 safemh.org.uk
你也可以联系你当地的社区团体，他们将能够帮助你或向你推荐其他可以帮助你的人。

#WeAreScotland

保证自己和他人的安全



自我隔离 相关信息和支持



有冠状病毒感染症状？你和你同住的人需要自我隔离

如果你出现咳嗽、发烧、味觉或嗅觉丧失/变化，你和你同住的人则需要留在家中，并且你需要立即做检测。为此，你可以登录 NHSinform.scot/test-and-protect 或者如果你无法上网的话，你可拨打 0800 028 2816。在检测结果出来之前，你和你同住的人都应该留在家中。如果你的检测结果呈阳性，你和你同住的人必须继续自我隔离。如果你的检测结果呈阴性，那么只要你感觉身体状况良好并且已连续48小时未出现发热（并且未服用任何退烧药），你就可以停止自我隔离，而你同住的人也可以停止隔离。

此外，如果你曾与检测呈阳性的人在一起，或者你去过在检测名单上的国家/地区，那么你应该自我隔离，即使你没有冠状病毒感染症状，也应该自我隔离。



我应该自我隔离多久？

如果你有冠状病毒感染症状，你应该留在家中10天。和你同住的其他人必须留在家中10天，以防他们出现症状。这包括所有住在你家里的人。



我怎么进行自我隔离？

自我隔离是指一直呆在家里，没有别家的人进来。

- 不要去商店即使你戴了面部遮盖物也不例外
- 不要去学校或托儿所
- 不要去酒吧
- 不要让别人把你所购的物品送进屋里。到你家照顾孩子或参加任何其它聚会

保证自己和他人的安全



317. As referenced in previous statements, the Scottish Government created the Expert Reference Group on Covid-19 and Ethnicity (“the Expert Reference Group”) who were asked to provide advice and recommendations by the Scottish Government in relation to data, evidence, risk and systemic issues [HY5/088 – INQ000571349]. Ministers accepted the recommendations of the Expert Reference Group [HY5/080- INQ000236308, HY5/081- INQ000320515], including those for health, in November 2020. These included a specific recommendation with regard to Test and Protect and future health measures:

“There must be Minority Ethnic participation at all levels of the Covid-19 response. It is also important to ensure that communication with individuals from minority ethnic communities by Test and Protect teams is effective and that Test and Protect teams have incorporated processes and expertise which reflect the diversity of the communities they serve and the intersectional framing of their experiences.

Further, as other health policies, such as shielding and vaccinations, are being developed the Scottish Government must ensure that the needs of minority ethnic communities are considered and acted upon. There is a risk of undermining the broader zero Covid-19 community transmission approach if this is not done.”

Prisons

318. During my time as Justice Secretary isolation restrictions in prisons were generally in line with national guidance. There was always nuances for particular situations, but overall prison guidance on isolation aligned with the national picture. Where I had any particular concerns, or wanted to deviate from national guidance due to the unique circumstances of the prison environment, I would have discussions with the Health Secretary and we would come to a position agreeable to us both.

319. As noted earlier in this statement, SPS ‘Test and Protect in a Custodial Setting’ [HY5/093 – INQ000475011] guidance was published in September 2020, and

was reviewed in line with Scottish Government developments. This guidance was reviewed on the following dates and as with most guidance, any significant changes would be flagged for me as Cabinet Secretary for sign off:

- 24 September 2020;
- 29 September 2020;
- 15 October 2020;
- 26 November 2020;
- 14 December 2020;
- 23 March 2021;
- 27 July 2021;
- 13 August 2021;
- 01 October 2021; and
- 09 June 2022.

320. SPS changes to isolation periods were in line with Scottish Government guidelines, for example, the reduction from 14 days to 10 days in December 2020. However, Scottish prisons were considered, for the purposes of Test and Protect as a 'complex setting', due to their unique environments, demographics and challenges, which included overcrowding. This meant that the local authority health protection team / Test & Protect may have been required on occasion to escalate incidents such as an outbreak, and establish an Incident Management Team ("IMT") or Problem Assessment Group ("PAG"). IMTs were chaired by the local health protection team and would have been attended by the following people:

- local health protection team;
- SPS Head of Health;
- prison Governor / Deputy Governor; and
- NHS Prison Healthcare Manager.

321. Any decisions or actions regarding testing or isolation were agreed by the PAG or IMT. This could have meant, during this time, that the IMT could decide that

an isolation period would be longer than the national guidance. However, this was by exception and considered on a case-by-case basis.

322. With implementing 'Test & Protect' in the prison setting this did result in high numbers of individuals being isolated when an outbreak occurred, which may have reduced the spread of Covid-19. However, this also resulted in individuals potentially being in and out of isolation frequently.
323. As stated earlier in this statement, testing of individuals in SPS care was the responsibility of NHS Scotland. However, in Spring 2022, SPS staff were then tasked with observing the LFD tests, as referenced previously in my statement, to allow for early release from isolation following a negative test result, this involved implementing a process of recording. Testing and isolation of close contacts/households ended in July 2022 as part of SPS' Transition Plan which meant that large numbers no longer had to isolate. Testing to end isolation early also ceased in July 2022, however symptomatic testing continued until September 2023 before a pause was agreed. As a result, while restrictions were already lifting in the community, and in line with revised Public Health Scotland prison specific guidance, SPS continued to isolate those symptomatic and testing positive for at least five days. Those who were symptomatic, but refused testing, were also isolated.

