

Tuesday, 22 July 2025

1  
2 (10.00 am)  
3 **LADY HALLETT:** Good morning, Ms Carey.  
4 **MS CAREY:** Good morning, my Lady. The first witness this  
5 morning is Mr Alasdair Donaldson.  
6 **MR ALASDAIR DONALDSON (affirmed)**  
7 **Questions from LEAD COUNSEL TO THE INQUIRY FOR MODULE 6**  
8 **LADY HALLETT:** Good morning, Mr Donaldson.  
9 **MS CAREY:** Mr Donaldson, your full name, please.  
10 **A.** Alasdair Donaldson.  
11 **Q.** Mr Donaldson, I'd like to ask you some questions about  
12 your time working in DHSC's adult social care policy  
13 team. And I think in your statement you say you started  
14 there on 30 April 2020 through until about October of  
15 that year; is that correct?  
16 **A.** Until 2 October, yes.  
17 **Q.** Thank you.  
18 By way of background, in your statement  
19 INQ000598578, you set out that you had been working as  
20 a senior policy adviser at the British Council and then  
21 volunteered for Covid response work.  
22 **A.** That's right.  
23 **Q.** Thank you. And I can see you nodding occasionally but  
24 would you mind just saying "yes" or "no" for the  
25 stenographer. Thank you very much.

1

1 First of all, the surveillance study led by  
2 Professor Shallcross. Secondly, the related work to fix  
3 the data, in particular the Pillar 2 testing data that  
4 my ONS team was leading. And thirdly, my dashboard,  
5 which has also been referred to as the Palantir  
6 dashboard or just the Covid care home dashboard, they're  
7 all the same thing, which came out of that work. And  
8 I move between the three, I realise.  
9 **Q.** No, well, I'll try to split them up if I may, but please  
10 correct me if I get it wrong. I primarily really want  
11 to start with the Vivaldi project and  
12 Professor Laura Shallcross's involvement in that.  
13 I think Department of Health and Social Care funded  
14 the project; is that correct?  
15 **A.** Correct, yes.  
16 **Q.** And when you arrived at the department on 30 April, in  
17 your paragraph 6 you describe it as being "complete  
18 chaos"?  
19 **A.** Yes.  
20 **Q.** Hundreds of staff, you say, had been parachuted in, like  
21 you, with no relevant knowledge or experience.  
22 Now, to help you, Mr Donaldson, the Department has  
23 told us that there was a significant expansion of staff  
24 from I think about 90 staff at the beginning to over  
25 320, certainly later on in the pandemic.

3

1 In your statement you make plain that you have no  
2 academic background in science or epidemiology.  
3 **A.** Correct.  
4 **Q.** And I think it's right that in preparing your statement  
5 you had limited or indeed no access to emails or minutes  
6 or documents to refresh your memory now some five years  
7 on?  
8 **A.** That's right.  
9 **Q.** I'm going to try to ask for a little bit of detail, but,  
10 please, I don't want you to guess or speculate and if  
11 you genuinely can't remember the answer, please say so.  
12 **A.** Understood.  
13 **Q.** I think at paragraph 5, and mainly my questions today  
14 will be about the Vivaldi project, you said:  
15 "... I was the official responsible for creating the  
16 Vivaldi Project."  
17 And to help you, Mr Donaldson, we have heard from  
18 Professor Laura Shallcross, who led Vivaldi.  
19 Can I be clear, what was your precise role or  
20 responsibility with the project?  
21 **A.** Certainly, and I think I may have muddled the waters  
22 slightly here in my statement, because when I talk about  
23 Vivaldi, I'm talking about three different things, all  
24 of which I was the leading, albeit junior, official in  
25 charge of.

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1 Can you help, the chaos, as you describe it, did  
2 that help or hinder the setting up of Vivaldi?  
3 **A.** Both. So the chaos, which was -- as you point out,  
4 there were hundreds of people like me coming in, and it  
5 slightly overwhelmed the HR systems, but what it did  
6 mean is that it wasn't always clear to everyone where  
7 people sat in the new structures, and I was able to  
8 carve out a degree of operational independence for  
9 Vivaldi by virtue of reporting both into the adult  
10 social care part of the department and also into the  
11 Pillar 4 surveillance part, led by John Hatwell, which  
12 was extremely effective and it allowed me to get more  
13 done than I probably would have been able to achieve  
14 otherwise.  
15 **Q.** Your actual role in Vivaldi itself Professor Shallcross  
16 has described as a project manager. I hope that's not  
17 being pejorative. Is that what you really were, is  
18 a kind of a middle man between the project and the  
19 department?  
20 **A.** That's exactly right. So I can claim no credit for the  
21 intellectual work behind either Professor Shallcross's  
22 study or the Palantir dashboard. I was the muscle, if  
23 you like, that got that -- that got those products seen  
24 by the people who mattered.  
25 **Q.** Right. Sticking with Vivaldi, you say in your

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statement -- obviously we know that April was the month where certainly there was reporting of the huge number of deaths in care homes, particularly related to Covid-19. So that's just where we were in the grand scheme of things.

You say you put together a team of non-civil servants but you were told you needed Public Health England's involvement, and you say in your statement it proved "mysteriously difficult" to get this involvement, nobody knew who was responsible for what, and PHE appeared "deliberately obstructive".

What gave you that impression, Mr Donaldson?

**A.** Yes, so the way it worked was that Sir Jeremy Farrar effectively put me in touch with the relevant parts of the Vivaldi team and I sort of brought them together and named the project. But I was then told that, in order to unlock the funding, I had to have a PHE senior partner, even if they weren't directly working on the project. We eventually got that in Susan Hopkins, but that was only after several weeks of trying to get other people in PHE to play that role, and getting nowhere.

**Q.** Why did you form the impression that PHE appeared deliberately obstructive?

**A.** Because I can't find any other explanation of why it was so difficult, given that we weren't asking for people to

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assemble the team.

I just want to ask you, we heard from Professor Shallcross and Professor Hopkins, in fact two days before they had spoken, and agreed to set up the study. Can you help with what happened in those two days between Professors Hopkins and Shallcross agreeing to set it up and then Sir Jeremy and Sir John speaking to you about assembling the team?

**A.** So -- not really, because I wasn't in all of the conversations. So I think -- and by the way, it's -- Susan Hopkins was busy on the SIREN study which was, sort of, as it were, the big sister study of the Vivaldi that was about hospitals, and so there were clearly conversations going on between those, between the senior scientists, including Professor Shallcross, Susan Hopkins and Jeremy Farrar, about the need for a study like this in care homes. And then separately, I'd been tasked to do a separate study within the Department of Health, and I was sort of trying to join the two together, if that makes sense.

**Q.** You mentioned there that Sir Jeremy and Sir John said resources shouldn't limit you. Can I ask you a little bit about the budget, because you say in your statement there was no significant accessible budget. Can you help us with what you mean and add any context to that,

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do extra work; we just needed, as it were, a badge, a PHE badge, on the project. And we just couldn't get it. And I wasn't the only person who found that. The team that I joined had said that that had been a problem that had been going on for a couple of weeks already.

**Q.** Professor Shallcross told us that she thought at the beginning there might have been a feeling that Vivaldi was "treading on toes", to use her words, and filling in gaps that it was perhaps someone's else's job to have filled. Does that accord with your recollection of how it was back in April and May 2020?

**A.** It does, effectively, we were swimming in their custard and inadvertently showing up problems that they had with their data, and I don't think this was a conscious thing but I think it was an understandable human reaction to find that a bit difficult and, no doubt, I may have made it worse by the way that I operated but there were certainly some significant tensions at that stage.

**Q.** Did you ruffle feathers, Mr Donaldson, if I can put it colloquially?

**A.** I'm sure I did, yes.

**Q.** You say in your statement that there was a meeting on 10 May involving Sir Jeremy and Sir John Bell who reinforced to you how important Vivaldi was and that resources should not limit it so you should go on and

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Mr Donaldson?

**A.** Yes, so initially, and I'm talking here about May, and into June, we weren't able to access funding immediately for the different parts of the team. We had some very helpful people from Pillar 4 who came in and helped us to fix that over the summer, but the emergency funding that had been available in April, because there weren't systems in place for immediate funding, had been used up on other things. So there was a significant period where we were operating at risk.

**Q.** I think -- presumably there were various procurement steps that had to be gone through. Were you involved in those measures?

**A.** Yes.

**Q.** And in due course, was there an issue with funding going on with the Vivaldi project after the summer?

**A.** No, one of the reasons I was able to roll off is that we'd effectively won that battle and we had very significant funding which then, my understanding is, it's continued ever since.

**Q.** Did the funding issues at the beginning impact the way that the study was able to be set up? Did it have any practical effect or was it more of a bureaucratic issue if I may put it like that?

**A.** It was a bureaucratic issue. The only practical effect

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1 was -- it wasn't just financial resource, it was people  
 2 resource. Because I was the only person within the  
 3 Civil Service who was working on Vivaldi, it meant that  
 4 there was an enormous amount of time that was being  
 5 wasted by having to sort out some of those procedural  
 6 process issues.

7 **Q.** Right. You said there, I think in -- you mentioned  
 8 there that there was a resource issue and you were the  
 9 only person. You said you were making weekly requests  
 10 to the department for reinforcements throughout the  
 11 summer. Why did you need extra staff and indeed, were  
 12 those requests met?