Individuals being admitted into SPS custody – testing and isolation process

324. Throughout the Covid-19 pandemic, there was not a requirement for individuals being admitted into SPS custody to be tested for Covid-19, but from September 2021 all Scottish establishments provided asymptomatic testing for individuals entering custody. This process was a choice for individuals to take part in. Following successful discussions between Scottish Government, SPS, National Services Scotland and the territorial Health Boards, the roll out of asymptomatic testing of all admissions to SPS prisons commenced in August 2021 and by September they were all offering a day one and day seven test to new admissions. Key considerations were to align with national testing strategies and recognition that prisons are a vulnerable environment. The Open

Estate, in conjunction with NHS Tayside, offered LFD tests to all those returning from Home Leave.

325. In both the case of new admissions and those returning from Home Leave participation in testing was voluntary.
326. Between March 2020 to July 2020 there was no requirement to isolate those entering custody unless they were symptomatic of Covid-19.
327. As of 08 July 2020, an addition to isolating was implemented where anyone entering SPS custody who had returned from outside the UK in the last 14 days were required to be isolated for 14 days from the day they returned to the UK.
328. From September 2020, when symptomatic testing was introduced, there was no requirement to isolate those entering custody unless they identified with one of the following reasons:
- symptomatic;
 - prior to admission they were sharing a household with someone who was symptomatic, and/or confirmed positive; or
 - a close contact of a confirmed case in the community (identified via test and protect).
329. Prior to admission if the individual was sharing a household with someone who was symptomatic they were required to be isolated on Rule 41 for 14 days.
330. Rule 41 in the Prisons and Young Offenders Institutions (Scotland) Rules 2011 allows a prison Governor to order that an individual in prison be accommodated in specified conditions due to a health condition where they are a risk to themselves or others, following advice from a healthcare professional.
331. Under Test & Protect if the symptomatic person had tested negative the individual in custody no longer required to isolate and could be removed from

Rule 41. If the symptomatic person tested positive the individual in custody was required to continue isolating for the full 14 days from the date of symptom onset, and if they then became symptomatic they were offered to be tested.

332. Additionally, if the person, prior to admission, had been sharing a household with someone who was symptomatic and it was unknown if that person was tested, the person in custody was required to be placed on Rule 41 and isolated for 14 days from the date of symptom onset.
333. Anyone entering custody who was a close contact of a confirmed Covid-19 case was required to be placed on a Rule 41 and isolated for 14 days.
334. As part of the health admission screen, NHS Scotland colleagues assessed the individual for signs or symptoms of Covid-19. Anyone who displayed signs of Covid-19 were required to be isolated and placed on a Rule 41 and tested as soon as possible by NHS colleagues.
335. Individuals who were suspected of having Covid-19 prior to admission required to be isolated within a designated residential area within the establishment. Additionally, Police Scotland had the opportunity to notify an establishment prior to arrival that a person entering prison custody is suspected of having Covid-19. In these instances, the person was not admitted via the normal Reception area. Instead, they were relocated to the designated residential area within the establishment and the admission process carried out from there by staff wearing appropriate PPE. SPS establishments were advised to create admission areas for this purpose.
336. From 06 September 2021 all Scottish prisons provided asymptomatic testing for individuals entering custody. This process was a choice for individuals to take part in. Out with the admissions testing, NHS did not routinely conduct asymptomatic testing of individuals in custody unless they had been identified as a close contact, or an IMT had recommended mass testing where there had been a confirmed outbreak of Covid-19 in a prison.

337. Asymptomatic testing for admissions continued until a pause was agreed through Scottish Ministers in early 2023. However, local health protection teams and IMTs remained able to recommend the short-term reintroduction of asymptomatic prisoner testing (including admissions testing) if required, for example, in outbreak situations or following a vaccine uptake risk assessment.

Four Harms framework

338. The Framework for Decision-Making [HY5/003 – INQ000182846] was essentially a document created early in the pandemic to inform the public, policy-makers and legislators about the rationale behind our decision-making, including in relation to imposing or easing NPIs and implementing our testing regime.

339. The Four Harms approach was adopted in Scotland and involved a careful balancing of conflicting harms to reach decisions that minimised overall harm. The four harms were:

- Harm 1: direct Covid-19 harm;
- Harm 2: other health harm caused by the pandemic;
- Harm 3: societal harm; and
- Harm 4: economic harm.

340. The easing of restrictions in prisons based on the Four Harms would, as with testing and vaccination, etc., have been discussed by me, my officials, the SPS on a fairly regular basis. Clinical advisors such as the CMO, DCMOs, NCD, CNO, would also have discussions with SPS when their advice was required. Isolation requirements were reduced from 14 days to 10 days for the public at large in December 2020; the same changes applied also to the Prison Service, a decision I would have fed into as Justice Secretary, and signed off.

341. Because of their closed, high-risk setting, Covid-19 posed a number of challenges in prisons and establishments saw a number of outbreaks during

the pandemic. Measures taken by SPS to restrict the regime throughout the pandemic were discussed with Ministers and were considered necessary, proportionate and aligned to public health advice in order to support the safe operation of prisons and to protect the health and wellbeing of those who live and work in them. In addition to a range of physical distance and hygiene measures, a number of testing pathways were put in place in prisons. This included testing for staff and new admissions, and the offer of regular LFD self-testing for those in custody.

342. In January 2022, while I was Health Secretary, the First Minister announced changes to self-isolation rules for anyone who tested positive and for close contacts, making it possible to end self-isolation early under certain conditions. SPS worked closely with Public Health Scotland (PHS), SG, NHS Boards and NSS to develop an approach to release from self-isolation in prisons. This included consideration of a number of factors: harm of covid 19, harm of self-isolation, prisons as vulnerable settings, equivalence with the community, and human rights. The decision was made to use self-verification of vaccination status since it was not possible to find a workable solution for how vaccine status could be objectively verified for those in custody.
343. In spring 2022, with a lower threat status, population-level asymptomatic testing and population-level symptomatic testing, tracing and isolating ended. There were a number of discussions around how this should apply in prisons, including with Ministers and SPS. These discussions aimed to find the right balance between testing and other restrictions (e.g. isolation, physical distancing), and other harms such as poor mental health. Key factors considered were also alignment of prison testing with the wider Covid-19 Strategic Framework and Testing Transition Plan, and ensuring a consistent approach to decision-making across sectors.
344. The closed nature of the prison setting meant that widespread transmission was more likely to occur and issues around deprivation of liberty were more acute. Some testing in prisons was therefore considered necessary for some

time, in particular symptomatic PCR testing for those in custody and asymptomatic prison admission PCR testing.

345. In July 2023, testing across healthcare, social care and prison settings was reverted to the pre-pandemic approach to infection testing (National Infection Prevention and Control Manual).

H. DATA

346. In my view Scottish Government had access to reliable, accurate, and timely data and information relating to Test and Protect. That data changed and evolved as our understanding did, but I cannot recall a time when I required particular data relating to Test and Protect and it wasn't available, or that there wasn't a good reason for it not being available.

347. There was a range of data collected. I looked at all data sources that were provided to me but as time went on you knew which sources to focus on in more detail, as they were often more helpful in giving us an indication of the spread of the virus, such as daily PCR data and wastewater data. I received data informing me of the total number of tests carried out in our labs – both NHS and Lighthouse – on both a daily and cumulative basis. I was also provided with data that allowed for helpful comparisons, such as the weekly number of positive cases compared to the week before.

348. I also received data on our testing capacity, in particular the operational capacity available in each laboratory.

349. Contact tracing data was also provided which allowed me to keep track of the number of weekly contacts traced; as with most of our statistics, this was broken down by local authority level. Contact tracing data, including the number of cases recorded and contacts who had been traced, was published by PHS as part of their weekly Covid-19 Statistical Report in June 2020. This reporting continued until May 2022. The Scottish Government collected data on the Local Authority Isolate and Support service. This included the weekly and cumulative

number of contact tracing practices completed and the weekly and cumulative number of contacts traced; summary data was collected weekly from local authorities on calls and text messages they made to those needing to isolate; inbound calls to the National Assistance Helpline; and support referrals made by local authorities. This data was shared with ministers as management information each week, and was summarised in monthly publications between October 2020 and April 2022.

350. I do not recall ever feeling that there was an inadequacy of data in relation to Test and Protect. There was quite a significant amount of data that I received, particularly as Cabinet Secretary for Health and Social Care, in relation to Test and Protect. The data was presented in different ways depending on the data source. It could come in form of a briefing, slides, tables etc. I had a sub-folder in my Ministerial e-box for statistics, which I would review daily.

351. I do not recall being aware at any time of any sources of advice or data relating to Test and Protect that was not available to me that I felt should have been.

352. I do not recall any significant issues about dissemination and coordination of data being raised by those bodies that I would have engaged with regularly, such as health boards, local authorities or UK Government. If there were such issues at a 'low' level, they would have been raised with officials and if not resolved raised with me on a Ministerial level, but I cannot recall that happening. There were a number of fora whereby Test and Protect was discussed which also included a range of relevant partners. These included:

- the Testing Operational Delivery Group;
- the Testing Programme Board;
- the Test and Protect Steering Group; and
- the Contact Tracing Executive Delivery Group.

353. If there were issues with receiving data from the UK Government they were usually accommodating in trying to find a solution. There was a frustration at

times that this data would come in last minute. For example, when I was Justice Secretary and taking part in regular discussions around the red, amber and green lists for international travel, the data from the UK Government on each country we were due to discuss would sometimes come in minutes before the meeting was due to start. However, on the whole, the data sharing with the UK Government was adequate.

354. PHS supported Test and Protect by developing guidance, digital systems and training resources to support contact tracing efforts. PHS was responsible for data protection of contact tracing data, complying with the data protection legislation.

355. I am unable to comment on Scottish Government's work with Public Health Scotland in relation to data exchange about testing, as this work would have been carried out before I became Health Secretary.

356. By the time I was in office the data exchange between PHS and SG was well-established and I was receiving the data and statistics I required. If there was bespoke data that was needed during any particular time I found officials worked well with PHS and the data was provided if available. There would often be caveats that the data was management data and still had to go through a further level of verification before becoming official statistics, so it was important that Ministers were aware of that before communicating said statistics, or using them during decision-making.

I. MODELLING

357. Modelling data generally, including data from Test and Protect about case numbers, was helpful, though was always caveated with the limitations any modelling has. The modelling data I most frequently looked at gave us an estimation of potential surges of the virus and any potential peaks or troughs; it was used to assess the impact that would have on the health service in relation to capacity issues, and what decisions we may have to make in relation to NPIs and testing if there was likely to be a localised, or indeed national, surge in

Covid-19 cases. We also received modelling in relation to demand for tests, which was helpful to monitor capacity and ensure appropriate measures could be taken during any potential waves of the virus.