13 **A.** So those requests weren't met and I think that was just  
 14 because, as I said, the HR systems had become  
 15 overwhelmed.

16 **Q.** Right.

17 **A.** I desperately needed more staff to do things like set up  
 18 the funding and things like that because we were all --  
 19 everyone on Vivaldi and, indeed, almost everyone we  
 20 worked with -- we were all working hundred-hour weeks  
 21 and there just wasn't enough time in the day to do  
 22 everything that needed to be done.

23 **Q.** So one shouldn't read into that that there was not  
 24 a desire to give you the staff, but more that the  
 25 processes weren't in place to accommodate those requests

9

1 memory, the deaths data, and then the Pillar 1 outbreak  
 2 testing data from PHE, and it was also difficult --  
 3 because of the extreme speed with which Pillar 2 had  
 4 been set up, it was a very complicated set of data feeds  
 5 that came through to us in the data lake, the data  
 6 foundry -- NHS Foundry, so we had to -- in order to get  
 7 the study to work, we had to sort of, as it were, go  
 8 upstream to find all the blockages and unblock them.  
 9 And as we did that, we realised that we were solving the  
 10 problem that was bigger than just the -- Vivaldi's  
 11 problem; it was a problem for everyone. And that work  
 12 then led into what became the dashboard, which was the  
 13 attempt to get all of the data in one place and analyse  
 14 it.

15 **Q.** Fine. I'm going to come on to the dashboard a little  
 16 bit later on but I just want to make sure I understand  
 17 that answer. It's not that someone wasn't allowing you  
 18 access, it's just that the systems didn't speak to each  
 19 other, if I may put it like that, or -- can you help  
 20 with what the blockage was?

21 **A.** I think it was probably both. I think the systems  
 22 didn't speak to each other and there was a culture of  
 23 information hoarding, I would suggest, which -- which  
 24 often made it difficult to get the data.

25 And to be clear, this wasn't a legal data sharing

11

1 giving everything else that the department was doing?

2 **A.** That's right, and also -- but it wasn't that there  
 3 weren't enough staff, because there were hundreds of  
 4 these people who had been brought in, like I had; the  
 5 problem was it was very difficult to persuade people  
 6 that -- everyone thinks what they're working on is  
 7 important but what we were working on, I thought at the  
 8 time and I still think, was much more important where  
 9 some of those resources were allocated, and it wasn't  
 10 possible to just move people from one team into another.

11 **Q.** Dealing with other potential problems in the setting up  
 12 of Vivaldi, you make a number of observations through  
 13 your statement about problems obtaining the data.

14 **A.** Yes.

15 **Q.** I want to be clear about what data we're talking about  
 16 and then what the problems were. Are you able to help  
 17 us with that?

18 **A.** Yes. So there's a series of different points here. So,  
 19 first of all, it was difficult for us to -- we wanted to  
 20 ingest all the data we could get from everywhere about  
 21 care homes, so that we could link it together and form  
 22 an overall picture, and then present that to seniors.

23 But different parts of the system owned different  
 24 data streams and were often reluctant to share them.

25 So, for example, it was difficult to get, from my

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1 issue. We'd looked into that and COPI notices and so  
 2 forth. We knew that wasn't the problem. It was  
 3 a problem of getting different parts of the DHSC and PHE  
 4 to share with each other and talk each other.

5 **Q.** All right. You did go on to say in your statement,  
 6 though, that you had arranged for ministerial pressure  
 7 to be brought to bear here to try to help the blockages  
 8 with the data. The minister wasn't able to recall that  
 9 when she gave evidence. Can you help it what the  
 10 minister actually did to try to unblock the problems?

11 **A.** Yes, certainly. And to be fair to the minister, there's  
 12 no reason that she would necessarily have known that  
 13 that's what she was doing. So I think, to my -- in my  
 14 mind, what happened was, there was -- there were  
 15 meetings where we were saying: look -- effectively --  
 16 we've got this data, we don't have this data, the  
 17 Pillar 1 data or deaths data, would it be possible to  
 18 have that?

19 And the minister wouldn't have known that by asking  
 20 that in front of the very people who we'd been arguing  
 21 with -- it was a bit of a faux pas on my part, but  
 22 I felt it was necessary to get that pressure from above  
 23 to get the data unlocked.

24 **Q.** So she may have facilitated the unblocking without  
 25 necessarily knowing that she was being asked to

12

1 unblock --

2 **A.** Yes, absolutely.

3 **Q.** All right. Can I just stick with the run-up to the

4 findings of Vivaldi, which we know were published in

5 July 2020, and can I ask you, please, about two specific

6 paragraphs in your statement, at 55 and 56.

7 And you say at paragraph 55 that:

8 "The new Director [at] the ... [adult social care]

9 team ... asked [you] 'who's telling you to do all

10 this?'"

11 And you go to say that Vivaldi and you were then

12 excluded from many of the relevant meetings. And

13 I would just like some background and context to that

14 comment. Do you know why the new director of the adult

15 social care team was sort of asking you who's telling

16 you to do all this?

17 **A.** Yes, so, first of all -- and before the moment in July

18 when Vivaldi officially reported -- we had been

19 reporting since May. As we got data, we reported it.

20 And that created these tensions that I've described.

21 **Q.** Right.

22 **A.** So I'm slightly reluctant to sort of pick on one person

23 or incident, but there was a series of moments, of which

24 this was an example, where it seemed that PHE had spoken

25 possible my bosses within the department and effectively

13

1 Can we be clear now, when you say she "effectively"

2 told you to stop doing the project, was that her actual

3 words or the impression that she gave you?

4 **A.** It wasn't her actual words, but I was under no uncertain

5 impression that I was being told off for what we were

6 doing and the way we were doing it, and that after that

7 call, I shouldn't be continuing in the way that we had

8 been.

9 **Q.** Now, can I be clear. Did you get the impression that

10 she wanted you to stop doing the project because she

11 didn't think it had value, or she wanted you to stop the

12 way you had, perhaps, been manoeuvring things to get the

13 project done and ruffling feathers?

14 **A.** I think it was probably a bit of both, or that's how

15 I interpreted it at the time.

16 **Q.** Right. But you did not stop what you were doing?

17 **A.** I'm afraid not.

18 **Q.** And I think you say in your statement you did not report

19 that conversation with Ms Roughton to your line manager?

20 **A.** No.

21 **Q.** All right. Now, that was at some point in June, and as

22 you rightly point out, although the study was published

23 on 3 July, we know from Professor Shallcross that she

24 was reporting preliminary findings in a number of

25 different meetings. She's told us about a DHSC Data

15

1 said: why are you cutting across us? This is coming out

2 of your team, why are you trying to do the same thing

3 that we're doing and creating these -- different

4 reporting?

5 **Q.** Right. So was it intergovernmental department --

6 **A.** Exactly.

7 **Q.** -- issues there. Did you get the impression that the

8 new director was telling you to stop doing Vivaldi or

9 anything of that nature? I want to be clear.

10 **A.** So it is certainly the case that the new director and,

11 indeed, others in the hierarchy above me did not want to

12 use Vivaldi for the purposes of the policy making and

13 the winter planning that was going on.

14 **Q.** We will come back to that. Put the interdepartmental

15 issues to one side, you go on to say in your statement

16 that in June 2020, you suspect after complaints from

17 Public Health England, the then director general,

18 Ros Roughton, rang you on your personal mobile.

19 Can you remember when this was, Mr Donaldson, apart

20 from it being that month?

21 **A.** At this stage I'm afraid not.

22 **Q.** All right. And you say she phoned you on your personal

23 mobile to ask why I was doing what I was doing in

24 launching Vivaldi, and effectively to tell me to stop

25 doing it.

14

1 Debrief meeting on a Thursday and a SAGE Social Care

2 Working Group or PHE meeting on a Friday; have I got

3 that right?

4 **A.** Yes.

5 **Q.** Data Debrief on a Thursday, SAGE on a Friday.

6 Professor Shallcross told us that she was reporting

7 preliminary findings to the Data Debrief Group --

8 **A.** Yes.

9 **Q.** -- without any difficulty. She also said she shared the

10 Vivaldi findings in the Friday meetings from 30 June.

11 That was the date she was able to put on it. You look

12 askance there, Mr Donaldson. Does that not accord with

13 your recollection?

14 **A.** No, there is no disagreement between me and Laura and --

15 Professor Shallcross on that, but what I would say is

16 that we had been making interventions into the Friday

17 SAGE working group since May, in my -- to my memory.

18 **Q.** It perhaps matters not because it was going into both

19 meetings.

20 **A.** Yes.

21 **Q.** But you do say in your statement in relation to the SAGE

22 care home group working meetings, you had to gatecrash

23 a June SAGE care home meeting. I suspect -- do you

24 remember now which one?

25 **A.** Forgive me, I am now not even convinced it was June

16

1 rather than May. I honestly can't remember.

2 **Q.** Right, okay.

3 **A.** But what I can remember very clearly, and I think I may

4 not have allowed Laura to know quite how difficult the

5 battle was with the secretariat to get her in, I didn't

6 want to professionally embarrass her, but initially it

7 was very difficult to get into those meetings and

8 present, but to be fair, the chair, Ian Hall, had an

9 admirably open chairing sort of -- it was like

10 a tutorial, almost. He was very happy to take

11 interventions so once we were in and reporting, it

12 became quite easy for us to start to be a formal part of

13 that structure.