358. Data received from Test and Protect that told us about the rate of the virus in any given region or indeed the country as a whole was very helpful. It allowed us to know if the spread of the virus was isolated in a particular local authority, or if it was more widespread. That in turn allowed us, when the levels system came into place, to make bespoke decisions about NPIs for different local authorities. It also helped inform us about health service: if Test and Protect data was telling us that there was a surge in, for example, Glasgow and hospitals there were already under extreme pressure, we would have to make a decision about whether to escalate the response level or the emergency level in any given hospital site or health board. Such data would have been helpful across all Cabinet portfolios.
359. Modelling is, by its very nature, limited in terms of what it can tell us. It is based on sound methodology, but nonetheless has its restrictions and we should never take it as an exact forecast. That was a challenge that we faced: we were transparent with the public, press and other politicians, about modelling and its limitations, but when modelling was discussed with the media they didn't always present it with the caveats we thought necessary, which was at times a frustration.
360. I have already referenced in the statement that the Expert Reference Group was asked to provide advice and recommendations by the Scottish Government in relation to data, evidence, risk and systemic issues. We acted upon the recommendations provided, including in relation to testing. We also carried out regular impact assessments in line with our obligations under the Equality Act 2010, and other relevant legislation, provided [HY5/089 – INQ000571264, HY5/090 – INQ000571339, HY5/091 – INQ000571338 and HY5/092 – INQ000147449].

J. PUBLIC COMMUNICATION

361. Every senior member of Government, every Cabinet Secretary, had a role in relation to communicating with the media in regards to our response to Covid-19, including questions about Test and Protect and rules around isolation and so on. Every member of Cabinet shared that responsibility. On visits and press interviews we had to be not only alive and alert to questions that would come from the media but also proactively communicate the importance of following guidance, including in relation to Test and Protect. That said, the vast bulk of Test and Protect communication fell on the Health Secretary, the First Minister, the CMO and the NCD. They took on the significant burden of public communications in relation to Scottish Government's Covid-19 response, including around Test and Protect.
362. In my time as Justice Secretary, public communication around Test and Protect was fairly limited. My communications were largely with stakeholders like the SPS, Police Scotland, the SCTS, and other justice partners. Some of that was about enforcement of isolation and NPIs more generally. I also had a role in relation to the approach to international travel as Justice Secretary, because I had responsibility to liaise with UK Government on that particular issue as has already been referenced. That involved discussion around isolation requirements for travellers. I recall that the first ever daily briefing I did with the First Minister was on the issue of international travel and isolation requirements.
363. When I became Health Secretary, that communication role significantly ramped up. I was communicating every day about our response to Covid-19. Probably the most significant public communication I was involved in with regards to testing related to the withdrawal of funding for testing by the UK Government and the consequent phasing out of universal testing. Public communication was also very important in relation to large-scale events such as COP26 and the Euros Fanzone, and I took part in media and communication particularly around the Euro Fanzone. We sent test kits out to those with tickets to the Euros Fanzone and had a mobile testing unit present there, and I was involved with the public communication encouraging those attending to test. I visited the

Euros Fanzone before it opened, and was able to emphasise to the media that we had put in place appropriate testing capability and infrastructure.

364. A chronology on decision making in relation to Test and Protect has been provided earlier in this statement.
365. I was involved in signing off public communications about how testing, tracing and isolation requirements evolved over time during my time as Health Secretary. Low-level changes, that did not alter the nature of the advice we were giving, could be made by senior officials, however Cabinet Secretaries and Ministers signed off significant changes to the messaging and any new campaigns. Low-level changes could, for example, be changing the design of a leaflet but not changing the actual messaging. High-level changes would include fundamental changes to advice that we were disseminating. Messaging would often be shared with clinical officials to make sure they were clinically appropriate, and often the First Minister too in order to determine if she had any particular comment.
366. By the time I became Health Secretary, the messaging used was well-established and the method of communication didn't change much. We were prolific in relation to social media, traditional media, radio adverts, television adverts and so on. One of our primary methods of communication was the First Minister's daily briefing, which was watched by a huge number of people across the country and often led news bulletins as well as being reproduced in copy by newspapers. As described earlier in this statement, I was involved in the daily briefings on occasion, particularly as Health Secretary.

K. EQUALITIES

367. The risks and implications of unequal access to testing for at-risk, vulnerable or lesser-heard groups would generally have been considered at the outset of the pandemic by my predecessor, the then Health Secretary Jeane Freeman, and her officials. However, during my time as Health Secretary I ensured that I, my junior ministers and officials had regular engagement with stakeholders

representing those who may be more vulnerable. This helped us to keep a 'sense check' on whether the measures in place continued to be adequate. My understanding is that appropriate Equality Impact Assessments ("EQIAs") were carried out and mitigating action taken in regards to those groups with protected characteristics, and any additional needs. We also made appropriate adjustments for those who lived in remote, rural and island Scotland to ensure testing facilities were accessible. For example, as part of population symptomatic testing, we worked with partners such as NHS Highland and the Scottish Fire and Rescue Service to develop small-scale test sites to distribute PCR tests in remote areas of NHS Highland to ensure remote and rural communities in NHS Highland had comparable levels of in-person testing access to the rest of Scotland, and to overcome the problem at the time of more limited access through the UK testing online ordering portal, where some NHS Highland and NHS Forth Valley postcodes were excluded from the ability to order. The UKG provided the tests to NSS, NSS managed orders and stock, and the Scottish Fire and Rescue Service distributed them on behalf of NHS Highland and SG.