14 **Q.** Did you get the sense that Vivaldi was being

15 deliberately excluded or it just takes time to invite

16 a new person to a new meeting and have some familiarity

17 with how those meetings are run?

18 **A.** I think there was perhaps initially a little bit of

19 a sense of, you know, who are these new people and why

20 are they, kind of -- (overspeaking) --

21 **Q.** Let me ask you this. Do you think there was a desire

22 not to hear the findings of Vivaldi as they became -- as

23 they emerged?

24 **A.** I think there may have been a purely subconscious

25 reluctance from parts of PHE to hear that we were

17

1 without it having shown up.

2 **Q.** Right, well, that just helps contextualise it for those

3 who are, perhaps, less familiar, watching. You say in

4 your statement that when the results were delivered,

5 there was a suggestion that the Vivaldi results needed

6 to be packaged as SAGE advice. Can you help explain

7 what you mean there?

8 **A.** Yes, and to be clear, I don't think that's quite right.

9 I think that the thing that was extremely concerning was

10 that when we finally published the results at the

11 beginning of July, we'd already been reporting the extra

12 cases and some of these risk factors around staff

13 movement and sick pay and cohorting and so on. But

14 there was a new and very important finding, which was

15 that only about half of the care homes had had any

16 cases, so there was a big danger with the second wave

17 with no natural immunity, and also that -- and this cut

18 against the modelling -- that people in small care

19 homes, which was about two-thirds of the care homes,

20 were per capita pretty much just as -- under just as

21 much risk as people in the large care homes, and the

22 initial drafts of the winter planning were going to

23 focus what was limited testing resource just on the

24 larger care homes, and what I had to do was get SAGE to

25 reconsider that based on the Vivaldi findings that they

19

1 inadvertently showing up problems with their data,

2 because Vivaldi immediately found that they had been

3 significantly underreporting -- (overspeaking) --

4 **Q.** Yes, so to be clear to people who are perhaps not as

5 familiar with this as you are, Mr Donaldson, we know in

6 due course that PHE found a relatively low number of

7 infections, for various reasons, and, indeed, we are

8 aware of the retrospective study they did in

9 July 2021 --

10 **A.** Yes.

11 **Q.** -- which found seeding of 1.6% of hospital discharges

12 led to infections in care homes.

13 **A.** Yes.

14 **Q.** Vivaldi was reporting slightly higher figures than

15 that --

16 **A.** So --

17 **Q.** -- but I'll come on to hospital discharge as a discrete

18 topic.

19 **A.** Yes, okay.

20 **Q.** But generally speaking, there was lower numbers being

21 reported by PHE than the Vivaldi findings?

22 **A.** So significantly lower, and also, we weren't just

23 finding that there were more cases; we were also finding

24 that there had been more cases because we could see from

25 the antibodies that many people had had the infection

18

1 were all at risk, and then get the department to take

2 that on board.

3 **Q.** Can I just ask you about the retrospective PHE study and

4 the 1.6% findings.

5 **A.** Yes.

6 **Q.** In your statement, and it's at paragraph 39,

7 Mr Donaldson, you have said that:

8 "Great caution is needed in interpreting 2020 PHE

9 care home data."

10 And we're familiar with the lack of testing in

11 January, February, March, at least up until about

12 15 April; all right?

13 **A.** Yes.

14 **Q.** And you were worried about the use of that data and

15 indeed, you said, in terms, that you were worried that

16 it:

17 "... did not tally with what Vivaldi had uncovered

18 and it carries a substantial risk of the system 'marking

19 its own homework'. It was not being checked by

20 independent epidemiologists with no 'dog in the fight'

21 or intellectual or professional interest at stake."

22 Can I ask you, please, to explain what it was you

23 were worried about and whether you are suggesting there

24 that perhaps they have either done something

25 inappropriate with the data or they wanted to cover up

20

1 the data. I just want to be very clear about what it is  
 2 you're saying.  
 3 **A.** Certainly. And this will take a minute to explain, if  
 4 I may.  
 5 **Q.** Take your time.  
 6 **A.** So I think there are briefly three problems with this,  
 7 because whether it's the Vivaldi Study in the summer or  
 8 subsequent studies in the autumn and the following year,  
 9 asking the question "What are the routes in for Covid to  
 10 get into care homes?", is a different question from  
 11 asking "What are the causes of excess deaths in care  
 12 homes?"

13 And it is dangerous, and I've seen this throughout,  
 14 that for perfectly understandable reasons, those two  
 15 things have a tendency to be conflated. So whether it's  
 16 Vivaldi looking at data from May, because we didn't have  
 17 any testing data from the time when all the -- most of  
 18 the excess deaths happen, or subsequently, by  
 19 changing -- this is the first point -- by changing  
 20 the -- expanding this time horizon, you're effectively  
 21 expanding a denominator with things that aren't relevant  
 22 to one of those two questions.

23 The second point is, the cases are defined by the  
 24 testing. So both the numerator and the denominator, if  
 25 you are saying, well, this case came from a hospital and

21

1 One of the other things that you speak of in your  
 2 statement is references to the Inquiry in meetings that  
 3 you attended. And I think you said at your paragraph 69  
 4 that there was comments made such as "come the Inquiry,  
 5 we'll have to be able to say [X or Y]", or "the Inquiry  
 6 will ask us [A, B or C]". Can you give us any context  
 7 in which phrases like that were said and whether that  
 8 was people covering themselves or it was saying from  
 9 a defensive point, or it was said from a "We need to  
 10 have a clear audit trail so we can remember this when we  
 11 go to the Inquiry many years down the line"? Help us  
 12 with the context, please.

13 **A.** Certainly. And to be clear, in terms of context and in  
 14 terms of your last suggestion, this is definitely not  
 15 the sort of thing that you would ever see paper-trailed.  
 16 This would have been oral comments in meetings.

17 And I want to very clearly state I don't think this  
 18 was -- I'm not suggesting that there was some kind of  
 19 conspiracy or cover-up here, it was just very striking  
 20 to me, as a then non-civil servant, that it was  
 21 a cultural habit, if you like, or culturally acceptable  
 22 to say, well, there's going to -- to focus on the fact  
 23 that there was going to be an inquiry, and therefore  
 24 that people, I think, were reluctant to take initiative  
 25 or responsibility for things that weren't immediately

23

1 then we found it again in a care home, that would only  
 2 be the case if you had tested for it in a hospital which  
 3 in March you would have only done for symptomatic cases  
 4 which were not as dangerous because people knew to  
 5 isolate then.

6 And the third point and I haven't seen this anywhere  
 7 else but I think it's really important, even if very  
 8 small -- even if a very small proportion of entries of  
 9 Covid into care homes came with, let us say, hospital  
 10 discharge, untested hospital discharge, that doesn't  
 11 mean that only a small proportion of the excess deaths  
 12 would have been caused by that, by any means, because  
 13 although all entry of Covid into care homes was  
 14 dangerous, some was much more dangerous than others and  
 15 asymptomatic ingress at the end of March, let us say,  
 16 untested into care homes that weren't protected was very  
 17 much more dangerous and likely to cause more cases than  
 18 something that happened in May or down the line.

19 And so when I say marking -- to be clear, I'm not  
 20 suggesting any impropriety, I just think that because of  
 21 a limited number of people working in this field,  
 22 I think there is a danger of us, as a system, marking  
 23 our own homework.

24 **Q.** Thank you. I just wanted to be clear about what it was  
 25 you were saying there. Thank you.

22

1 within their explicit remit. And what that meant was  
 2 that there was a greater likelihood of sins of omission  
 3 than sins of commission, if that makes any sense.

4 **Q.** Different topic, please, and the dashboard data.

5 In your witness statement, you say you were told not  
 6 to share it with ministers, local authorities, Cabinet  
 7 Office, Number 10, and you went on to say you granted  
 8 access to everyone in local or central government who  
 9 requested it.

10 We have in fact seen emails where there was --  
 11 various access granted to all those people, but can you  
 12 help us with the reference to why you were told not to  
 13 share it with ministers and other government  
 14 departments.

15 **A.** Yes, so -- and to be fair, the context of this is  
 16 I'd asked for this dashboard to be created sort of  
 17 without anyone asking me to do it, because I knew that  
 18 we had all this valuable data and we had -- I can't  
 19 claim credit for it -- Gemma Hallatt from Palantir had  
 20 created this excellent tool. I could see how powerful  
 21 it was going to be for the second wave that we could  
 22 already see from the data in this dashboard was coming.

23 But I was very, sort of, surprised that my seniors  
 24 on the adult social care side were not using it to  
 25 report upwards to ministers; they were still using the

24

1 flawed PHE data. And I didn't feel that they  
 2 necessarily understood either the data itself or the  
 3 potential power of this dashboard. So, I confess, I did  
 4 use my control over the log-in access or my initial  
 5 control over the log-in access to share it as widely as  
 6 I could.

7 **Q.** Because you wanted to see what potentially it was able  
 8 to show us, infections at national level, regional  
 9 level -- as we understand it, it went down in due course  
 10 to care home level?

11 **A.** Even at the start, in August, it went down to that level  
 12 of granularity, individual care homes. And the thing  
 13 that was terrific about Minister Whately is that she  
 14 would -- she really wanted to interrogate the data and  
 15 was then able to follow up and effectively, sort of,  
 16 you know, ring up individual care homes or local  
 17 authorities and say, "Look, we can see you've got  
 18 a problem here. What is it? How can we help?"

19 So, because in August we could see that the second  
 20 wave was taking off, we thought it was absolutely urgent  
 21 to get this out to as many people as possible.

22 **Q.** Right. And just -- you mentioned there  
 23 Minister Whately. You say you were told by your  
 24 director not to share it with the minister and had to  
 25 give briefings to the minister in secret without your

25

1 of the data that the dashboard could tell us?

2 **A.** I think in general people were extremely pleased with  
 3 the dashboard because it was a very powerful tool for  
 4 the second wave.

5 **Q.** Can I ask you one final question, please, and it's about  
 6 your paragraph 111 and it may help if we have up on  
 7 screen, please -- thank you very much -- page 35.

8 Now, some of the other witnesses that her Ladyship  
 9 has heard from have been asked about this paragraph and  
 10 I'd like your observations on it, but you say by way of  
 11 summary:

12 "... we had to create Vivaldi because PHE and DHSC,  
 13 [adult social care] Policy teams, had failed to do so.  
 14 We had to use outsiders because they wouldn't and  
 15 perhaps couldn't do it themselves. Parts of [Public  
 16 Health England] and [the Department] effectively tried  
 17 to stop Vivaldi happening, then tried to stop it  
 18 reporting, then tried to avoid acting on the results,  
 19 then tried to stop the creation and use of our ...  
 20 dashboard. Having tried to stop our initial report, PHE  
 21 first tried to ignore it, then tried to steal it and  
 22 present it as their own, then tried to reinterpret it as  
 23 justifying its own previous policy failings."

24 You go on to say:

25 "DHSC refused to share data, even when ordered to by

27

1 own managers knowing until the data became recognised as  
 2 too valuable to stop.

3 **A.** Yes.

4 **Q.** Now, the minister didn't recall being briefed in secret.  
 5 Maybe she wouldn't know about that. But are you able to  
 6 provide any background or context as to why you had to  
 7 brief the minister in secret, as you describe it?

8 **A.** Yes. And again, to be fair, there's no reason the  
 9 minister -- so this was -- I effectively had a good  
 10 relationship with Minister Whately's private office, and  
 11 the fact we were all in lockdown here was our friend,  
 12 because usually a junior official would find it  
 13 difficult to get into the physical room with the  
 14 minister but on Teams it was quite easy to say to the  
 15 private office, "Oh, I think the minister will want to  
 16 see this, can you add me to the invitation list?" So my  
 17 bosses would, to their slight horror, I'm sure, would  
 18 see me turning up in a meeting without anyone having  
 19 asked me to be there. But they -- they were reluctant,  
 20 I think, to take responsibility for this product which  
 21 I had asked to be created and which did not have PHE,  
 22 sort of, approval or badging on it.

23 **Q.** Once the dashboard was shared with a number of people  
 24 different and bodies, did you get any sense then that  
 25 people were not grateful or didn't appreciate the value

26

1 ministers, and regularly proposed not telling ministers  
 2 important information. I believe that all this suggests  
 3 a pattern of dysfunction that helps to explain why  
 4 things were so bad with the care home policymaking at  
 5 the start of the pandemic, and gives broader clues as to  
 6 the systemic problems Covid revealed."

7 Now, the next line of paragraph 112 hasn't been  
 8 shown before but you go on to say:

9 "In my view, none of this was because of bad faith  
 10 or malicious or lazy individuals ... It was, rather,  
 11 part of a wider problem of systemic bureaucratic  
 12 inflexibility ..."

13 And you go on.

14 Now, wider systemic issues are perhaps not within  
 15 the remit of this Inquiry but certainly  
 16 Professor Hopkins was asked about this paragraph and she  
 17 said she didn't recognise the matters that you set out  
 18 there, and would like to see the evidence upon which it  
 19 was based. Do you have any additional comment to make  
 20 about what are, on any view, relatively strong  
 21 criticisms there of both PHE and the department, and any  
 22 other context you would like to add to that paragraph,  
 23 Mr Donaldson?

24 **A.** Yes. So, first of all, I'd like to point out I say  
 25 "parts of". I'm not trying to be too blanket in this.

28

1 And of course it was different parts doing different  
 2 bits of this, so I think this paragraph only makes sense  
 3 in the context of my wider statement, but I still think  
 4 it's an accurate summary, and as I say, just make it  
 5 clear, I don't -- everybody was working extremely hard,  
 6 and I didn't see any evidence of anyone doing anything  
 7 inappropriate individually, but it was an enormous  
 8 struggle against a set of systemic problems.

9 **MS CAREY:** My Lady, they're all the questions I ask but  
 10 I think there is one Core Participant who has been --  
 11 (overspeaking) -- some questions.

12 **LADY HALLETT:** There is.

13 **Questions from MS STONE**

14 **MS STONE:** Thank you, my Lady.

15 Good morning, Mr Donaldson. I ask questions on  
 16 behalf of Covid Bereaved Families for Justice UK, and  
 17 I have just got three questions for you, please, which  
 18 relate to your evidence as to the impact of the hospital  
 19 discharge policy.

20 So the first one is this: the Inquiry has heard  
 21 evidence about the limitations of the PHE data linkage  
 22 study given how constrained testing capacity was in  
 23 March and April 2020. And you've touched on that this  
 24 morning.

25 As Ms Carey King's Counsel noted at the outset, you  
 29

1 come to that conclusion?

2 **A.** My personal belief? So just because of Occam's Razor,  
 3 I suppose. If you take lots of people who -- from  
 4 hospitals full of Covid and put them into a vulnerable  
 5 setting without testing them, given how many  
 6 asymptomatic cases there were, it would be surprising if  
 7 that did not cause, unfortunately, further cases and  
 8 deaths, and the problem for all of us who were working  
 9 on these issues at the time is that that policy was --  
 10 it was difficult to analyse for the same reason it's  
 11 been controversial, there were no tests so it was  
 12 impossible to know which of those people, unfortunately,  
 13 were infected.

14 **Q.** Finally, Mr Donaldson, in your statement you describe  
 15 a "generational slaughter" within care homes. And  
 16 that's clearly not everyday language. Why or what  
 17 prompted you to use such strong language in the context  
 18 of this, of the hospital discharge policy?

19 **A.** Well, I think I use it in the context of the overall  
 20 situation. I was asked to give this witness statement  
 21 in my own words, and I can't think of a better form of  
 22 words, given the horrible scale of the tragedy in the  
 23 care homes, particularly in that first wave. We're  
 24 talking about something like 27,000 excess deaths in the  
 25 space of a few weeks, and of course, unfortunately,

31

1 stress, fairly, at the beginning of your statement,  
 2 that, you have no academic background in science or  
 3 epidemiology.

4 **A.** Yes.

5 **Q.** But is such a background necessary to recognise those  
 6 limitations?

7 **A.** So to be clear, I had a team of epidemiological and  
 8 statistical experts who were helping me throughout that  
 9 summer to interpret the raw data that we were looking at  
 10 and it was my job as a policymaker to summarise their  
 11 findings and interpret them for the purposes of policy.

12 **Q.** So is the answer no, that you were able to do that  
 13 within the parameters of your role, relying on those  
 14 experts?

15 **A.** So I think precisely because I had those experts in my  
 16 team to help me, I think that I'm -- I make absolutely  
 17 no claims for my own knowledge but I think I was in  
 18 a good position, from where I was sitting, to understand  
 19 the data, yes.

20 **Q.** Thank you. Second, please. You also say in your  
 21 statement that given those data constraints, it's not  
 22 possible to prove definitively whether the hospital  
 23 discharge policy was the cause of significant numbers of  
 24 unnecessary infections and deaths, but nevertheless, you  
 25 say you believe it probably was. How were you able to

30

1 concentrated, because of the nature of the virus, on one  
 2 particular generation.

3 **MS STONE:** Thank you very much, my Lady.

4 **LADY HALLETT:** Thank you very much, Ms Stone.

5 That completes the questions we have for you,  
 6 Mr Donaldson. Thank you very much for your help, for  
 7 coming today to assist the Inquiry.

8 **THE WITNESS:** Thank you.

9 **LADY HALLETT:** Thank you.

10 **MS CAREY:** My Lady, the next witness is Jeane Freeman, and  
 11 I'm going to hand over to Ms Jung.

12 Hello again, Ms Freeman.

13 **MS JEANE FREEMAN (sworn)**

14 **Questions from COUNSEL TO THE INQUIRY**

15 **MS JUNG:** Thank you, my Lady.

16 Ms Freeman, can you start by confirming your full  
 17 name, please.

18 **A.** It's Jeane Tennent Freeman.

19 **Q.** Thank you. And thank you for coming today to assist the  
 20 Inquiry for, I think, the fifth time; is that right?

21 **A.** Yes.

22 **Q.** The statement that you've produced for this module is at  
 23 INQ000606530. And I understand that you have a copy of  
 24 that?

25 **A.** I do.

32



1 Q. Thank you.

2 Dealing first with professional background. You

3 served as the Cabinet Secretary for Health and Sport in

4 Scotland between June 2018 and May 2021. After that,

5 you did not stand for re-election and you did not have

6 any further involvement in the Scottish Government's

7 response to the Covid-19 pandemic; is that correct?