368. At the outset of the pandemic, I was Justice Secretary and the most-at-risk populations in my portfolio were police officers, who were on the front line engaging with people daily, and those in or care within our prisons, particularly given the risk of the virus spreading in built-up environments that were over-occupied.

369. I had concerns about vulnerable people in relation to those in our care in prisons, including both male and female adult prisoners and young offenders. The prison population as a whole was generally more vulnerable, whether as a result of coming from a lower socio-economic background, there being a growing older population in prisons and consequently more prisoners with respiratory issues, or addictions issues. The clinical understanding was that their risk was higher than the average member of the public and the population as a whole, so I needed to ensure that we had a robust testing regime in place for the prison service. For that reason, early on in the pandemic I insisted on access to mobile testing units and for that testing to include asymptomatic testing

given the possible prevalence of the virus in our prisons. I also made sure there was appropriate testing in place for prison staff.

370. As stated in the Scottish Government opening statement for Module 2A, the Scottish Government works closely with stakeholders to amplify campaign messages and communicate effectively to the whole of Scotland, encompassing all geographies and minority communities. The team worked closely with NHS 24, Public Health Scotland and third sector partners to ensure key public health information on Covid-19 was available in multiple languages (17 languages) and accessible formats via the NHS Inform website. The Strategy and Insight and Partnerships teams co-created materials specific to Minority Ethnic communities. For example, the Communications team worked with the Scottish Public Health Network (ScotPHN) to create a bespoke, printed Easy Read Version of the Test and Protect information specifically for the Gypsy/Traveller community, provided: [HY5/082 - INQ000348705]. This was distributed by the Convention of Scottish Local Authorities (COSLA) to Gypsy/Traveller sites.

371. The Covid-19 pandemic was not the first time we had communicated health messaging, and we had well-established protocols to make sure messaging could be widely received and understood. For example, translations of messaging into different languages were available and were shared via bespoke media channels. Materials were produced in Braille, and BSL interpreters were used in daily briefings. We were using tried and tested methods that had been deployed effectively previously. We were alive to and aware of the fact that there was and is a need for communications to be easily digestible, available and accessible for as wide a section of society as possible.

372. The Scottish Government played a role in the 'Equality and Fairer Scotland Duty Impact Assessment, published on 17 March 2021, which aimed to make the implementation of Test and Protect strategy equitable. That assessment set out impacts and actions for various groups.

373. We were very alive to the fact that the digital route was simply not available for everyone, so it was possible to book a test using your telephone without any need for access to the internet. The results of any test could also be given over the phone. We tried to make our testing availability as accessible as possible, including delivering test kits to people's homes as well as ensuring easy access to walk-through testing sites for the population at large.
374. The First Minister's daily televised briefing was also a key source of information for many people who did not have digital access. BSL interpreters were present during daily briefings.
375. For those with learning difficulties, we ensured an easy-read version of communications on testing [HY5/040 – INQ000571285], and any other important information relating to our response to Covid-19, was available.
376. Translations of materials were also available in different languages, including Braille. Signposting to cultural organisations in the third sector, with the assistance they could provide, was also made available.
377. We were also conscious that a number of people had specific dietary requirements due to their religious observance; as such, provisions were made to ensure appropriate food was available for those with such requirements who were in need of food during isolation.
378. One of the key concerns Ministers across the Scottish Government had was in relation to those who were economically disadvantaged and the significant impact self-isolation could have on them and their families. The key measure we brought forward in this regard was the Self-Isolation Support Grant.
379. In relation to what consideration was given to those who did not / could not use the apps and/ or telephony services, as stated in the Scottish Government Director General for Health and Social Care statement for Module 2A [INQ000346089], paragraph 231, being able to use digitally enabled services requires people to have access to devices, connectivity and the skills to use the

device. The importance of digital inclusion has been underscored and, along with the raised awareness across all policy areas, resulted specifically in the Connecting Scotland initiative. The objective of this Scottish Government initiative, managed by the Scottish Council for Voluntary Organisations, was to increase the number of individuals and families who are digitally connected.

380. We had to have bespoke communication for those in the prison environment, who cannot just go out and pick up a newspaper or put on the radio and hear an advert. For example, leaflets could be dropped under every cell door, and there was prison television and radio. I appeared on prison radio to help communicate information about Covid-19. We could also go into the prisons themselves, as the NCD did, to speak to the staff and some prisoners about the pandemic. Prisons are an example of how we could use bespoke media in order to try to reach people in specific environments.
381. I do not recall any trends being brought to my attention concerning the demographics of people who had not downloaded the app or did not appear to be using it.
382. I do not recall any other inequalities being identified in relation to the manner in which contact tracing was delivered across Scotland.
383. We understood that those groups historically facing disproportionate health impacts and those from lower socio-economic backgrounds were more disproportionately impacted by isolation requirements, and that efforts were needed to address that. Other groups who were disproportionately impacted included those with health challenges including mental health, the clinically vulnerable, those who were shielding, and those in care homes. Children and young people were another at-risk demographic I was aware of, due to online schooling taking away the social element of education that is very important during their formative years.
384. That understanding evolved over time through further data analysis, drawing on both quantitative, for example survey, and qualitative data. The best way to

receive qualitative data was through direct discussion with those impacted and affected, for example by Ministers speaking to care home residents, speaking to stakeholder groups representing different ethnic minority groups, speaking to groups representing communities where there's a higher level of deprivation, and engaging with bodies like the Scottish Youth Parliament. This helped to develop our understanding.