8 A. It is.

9 Q. Prior to being appointed as Cabinet Secretary for Health

10 and Sport you served as Minister for Social Security.

11 Previous to that you worked as a senior civil servant in

12 education. You worked also as a special adviser, had

13 a decorated career in social justice, and you originally

14 trained and qualified as a nurse; is that all correct?

15 A. All correct, yes.

16 Q. Did you have any professional experience in adult social

17 care before your appointment as Cabinet Secretary for

18 Health and Sport?

19 A. No.

20 Q. Dealing, then, with your role as Cabinet Secretary for

21 Health and Sport, you had primary responsibility for the

22 Health and Social Care Directorate and also NHS

23 Scotland; is that right?

24 A. That's correct.

25 Q. That included primary care, allied healthcare services,

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1 delivery of adult social care."

2 The point that you've just made. To what extent did

3 that constrain your ability to direct and coordinate the

4 social care sector's response to the pandemic?

5 A. So it is a constraint, in as much as, in terms of

6 the NHS, then, particularly using the legislation, it

7 was possible for me to direct what we were doing in our

8 health service. It's not the case that a health

9 secretary has the power to direct what happens in adult

10 social care, whether that is in a residential or an

11 at-home setting. That sits with local authorities and

12 with their umbrella body, COSLA. And so the way in

13 which you work is to reach agreement with COSLA on those

14 matters that you've just described, the strategic

15 approach, the resourcing. But then you are dealing with

16 individual stakeholders and, as you know, adult social

17 care in Scotland is delivered by a range of agencies,

18 both private and public.

19 Q. Thank you. Is it the case that local authorities and

20 health boards delegate their social care duties to, in

21 the majority of cases, what are called integrated joint

22 boards? They then set the strategy and commission the

23 work, and adult social care is delivered by what are

24 called health and social care partnerships?

25 A. Broadly speaking, that is correct. Health and social

35

1 vaccinations and therapeutics, healthcare and social

2 integration, and carers and adult care; is that right?

3 A. That's correct.

4 Q. Did you also have lead responsibility for a number of

5 public bodies, including NHS Scotland, the Care

6 Inspectorate, the Scottish [Social] Services Council and

7 Sports Scotland?

8 A. Yes.

9 Q. And dealing then with your role during the pandemic, is

10 it right that you were primarily responsible for health

11 and social care, and in terms of the areas that are

12 relevant to this module, you had responsibility for

13 adult social care policy, setting direction, and making

14 decisions on resourcing and strategic decisions.

15 However, you did not make day-to-day operational

16 decisions on adult social care; is that correct?

17 A. That's correct, because, of course, the statutory

18 responsibility for delivery of adult social care sits

19 with our local authorities.

20 Q. Thank you. Can I ask you about levers, please.

21 A. Yes.

22 Q. At paragraph 6 of your statement you make the point

23 that:

24 "Unlike health [care], the Scottish Government does

25 not have direct statutory responsibility for the

34

1 care partnerships will then commission the delivery of

2 adult social care. So that might be to the private

3 sector or, in some instances, local authorities deliver

4 that directly by employing the staff themselves to do

5 that.

6 Q. Thank you. And I think the only health board that's

7 slightly different is Highland, where the NHS board is

8 responsible for adult social care, I think, and the

9 local authority is responsible for children's social

10 care; is that right?

11 A. Yes.

12 Q. Can I ask you for clarification, please. At paragraph 6

13 you say:

14 "While Scottish Ministers can issue directions to

15 local authorities, Health Boards and Integration Joint

16 Boards/Health and Social Care Partnerships, [you] do not

17 have statutory powers to issue directions to care

18 providers."

19 Can you just be clear, please, what levers did you

20 have during the pandemic, as far as the adult social

21 care response was concerned?

22 A. In terms of the providers, or -- do you mean in terms of

23 the providers --

24 Q. In terms of directing the response. So whether that --

25 we know that you didn't have any power to direct the

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1 care home providers, but as far as the integrated joint  
2 boards of the health and social care partnerships were  
3 concerned, and also the local authorities and the health  
4 boards, can you tell us what levers you did have,  
5 please.

6 **A.** So there are some statutory levers, but at the same  
7 time, we have to remember that individual local  
8 authorities are themselves democratically elected  
9 bodies. So you have to respect the democratic basis of  
10 a local authority.

11 So the bulk of the work in practice involves  
12 discussion and agreement, which is why, as I think I say  
13 in my witness statement, and have said previously, the  
14 quality of the relationship with COSLA, and in  
15 particular their lead member for social care, was  
16 critical to being able to secure agreement on our  
17 overall approach, on resourcing, on additional support  
18 that might be needed, and so on.

19 **Q.** So is my understanding correct, then, that you did have  
20 some statutory levers but you chose not to use them for  
21 the reasons that you've just stated?

22 **A.** No, I wouldn't say I chose not to use them. It was --  
23 there was limited difficulty in securing agreement  
24 between myself and COSLA on the direction of travel and  
25 what needed to be done, both in the overall strategic

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1 Scottish Government can take to address that, both  
2 through our clinical teams but also directly as  
3 throughout NHS Scotland but also as government. Those  
4 steps are not as available in adult social care, so  
5 inconsistency of delivery is unfair on those receiving  
6 the care.

7 **Q.** And I think in fact, during the pandemic, you exercised  
8 your emergency powers to put the NHS on an emergency  
9 footing; is that right? And did that give you control,  
10 I think you refer to it in your statement as the NHS  
11 acting as one single unit?

12 **A.** Yeah.

13 **Q.** Is that the kind of lever that you would recommend  
14 should be in place in future to give ministers -- allow  
15 them to be better equipped to lead a response in the  
16 future?

17 **A.** So for accuracy, I used the legislation that allows  
18 a Health Secretary, I think it's the '78 legislation  
19 that allows the Health Secretary to put the NHS on to an  
20 emergency footing. That means that I could use powers  
21 if required. As it happened, I did not require to  
22 because our NHS all faced in the same direction, and  
23 so on.

24 I think it's worth consideration, in terms of adult  
25 social care, but I can see complications with that

39

1 approach and in some of the detail of delivery. Where  
2 there were issues, it arose in terms of individual  
3 providers.

4 **Q.** Thank you.

5 **A.** And on occasion, to be fair, with individual local  
6 authorities.

7 **Q.** Looking back, then, are there any particular levers that  
8 you wish you had had at your disposal or are there any,  
9 in hindsight, you wish you had used differently?

10 **A.** I think that's a difficult question. There were none  
11 with hindsight that I wish I had used differently, given  
12 what was available to me at the time. I think my answer  
13 to the second part of your question about what would  
14 I like to have had but didn't have, is really picked up  
15 in some of the recommendations of the Feeley report.

16 So the key one there is about securing consistency  
17 of standards across adult social care provision in  
18 Scotland, where, prior to the pandemic and indeed during  
19 the pandemic, there were differences in the consistency  
20 of delivery of some of the requirements we made, for  
21 example, visiting guidance in some instances, that would  
22 be best to not have that inconsistency.

23 And the comparison I'd make is where you have  
24 inconsistency in the delivery of healthcare between one  
25 health board and another, there are various steps that

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1 because the provision of adult social care is split  
2 between private and public, whereas our NHS in Scotland  
3 is a publicly provided, entirely publicly funded,  
4 healthcare service. So the basis on which an elected  
5 government minister can direct that publicly funded  
6 agency is clear. I think it is less clear where you  
7 have that mix of provision.

8 So I'm not discounting that, I think it's worthy of  
9 some consideration, but I can see complexity in that.

10 **Q.** Thank you. Can I ask for your general reflections on  
11 a number of matters, please.

12 In your view, what aspects of the adult social care  
13 response in Scotland went well?

14 **A.** So I think, without exception, the response of staff  
15 working in adult social care, both in residential  
16 settings and at home, was exemplary. In many instances,  
17 staff sacrificed time with their own families in order  
18 to deliver as safe care as they could. In some  
19 instances, staff left their homes and lived in the  
20 residential setting, where they were providing care. So  
21 I think that the response of adult social care staff was  
22 absolutely exemplary.

23 I think, overall, the relationship with  
24 Scottish Care and with COSLA worked very well, and we  
25 benefited from a range of clinical expert advice on the

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care and vulnerabilities of the population, particularly those cared for in residential settings.

**Q.** Were there any particular decisions where you feel, with hindsight, alternative actions may have led to a better outcome?

**A.** So I think, if I was currently dealing with a pandemic, then I think more consideration could have been given to the impact on those receiving adult social care of some of the measures introduced in order to safeguard them from the virus.

So I'm thinking particularly of those in residential care who suffer from dementia, for example, but also younger adults, perhaps with learning disabilities or other issues in residential care, who also suffered from the imposition of restrictions on their movement, on being outside. But at the time I did not believe there was a reasonable alternative to balance that concern against the overriding concern to try and prevent the transmission of the virus to a vulnerable population.

**Q.** Thank you.

Was the adult social care sector, in your view, the poor relation to the NHS in Scotland?

**A.** No, I don't believe it was, in terms of my actions with respect to how we would respond to the pandemic in that setting. I think, though, it is clear that the adult

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terms of what it said, and I had many meetings with Scottish Care, multiplied a number of times by the number of meetings my officials would have had. We also benefited from specific clinical advice in terms of geriatrician advice and I did myself meet care home providers and adult social care providers.