385. In relation to secondary harms caused by self-isolation requirements we were, from very early on in the pandemic, guided by the Four Harms framework and the Framework for Decision-Making. The first, and most important, of the harms was the direct health impacts of the virus which at their worst could mean death. Our primary focus was mitigating the worst health impacts. The other harms were considered, too, such as the secondary harm of the virus in terms of its impacts on our health and social care systems. That became very important when I became Health Secretary, because that in turn impacted other harms like physical and mental health. If a person was having to wait a year for a hip operation and suffering from chronic pain, that had a real impact on their physical and mental health and their quality of life, which was significant in terms of isolation requirements.
386. We were also cognisant of the impact of 'harm three', i.e. the societal impacts of Covid-19 and in turn of isolation requirements. Children's education was clearly impacted by isolation – something I personally saw and was experienced by families up and down the country.
387. We were also aware of the impact of isolation in terms of the fourth harm, the harm to our economy. We were doing what we could do to support businesses, for example through financial support schemes, but clearly self-isolation requirements had a significant impact on business and their ability to operate.
388. When I became Cabinet Secretary for Health and Social Care the self-isolation requirements were reviewed on a very regular basis when it came to healthcare workers and social care workers. That included evolving the testing and then self-isolation requirements for healthcare workers that impacted on when they

could come back to work, which helped us to then resume healthcare services such as elective care.

Advice and support for specific groups

389. Scottish Government was aware that rules and guidance around isolation could impact certain groups, such as those with physical or mental health conditions, those with learning disabilities, minority ethnic or religious groups, those living in areas with higher levels of deprivation, and so on, more significantly than others. As a result, a lot of work was done in terms of practical steps being taken to help support those groups and mitigate the impact on them of self-isolation. A number of the measures previously described were funded through the £350m community support fund. As Justice Secretary, I was also in regular discussions with partners and stakeholders about any specific needs that might arise due to self-isolation measures. Some specific issues, for example the impact of lockdown on victims of domestic abuse, were raised by Women's Aid and Rape Crisis Scotland, who were given additional funding as a grant from the community support fund to support those they work with. Other measures that were taken in regards to specific groups out with the justice system would have been taken by other Cabinet Secretaries at the time Test and Protect was initiated.

390. Higher risk groups were always high up in our thinking about our Covid-19 response, including Test and Protect. When I became Health Secretary, by which time a lot our focus had moved on to health risks, mental health issues, older people in care homes, social care workers and staff, we had well-established communication channels and mitigation measures in place such as additional access to testing in place to support those groups who suffered disproportionately.

391. Generally, the data that we received in relation to uptake of testing tended to show people were engaging with the Test and Protect system. If people were symptomatic they knew to test; if they were in a particular staffing group, such as health and social care, people tended to know the testing obligations that

were placed upon them. The feedback we were receiving was showing particularly high engagement with the Test and Protect protocols in place.

392. Proximity to and accessibility of testing centres was an issue in rural Scotland, arguably even more so than island Scotland as island communities are well-used to the geographic challenges that they face compared to the mainland and have their own protocols and ways of mitigating against those challenges. The rurality of some parts of Scotland, and the sheer size of some health board areas such as that of NHS Highland, meant that ensuring testing centre accessibility was a challenge. We were very alive to and aware of that issue, and took steps such as opening more testing centres or ensuring that there were mobile testing units that could travel to certain communities at certain times.
393. Proximity to and accessibility of testing centres was less of an issue in urban Scotland.
394. I do not recall access to LFD tests ever being a significant issue. If there was a shortage, we could lean on the Four Nations systems and procure additional tests from other nations, as they did from us.
395. Levels of mistrust were, relatively speaking, low and did not appear to significantly impact on the general public testing when required or advised, as evidenced by the numbers of those testing. We were of course countering public misinformation that was being amplified through social media and people who had quite a significant platform. Ministers would not necessarily directly engage with those individuals, but would seek to proactively push out the true, fact-based and evidence-based public messaging to attempt to counteract or even drown out some of the misinformation that existed. Our daily briefings, which people watched on television and listened to on the radio, played a large part in that. Other efforts included, for example, using influencers with relatively large followings and large levels of trust to help with our messaging. As Cabinet Secretary, I was not involved in the logistical minutiae of whether influencers were given scripts, or not. We had trusted clinical voices communicating that message as well. We didn't just rely on politicians in suits telling the public what

we thought they had to do in terms of testing and isolation. There is little I would have changed about our communication and messaging, other than possibly being more direct in challenging disinformation, largely in relation to the vaccine.