There were other organisations, too, that raised concerns and we had discussions with, particularly those who represented adults with disabilities or with learning difficulties.

**Q.** What changes do you think are needed to ensure that adult social care in Scotland is better understood, recognised, and equally prioritised alongside the NHS in future pandemic planning and response?

**A.** So I would not agree that it wasn't prioritised alongside the NHS in our pandemic response. And I think it's important for me to say that. But as we look ahead to what we need to do for the next pandemic that will appear, I think many, if not all of the recommendations from the Feeley report, should be implemented. I think, as I've said before, that our testing infrastructure needs to be, at a base level, better than it was at the start of the pandemic we're discussing.

I think we need to -- and in terms of the Feeley report, that is about agreed national standards,

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social care sector is disadvantaged in terms of the terms and remuneration to the staff who work in that sector and the absence of clear career progression, all of which makes it difficult to attract the numbers of staff that you would need to that profession.

Now, that is complicated, as we've said before, by restrictions that arose from Brexit, but the fundamental problem is the terms and conditions. And that was one of the reasons, for example, why, during the pandemic, we intervened in order to provide sick pay to those whose terms and conditions of employment provided nothing more than Statutory Sick Pay and made it very difficult, then, for staff who wanted to comply with our requirements, for example, if they had Covid themselves or, more often, a member of their family did, with our requirements for them to stay at home, that was a financial loss that we stepped in to try and alleviate so they could comply. But that was because their terms and conditions of employment were poor.

**Q.** Thank you.

Do you think there was a fair balance and a broad enough range of adult social care voices that informed decision making during the pandemic?

**A.** Yes, I do. I think Scottish Care was a key and critical voice, critical both in its importance, and at times in

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consistently applied across the country in whatever setting adult social care is delivered, and inspected and regulated to ensure that that is happening and where it's not, that steps are taken to achieve those improvements.

That all also links into how, as any Scottish Government works with and seeks to offer people with disabilities the equity of opportunity that those of us without that enjoy or have before us.

**Q.** Looking back, do you consider that the care at home sector and unpaid carers received sufficient and timely attention and support from the Scottish Government during the pandemic, particularly in comparison with care homes?

**A.** So the care at home sector was included in the additional supply of PPE that we introduced. So the concern about the supply of PPE to residential social care first flagged up the problem that existed, to which our response was then to use our National Services Agency which supplies PPE to our NHS, to increase the volume of supply and the routes to include residential care but also care at home, and unpaid carers, personal assistants, and a range of others. And you'll know from the material that's already been provided to the Inquiry the various routes that we implemented in order to

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1 ensure that that was the case.

2 I don't recall specific issues being raised with me  
3 in terms of care at home, with one exception, and that  
4 does relate to PPE, where, from the trade unions  
5 representing staff delivering care at home, they raised  
6 a concern that their members in some instances were not  
7 given an adequate supply of PPE to deal with the number  
8 of individuals in any given day that they would be  
9 visiting to provide care, and I made the determination  
10 that those staff in all circumstances should be given,  
11 if they were visiting, for example, five clients, they  
12 should be given five full sets of PPE and allowed to use  
13 their professional judgement on what PPE was appropriate  
14 for each individual.

15 **Q.** Thank you.

16 **A.** So that was one specific instance but there were --  
17 I don't recall others being raised directly with me, in  
18 terms of adult social care.

19 **Q.** So the question was, do you think that they did receive  
20 sufficient support and attention and were they  
21 prioritised alongside care homes?

22 **A.** Yes. For me, yes, they were. And in terms of all the  
23 issues that came to me for me to then address in the  
24 practical delivery of our work, I don't recall any that  
25 were raised that I did not address.

45

1 pandemic preparedness, or lack thereof, of the adult  
2 social care sector in Scotland, please.

3 **A.** I do not recall specific risks being raised with me with  
4 respect to the adult social care sector in terms of  
5 lessons from those exercises that had not been  
6 implemented.

7 What was clear, and was discussed many, many times,  
8 was the overall vulnerability of that sector, and its  
9 disparate nature, and that was what factored into our  
10 thinking and our planning, and with the help of  
11 specialist advice, in terms of geriatric care, the  
12 issues that I've already touched on in terms of the  
13 particular vulnerabilities that were not clinical  
14 vulnerabilities but other vulnerabilities of that group.

15 **Q.** One of the recommendations that was not fully  
16 implemented was that local plans should integrate the  
17 health and social care partnerships.

18 Did you have oversight at the start of the pandemic  
19 as to how many of the health and social care  
20 explanations had been implemented, fully implemented or  
21 integrated into the local pandemic plans?

22 **A.** No, I didn't.

23 **Q.** Is that something you think a minister should have  
24 oversight of, at the start of a pandemic? Not only to  
25 assure themselves of the existence and the adequacy of

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1 **Q.** Do you think that anything more can be done to increase  
2 the recognition and visibility of unpaid carers and the  
3 care at home sector in Scotland?

4 **A.** So I think ... mm. I think that in terms of, if you  
5 like, the narrative around adult social care, too often  
6 we, collectively, confine our thinking to only those in  
7 residential settings and confine our thinking to the  
8 elderly, where, as I've said, adult social care is also  
9 a vital service to many much younger people which,  
10 provided properly to meet their individual needs, allow  
11 them to, for example, go to work, meet their friends,  
12 have the kind of opportunities in terms of education and  
13 otherwise that those of us who are fortunate take for  
14 granted.

15 So I think there is an attitudinal question that  
16 needs to be addressed with respect to adult social care  
17 as you would broadly define it, and properly define it.

18 **Q.** Thank you. Can I move on to a different topic, please,  
19 which is pre-pandemic preparedness and plans.

20 In your Module 1 evidence, Ms Freeman, you accepted  
21 that there were several key lessons from exercises  
22 Cygnus, Silver Swan and Iris that had not been  
23 implemented or fully implemented by the time the  
24 Covid-19 pandemic arrived. Can you tell us what risks  
25 were known to you as at January 2020 regarding the

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1 the plans, but also to inform the response of the  
2 sector?

3 **A.** Yes, I do. Yes, I do. And I think our colleagues in  
4 Scottish Care and otherwise have made the point about  
5 that sector being represented more consistently in  
6 non-pandemic times at that level of strategic decision  
7 making. And I think that is a very fair point.

8 **Q.** Can I ask you about the initial period of planning and  
9 response. So focusing for now on the months of January  
10 and February 2020, please.

11 **A.** Yes.

12 **Q.** And could I ask to be shown on screen INQ000238703,  
13 please, page 4. And if we could focus on  
14 paragraphs 15-17, please.

15 Can you see in paragraph 16 it says, three lines up  
16 from the bottom:

17 "Planning included work to assess the vulnerability  
18 of the social care sector."

19 Do you see that?

20 **A.** Yes.

21 **Q.** Can you tell us what specific work was done in relation  
22 to assessing the vulnerability of the social care sector  
23 and what the findings were, please?

24 **A.** So this was work undertaken by officials, and it would  
25 be undertaken in consultation with, for example,

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1 Scottish Care, to look at -- and the Care  
 2 Inspectorate -- to look at Care Inspectorate reports up  
 3 to that point, identifying any particular residential  
 4 settings where improvements were needed and how that had  
 5 been progressed or not, and also looking at the mix of  
 6 agencies and the delivery of social care. So for  
 7 example, what proportion of adult social care delivery  
 8 was direct from local authorities in that they employed  
 9 the staff to do that? And then in the private sector,  
 10 what was the mix between large-scale operations and  
 11 small operations, a single care home run, but the  
 12 operators only had one care home compared to others  
 13 where maybe there was more than one.

14 **Q.** Do you think there are any steps that could have been  
 15 taken in those early months to try to deal with some of  
 16 the vulnerability issues going into the pandemic?

17 **A.** No, I'm not sure that there are any steps at that point  
 18 that were not addressed that should have been addressed.

19 **Q.** Can I ask you about some early correspondence, please,  
 20 between Professor Woolhouse and the then Chief Medical  
 21 Officer. You were asked about correspondence in  
 22 Module 2A. Was it fed back to you that in January,  
 23 Professor Woolhouse had warned Ms Calderwood, who was  
 24 the then CMO, that an integrated surveillance system  
 25 that combined clinical surveillance, genomic

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1 the existing surveillance system that we had which was  
 2 primarily through GP practices.

3 **MS JUNG:** And could I just ask you, while we're on this  
 4 topic, what the existing data system was in relation to  
 5 adult social care, and in particular, whether there was  
 6 any real-time data available in relation to care homes?

7 **A.** So there was real-time data available through the Care  
 8 Inspectorate. It depends what kind of data you're  
 9 meaning. So the existing -- or the pre-existing  
 10 surveillance system, the Sentinel system, through our GP  
 11 practices, would encompass care homes, and that is  
 12 around infection, primarily. Other data around the  
 13 provision of care, the quality of care, would come  
 14 through -- the adequacy staffing and so on, would be  
 15 data that would be available through the Care  
 16 Inspectorate.

17 **MS JUNG:** Thank you.

18 My Lady, I see the time. I can either deal with  
 19 a short topic now, or if it would be convenient --

20 **LADY HALLETT:** I'll return at 11.30.

21 **MS JUNG:** Thank you.

22 (11.14 am)

(A short break)

24 (11.30 am)

25 **LADY HALLETT:** Ms Jung.

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1 surveillance and serological surveillance and data  
 2 sharing was needed and that should be set up in advance  
 3 of the pandemic arriving in Scotland?

4 **A.** So that level of detail was not provided to me by  
 5 Professor Calderwood, but I was aware that she was in  
 6 touch with Professor Woolhouse, and I think met him  
 7 along with other experts in the field of epidemiology or  
 8 virology who were also in contact with her or her  
 9 colleagues expressing views and offering advice.

10 **Q.** Did you take any steps in January and February in  
 11 relation to building up the data infrastructure in  
 12 relation to adult social care?

13 **A.** At that point, no.

14 **LADY HALLETT:** Can I, sorry to interrupt, but can I just  
 15 ask, is it a level of detail that you wouldn't expect  
 16 a minister to be alert to if we're talking about  
 17 a surveillance system, or we're talking about data  
 18 infrastructure? Isn't that the kind of detail that  
 19 ought to come to the minister?

20 **A.** So I understood what our existing surveillance system  
 21 was, and if Professor Calderwood had thought that there  
 22 should -- that that should be improved in any respect,  
 23 then she would have raised that with me and we would  
 24 have discussed how that might have been done. I don't  
 25 recall that being raised with me but I did understand

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1 **MS JUNG:** Thank you, my Lady.

2 Ms Freeman, in your Module 2A evidence you said that  
 3 the Scottish Government's knowledge of and complete  
 4 understanding of how the adult social care sector  
 5 operated was not as adequate at the outset as it needed  
 6 to be, and some other areas of understanding,  
 7 particularly of the care at home sector, was not  
 8 adequate at the outset.

9 First of all, was that a reference to your own  
 10 personal understanding, or the government's  
 11 understanding?

12 **A.** I think both.

13 **Q.** And in what ways was your understanding and the Scottish  
 14 Government's understanding of how the sector operated  
 15 inadequate?

16 **A.** So I think the most important way -- I think both I and  
 17 the Scottish Government, ie officials, understood the  
 18 structure of adult social care sector, the delivery of  
 19 the adult social care sector, and importantly, the  
 20 contractual arrangements around the delivery of adult  
 21 social care. Where, importantly, I think there was less  
 22 understanding was a presumption, certainly on my part,  
 23 that the 2012 national manual for infection prevention  
 24 and control, which is -- the obligation to deliver  
 25 infection prevention and control, according to that

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1 manual, is part of the contract that providers have.  
 2 My presumption was that that was understood, that  
 3 staff were trained, consistently across the piece, to  
 4 know what to do, and it was being delivered.  
 5 I think the -- from early in the pandemic response  
 6 it became clear that that was not consistently the case.  
 7 **Q.** You said in your Module 2A evidence that there were some  
 8 presumptions made, which, as you worked through the  
 9 days, became clear could not stand. You've just  
 10 referred to one of those presumptions there.  
 11 **A.** Yes.  
 12 **Q.** Were there any other presumptions made which turned out  
 13 not to be true?  
 14 **A.** I don't believe so, but I think, for example -- this is  
 15 not a presumption -- well, arguably it might be, but  
 16 I don't see it as a presumption -- the difficulties that  
 17 the sector faced in securing adequate PPE.  
 18 So that had never been a difficulty raised, I don't  
 19 believe, with government in any respect prior to the  
 20 pandemic, but of course, was raised during the pandemic,  
 21 because it was a global pandemic, there was global  
 22 demand for PPE, and individual care homes, and indeed  
 23 individual local authorities, seeking relatively small  
 24 volume of PPE were being pushed out of the market, if  
 25 you like.

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1 **A.** No, but I was aware of very early in 2020, because  
 2 I believe Mr Macaskill raised it with me.  
 3 **Q.** Thank you. On a podcast in April 2021 you said this:  
 4 "I think our failures were not understanding the  
 5 social care sector well enough. So we didn't respond  
 6 quickly enough to what was needed in our care homes but  
 7 also in social care in the community."  
 8 Have you reflected, Ms Freeman, as to why, as the  
 9 Cabinet Secretary for Health and Sport, primarily  
 10 responsible for social care during the pandemic, your  
 11 knowledge of the sector was not adequate?  
 12 **A.** Yes, I have, and believe I've just explained in what way  
 13 it was.  
 14 **Q.** Sorry, it may be my fault for not asking the question  
 15 clear enough. The question is: why wasn't your  
 16 knowledge adequate?  
 17 **A.** Because I think the presumption that I made about  
 18 infection prevention and control in the adult social  
 19 care sector was a presumption made across government.  
 20 **Q.** Across the whole of government?  
 21 **A.** Well, health and social care.  
 22 **Q.** Do you think that, as a minister, you should have been  
 23 asking questions where things were unclear in your mind?  
 24 **A.** I think I should have, and I did.  
 25 **Q.** In your Module 6 statement you say at paragraph 72:

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1 **Q.** Thank you.  
 2 **A.** And that's why we intervened. I'm not sure that's  
 3 a presumption, but it is certainly an issue that arose  
 4 early in the pandemic which had not been an issue  
 5 pre-pandemic.  
 6 **Q.** We'll come to PPE a bit later.  
 7 **A.** Okay.  
 8 **Q.** But could I ask you this: in relation to the  
 9 recommendations made pre-pandemic, one of them was that  
 10 there wasn't enough awareness of the PPE stockpile and  
 11 of the distribution. Is that something that you were  
 12 aware of was an issue in relation to the adult social  
 13 care sector pre-pandemic?  
 14 **A.** No, because the pre-pandemic stockpile was not  
 15 necessarily something that the pre-pandemic would have  
 16 access to.  
 17 **Q.** In a pandemic?  
 18 **A.** In a pandemic they would do, but --  
 19 **Q.** Yes, and so I think the recommendation was saying that  
 20 the staff did not have enough knowledge that such  
 21 a stockpile existed --  
 22 **A.** Right.  
 23 **Q.** -- to be accessed in the event of a pandemic.  
 24 **A.** Okay.  
 25 **Q.** So is that something you were aware of pre-pandemic?

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1 "I do have a good understanding of the adult social  
 2 care sector in Scotland and took this into consideration  
 3 when making key decisions."  
 4 Can you please clarify, does that represent a change  
 5 in your position or should we take that to read that  
 6 you're referring there to decisions made later in the  
 7 pandemic because you've just accepted that your  
 8 knowledge at the beginning of the pandemic was not  
 9 adequate?  
 10 **A.** No, I think what you should take it as is that from the  
 11 outset, from being appointed the Cabinet Secretary in  
 12 2018, I understood the structure, contractual nature and  
 13 multiplicity of agencies delivering adult social care.  
 14 So in that sense I had a good understanding of how adult  
 15 social care was delivered, and the requirement of  
 16 government, in terms of funding, strategic decision  
 17 making, and so on. I understood about integrated health  
 18 and social care and the health and social care  
 19 partnerships you've referred to earlier.  
 20 The practicality of delivery is something that early  
 21 on in responding to the pandemic, became much clearer to  
 22 me, and that is where I would say my understanding was  
 23 not as full as I needed it to be at the outset, but  
 24 I have to say I think it became pretty full, pretty  
 25 early on.

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1 Q. Thank you.

2 You say at paragraph 166 of your statement that:

3 "Any assumption that dealing more effectively with  
4 the issue of delayed discharge in March 2020 increased  
5 the risk of introduction, or transmission, of COVID-19  
6 to care homes is, in my view, based on limited, if any,  
7 evidence."

8 Can you clarify, please, is that a view that you  
9 held at the time when you were making the discharge  
10 decision?

11 A. At the time when I was making the discharge decision, as  
12 I think I've explained previously, two points. First of  
13 all, it's really important, in all the decisions that  
14 were made during our response to the pandemic, to  
15 understand that these were not binary decisions. They  
16 were not decisions between a self-evidently risk-free  
17 approach and a risk approach. They were decisions  
18 between levels of risk. And so I understood, when I was  
19 making the decision, to ask that delayed discharge be  
20 paid attention to, which had been a position, prior to  
21 the pandemic, on my part and many previous Cabinet  
22 Secretaries', that in doing that, we needed to also  
23 ensure that mitigation measures were put in place in  
24 care homes, but we were looking to remove, where they  
25 were clinically ready to be discharged from hospital,

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1 A. I may have done, but, reflecting on it now, I don't  
2 believe there was a delayed response from us.

3 MS JUNG: It may be that you were referring to the April  
4 enhanced oversight package of measures.

5 A. It may have been, but that podcast was some time ago,  
6 and I have not listened to it. So I'm not entirely  
7 sure.

8 Q. Thank you.

9 Can we turn to the discharge policy in March,  
10 please.

11 There are number of area in which the Inquiry seeks  
12 clarification in relation to this policy. Dealing first  
13 with your role and accountability, you say at  
14 paragraph 122 of your statement that:

15 "The Scottish Government did not make individual  
16 discharge decisions. Scottish Ministers do not have  
17 powers, and did not, place named individuals in named  
18 care homes. Those types of discharge decisions are to  
19 be made on a case-by-case basis with clinical input.  
20 What the Scottish Government did do was to ask local  
21 authorities, through their adult social care staff, to  
22 prioritise and put additional effort into reducing  
23 delayed discharges in their hospitals."