396. EQIAs would bring to the fore any particular issues impacting anyone with a protected characteristic and we would, where possible, put in place mitigations. As stated in my Module 2A statement [INQ000273956], paragraph 201, equality Impact Assessments were used to support strategic decision making throughout the pandemic and ensured that the potential impacts a change on policy would have on groups with protected characteristics was fully considered within any policy proposal. The impact imposing or easing NPIs would have on the most vulnerable and those part of groups with protected characteristics was at the forefront of Cabinet's discussions, whether these were set out formally in an EQIA or not. For example, the EQIA completed for the Coronavirus (Scotland) Act 2020, provided [HY5/083 – INQ000182765], considered the impact various justice related provisions within the Act, including the emergency release of prisoners, would have on those with protected characteristics. It was stated that for the emergency release of prisoners the "availability of any specialist services in the community may be a factor in release and those with disabilities where a specialist need cannot immediately be met in the limited time available may not be able to be considered for release", but concludes that where there is an impact "such impact has been considered and addressed as far as possible within associated procedures for release."

397. Ministers typically would read the results of the EQIA that was conducted and these were normally included within whatever briefing we had asked for or that was provided by officials.

398. I have previously told the Inquiry, "The impact imposing or easing NPIs would have on the most vulnerable and those part of groups with protected characteristics was at the forefront of Cabinet's discussions, whether these were set out formally in an EQIA or not". One example of that is the paper on

self-isolation [HY5/084 - INQ000078464] presented on 13 July 2021 by the then Deputy First Minister.

399. For any future pandemic, taking preventive measures such as testing and isolation will be important, so having early, direct and ongoing engagement with those with lived experience will also be important. My view is that we had a good level of engagement with those groups disproportionately impacted by the requirements to test and isolate. From their perspective I suspect we could always have improved that engagement, particularly given the pace at which certain decisions were made, but there was in my view always a good level and depth of engagement.
400. One lesson learned from the pandemic in this regard is that it would be very helpful to have to hand a set of protocols and handbook about who we need to communicate and engage with immediately in order to quickly get our message out to as wide an audience as possible. That could include information about those bespoke media channels and community networks, and could be maintained in one central, regularly-updated system with the DFM as lead Cabinet Secretary, as the DFM has cross-government responsibility for delivery.
401. Another is the value of using trusted voices when it comes to communicating with those who belong to particular groups and or share particular characteristics, for example by involving religious leaders in communications in order to reach a specific religious group. The feedback we got during Covid-19 often from stakeholder groups, as well as anecdotal feedback from our own interactions, was that using people within those groups to help disseminate the message was hugely helpful.

L. LESSONS LEARNED

402. Above and beyond what is included already in this statement, as far as I am aware there are three key evaluations that are relevant to Test and Protect and

cover the issues of strategy and planning, decision making and policies, and roll-out and implementation.

403. Firstly, there was an initial evaluation of asymptomatic testing in Scotland that covered the period November 2020 – June 2021 [HY5/086 – INQ000571342]. The study found that over 7,000 positive cases were identified that may otherwise have not been found. This figure is thought to be an underestimate given the number of unreported LFDs.
404. Secondly, in areas of highest transmission of the virus, the Targeted Community Testing programme undertook testing of those who were otherwise not eligible. Its key finding was that around a third of asymptomatic cases turned out to be positive; again, much like the evaluation mentioned above, it is unlikely these cases would have been identified unless the individual became symptomatic.
405. Thirdly, the Technical Report on the Covid 19 Pandemic in the UK [HY5/085 - INQ000203933], which is available publicly, had a range of Scottish expertise feeding into it. Chapters 5 & 6 relate to “Testing” and “Contact Tracing and Isolation” respectively. The Scottish Government has said that it aligns itself with the recommendations and key findings of the Technical Report.
406. The following quotes are reflections from the CMOs or the Government’s Chief Scientific Advisor in relation to test, trace and isolate systems / Test and Protect, and are taken directly from the Technical Report [HY5/085 – INQ000203933]:

“Limitations in testing capacity and an end-to-end system to effectively use the output of testing were initially a major constraint. The magnitude and speed of scale-up required in the testing system for Covid-19 was unprecedented. The major efforts required to expand testing capacity highlighted the importance of building testing systems that maintain some form of contingency response or at least retain some expertise on how to surge in the event of a new variant or an

entirely new pandemic. The diagnostics industry should be included in planning as they may be a key partner (for example, in providing rapid surge capacity).

“It was important – and the UK did not always get this right – to align testing aims, use cases, technologies, data flows and communications in coherent testing strategies. This can be challenging in the context of new systems and processes, new testing technologies and use cases, and inter-organisational working. An agreed plan for prioritising usage was also required – for example, targeted at high-risk settings (staff and patients in hospital and in care homes) and for outbreak management.

“Testing was deployed for a wide range of use cases in this pandemic, some of which may be required in future pandemics. Some use cases were very similar to normal use of tests in infectious disease outbreaks, including for clinical diagnosis, infection control in hospitals, case finding, surveillance and research. Others, such as repeated testing using self-read and self-reported testing, were new at this scale.

“Once reliable lateral flow tests were available it significantly improved people’s ability to manage their own risks and the risks for those, they were meeting, as well as supporting surveillance at scale.

“Testing innovations came at speed and required a rapid, independent quality assurance and validation process. Quality in the market was very variable, and the regulatory approach globally was variable.

“Communication of the rationale and practical requirements of testing strategies and changes to testing policy was important, whether with the public or professionals. Although better communications were developed throughout the pandemic, there are some specific interventions – such as translating testing instructions and advice from the very outset and engaging through trusted community leaders –

which could be delivered better in future responses. Some elements of testing were, and will remain in a future pandemic, complex to communicate – such as the link between the positive or negative predictive value of a test and prevalence. Pilots were helpful in understanding how new strategies or policies might operate and how people might respond to them.

“Contact Tracing Reflections and Advice for a Future CMO or Government Chief Scientific Advisor

“It is important, but not always easy, to be clear with decision-makers and the public about what contact tracing and self-isolation can and cannot achieve in different circumstances. The role and impact will vary depending on:

- the pathogen and disease being managed*
- the stage of the pandemic response, prevalence and incidence wider pandemic control strategies*

“Pre-symptomatic and asymptomatic transmission, in the absence of routine mass asymptomatic testing, are a huge challenge for even a highly effective contact tracing system and place a premium on short turnaround times. Contact tracing is an effective public health tool particularly in situations where case numbers are relatively low, or the focus is on rapid detection of clusters and outbreaks. Backward contact tracing can be effective to identify sources or risk factors in clusters and outbreaks.

“The scientific and public health principles of contact tracing and self-isolation are well established, and most of the challenges in this pandemic were operational, and not directly within the remit of CMOs or GCSA. However, if contact tracing at this scale is needed again, operational planning and experience on scaling up across the Four Nations will be helpful.

“Large-scale contact tracing should wherever possible build on existing systems and expertise. Local teams may have important intelligence about their communities that can guide the response to ensure it meets local needs. They may also be effective in building rapport and tailoring support for individual cases and contacts. Regional teams can bring together epidemiological signals from across their patch and can also support pooling of resource to adapt operations to a fast-moving epidemic. National teams have an important role in:

- pooling resource rapidly scaling up unified systems such as digital platforms and data sharing systems*
- providing scientific advice*
- producing guidance to support local and regional contact tracing teams*

“Preparedness plans should include the need for large-scale digital platforms. Early development and use of a digital platform enabling contact management, rapid epidemiological data reporting, and management information was needed but took time to design and implement. Developing disease-agnostic case and contact management platforms ahead of another pandemic should enable a faster response to deliver a large-scale contact tracing service. Digital self-service platforms for cases to enter contacts’ details were also an important innovation that helped manage the demands on the telephone-based contact tracing service.

“The rapid design and execution of pilots and research studies was needed to support dynamic evaluation of contact tracing and to address evidence gaps. Gaps in the evidence base included effective methods and approaches to contact tracing in different settings, different stages of the response and in different population sub-groups. Other gaps were addressed through rapid research; for example, a randomised control trial of daily contact testing as an alternative to self-

isolation for contacts showed that daily contact testing was non-inferior to self-isolation.

“The health equity dimension to contact tracing is important but was not always fully addressed. Digital-first approaches can exclude, for example, people with visual, hearing, and other disabilities – and so it was important to provide phone and other support alongside this. Some people were not closely engaged with formal information sources and were disengaged from systems delivering elements of the pandemic response.

“Long-term engagement with all communities is important in reducing the risk that people become disengaged or misinformed. Digital and other technological solutions deployed to support the delivery of contact tracing should proactively address accessibility and other health equity gaps identified from impact assessments and by local partners.”

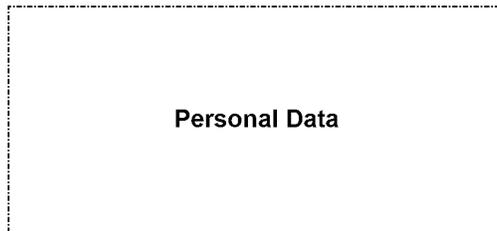
407. The legacy of our Test and Protect system, based on learning that we have captured, should be an ability to stand up a system that helps us to identify through testing any particular virus, take the requisite action in terms of processing that test, and communicate any actions that individuals who test positive should take to adequately protect themselves and wider society from the worst effects of the virus, for example self-isolation. The legacy of Test and Protect should be that we can respond quickly, given we are not establishing things ‘from scratch’ and now have the foundations in place for responding to a future pandemic.

408. I have referred throughout this statement to a number of lessons that I consider need to be learned for the future in respect of testing, tracing and isolation, including missed opportunities around routine testing for those discharged from hospitals to care home, and also in relation to international travel.

409. It is clear that the UK's digital health offer is not good enough. We should have developed a Covid Certification scheme far sooner than we had, which may well have helped mitigate Harm 4 (harm to the economy) sooner.
410. For a future pandemic, we should have the essential building blocks in place to quickly upscale a testing and tracing system. That should include having contingency in place to rapidly upscale the number of people doing contact tracing should there be a future pandemic, and also identifying premises that could be suitable for this purpose. The training that was used for contact traces should be regularly reviewed, and we should explore how this can be done in the most efficient way possible. This speed at which this can be rolled out is, of course, dependant on there being a reliable test available.
411. There are some elements to a testing programme that will naturally become contentious, such as who to prioritise at times of high demand, which will require early engagement with various sector groups. Decisions should continue to be driven by the data, and by the clinical advice Ministers receive. However, ultimately there will be issues that will require Ministerial judgement. In such instances, it is the duty of governments to be open and transparent in explaining to the public the rationale for such decisions.
412. The evaluations we have produced, as well as the recommendations of the Public Inquiries, will undoubtedly be a useful source of material for whatever Government is in place for a future pandemic.

Statement of Truth

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



Signed:

Dated: 04/03/2025