24 So putting aside the individual decisions, do you  
25 accept that the Scottish Government did direct social

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1 individuals from high-risk environment, ie, a hospital,  
2 where we expected largish numbers of Covid patients as  
3 well as other hospital infections, to an environment  
4 that was, relatively speaking, less risky, plus those  
5 additional mitigation measures.

6 Q. Can we move on, please, to the discharge --

7 LADY HALLETT: Sorry, just before you do, I'm sorry to  
8 interrupt.

9 MS JUNG: Of course.

10 LADY HALLETT: I'm just trying to get straight in my own  
11 head what you're saying, Ms Freeman. I haven't listened  
12 to the podcast, forgive me, but I understood from  
13 Ms Jung's questioning that you said the lack of  
14 understanding across Scottish Government, including your  
15 own, had led to a delayed response but you've just told  
16 Ms Jung that you became -- that you had understood the  
17 structure, contractual nature and multiplicity of  
18 agencies, and you pretty early on had a pretty full  
19 understanding of the practicalities of delivery.

20 I'm not quite squaring the two because if you pretty  
21 early on got a full understanding then there wouldn't  
22 have been any delayed response, would there?

23 A. I'm not sure there was a delayed response, my Lady.

24 LADY HALLETT: I thought that's what you said in the  
25 podcast.

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1 care staff to reduce delayed discharges and that in fact  
2 targets were set for them to do so?

3 A. Yes, but that was no different from the pre-pandemic  
4 position. If we look at the work that I was undertaking  
5 in 2019, that was to reduce delayed discharge because  
6 delaying someone's discharge from hospital because the  
7 social care support is not in place, is detrimental to  
8 that individual, particularly to an individual who's  
9 elderly, in terms of both their physical and their  
10 mental health.

11 Q. And as Cabinet Secretary for Health and Sport, do you  
12 accept ultimate accountability for that decision and the  
13 consequences of it?

14 A. Yes.

15 Q. Turning to the rationale for the discharge policy, the  
16 Inquiry understands that the first positive Covid case  
17 in Scotland was confirmed on 1 March and that it was  
18 around this time that it was realised, in SAGE, and  
19 throughout the UK, that community transmission was  
20 further along than initially thought. Did that change  
21 in understanding influence the pace and urgency of  
22 hospital discharges into care settings?

23 A. So, in terms of preparing our hospitals to be ready to  
24 receive the worst-case scenario of a number of people  
25 expected to contract Covid and to require

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1 hospitalisation and of that number to require intensive  
2 care, a number of steps were taken, of which a focus on  
3 delayed discharge was but one, and arguably, the  
4 greatest impact was the pausing of elective care.

5 So delayed discharge had always been on the desk of  
6 a Health Secretary. It was on my desk, and --

7 **Q.** Ms Freeman, I'm sorry to interrupt, I don't dispute  
8 that. The question is, did that change in understanding  
9 influence the urgency and the pace of the need to  
10 discharge patients in a care settings?

11 **A.** No.

12 **Q.** No. Thank you.

13 Can I just deal with some of the chronology as  
14 background context, please.

15 You were asked in Module 2A about an email from the  
16 First Minister asking whether sector-specific guidance  
17 needed to be issued, because it had come to her  
18 attention that one particular care home was refusing  
19 admissions.

20 **A.** Mm.

21 **Q.** Is it right that on 11 March, so the next day, there was  
22 a submission in relation to care homes closing their  
23 doors, and it was in response to Scottish Care  
24 indicating that four large corporate care home providers  
25 had closed their doors to new admissions and had

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1 brought up, please.

2 It's INQ000362665. Page 5.

3 And Ms Freeman, if you want to turn it up, it's  
4 tab 19.

5 Can we see paragraph 15(d), sorry, it may be page 4.  
6 It says:

7 "The overall objective should be to do everything  
8 possible to keep the number of severe cases to  
9 a minimum: that is, to reduce hospital admissions and/or  
10 deaths among the ... vulnerable."

11 Can you help us as to why the "or" is in there? So  
12 it's "to reduce hospital admissions and/or deaths among  
13 the ... vulnerable". Was there any discussion about the  
14 need to choose or prioritise between those two?

15 **A.** No.

16 **Q.** That can come down now. Thank you.

17 Can I ask you about consultation on the policy,  
18 please.

19 You met with COSLA on 4 and 5 March 2020; is that  
20 right?

21 **A.** (No audible response)

22 **Q.** You refer in your statement to a meeting of the NHS  
23 board chief executives on 11 March, and what you say in  
24 relation to that is that:

25 "... no one identified as a particular risk the

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1 restricted visitors to care homes and that there was  
2 a worry that smaller providers would follow suit? As  
3 I've mentioned, that issue had been raised previously by  
4 the First Minister the previous day.

5 The submission indicated that Health Protection  
6 Scotland had been urgently asked to draft some guidance  
7 to issue to the sector, and what was recommended was  
8 that you send a letter to providers highlighting that  
9 there was clinical advice, pointing to the fact that  
10 there was sector-specific guidance coming, and providing  
11 reassurance to the sector about supporting them for  
12 their role.

13 So the question is, was the letter that was then  
14 issued on 13 March, along with the Scottish Government's  
15 guidance, in response to you being told that care homes  
16 were closing their doors to admissions, as a way of  
17 reassuring them and encouraging them to continue to take  
18 discharges?

19 **A.** It was a means of reassuring them to take discharges if  
20 they felt that that was appropriate, because it was  
21 always their decision whether or not they took any  
22 admission to the care home, whether that was someone  
23 discharged from hospital or not.

24 **Q.** We're going to look at what the letter actually said,  
25 but could I first of all ask for a document to be

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1 movement of people being delayed in hospital to care  
2 homes; and no one asked for a comparative risk  
3 assessment of the respective hospital and care home  
4 environments.

5 "164. Rather, there was [a] consensus at that  
6 meeting that delayed discharge had to be effectively  
7 tackled ..."

8 This was a meeting of the NHS board chiefs, chief  
9 executives. Were there any voices representing the  
10 adult social care sector at that meeting?

11 **A.** No.

12 **Q.** So why were you expecting anyone or why do you say no  
13 one identified a particular risk? Is that surprising,  
14 considering there were no voices of the adult social  
15 care sector there?

16 **A.** No, it's not surprising, because NHS board chief  
17 executives have medical directors, and they will have  
18 consulted with them prior to the meeting itself on  
19 a number of issues with respect to the pandemic. And  
20 those medical directors will be in contact with our  
21 Chief Medical Officer, so they too will have a degree of  
22 clinical advice, as I had, on this and other issues.

23 So if any of their individual medical directors had  
24 raised a concern, then that chief executive would raise  
25 that concern with me.

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1 Q. So following the submission on the 11th, the Inquiry  
2 understand that Health Protection Scotland issued their  
3 guidance on the 12th, and then on the 13th you issued  
4 the Scottish Government clinical guidance along with the  
5 letter to the sector?

6 A. Yeah.

7 Q. Did you consult with any other voices from the adult  
8 social care sector apart from COSLA prior to that  
9 13 March letter being issued?

10 A. I believe Scottish Care were consulted.

11 Q. I think that first meeting was on 18 March?

12 A. That was their meeting with me. That is not the same as  
13 the range of discussions and consultations they would  
14 have with my officials.

15 Q. So what consultation had taken place prior to 13 March  
16 with the sector, please?

17 A. I can't give you specifics on that, because those would  
18 not be with me. But my officials were in relatively  
19 constant contact with Scottish Care.

20 Q. Did you yourself seek out the opinions of anyone in the  
21 sector on this particular policy?

22 A. I would ask my officials if any concerns had been raised  
23 with us, with the expectation that they would have been  
24 speaking to both local government, through COSLA, and  
25 Scottish Care.

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1 some people to understand that they were being asked or  
2 required to prioritise accepting hospital discharges?

3 A. No, I don't believe so.

4 Q. Can we look next, please, to another document at  
5 INQ000147441, page 2, paragraph 2, please.

6 This is your letter that was sent out on the 13th.

7 And it says:

8 "The long-term care and residential care sector is  
9 vital to the wider health and social care system. It is  
10 essential that it continues to function in an effective  
11 way so that people in communities are supported in the  
12 right way. It also in some cases provides a safe  
13 alternative to more acute settings, including hospital  
14 care. It is therefore imperative that care homes  
15 continue to take admissions if it is clinically safe to  
16 do so."

17 And at page 4, please, the section titled  
18 "Transitions from hospital", this is an extract from the  
19 Scottish Government guidance itself. It says:

20 "There are situations where long term care  
21 facilities have expressed concern about the risk of  
22 admissions from a hospital setting. In the early stages  
23 where the priority is maximising hospital capacity,  
24 steps should be taken to ensure that patients are  
25 screened clinically to ensure that people at risk are

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1 Q. In your statement you say that admission was by  
2 agreement, and that the care facility were perfectly  
3 able to refuse to take admissions.

4 Can we have a look, please, first of all, at  
5 INQ000470123.

6 This is a letter that was sent out on 6 March from  
7 the then director general of Health and Social Care.

8 A. Mm-hm.

9 Q. And can we see in the second paragraph, it says:

10 "We now need to be able to create capacity and space  
11 within our hospitals ... I appreciate that this  
12 necessarily increases the pressures on ... social care  
13 systems at a point when there are challenges around how  
14 to provide care to vulnerable people in their homes ...

15 "Nevertheless, I would expect that appropriate steps  
16 are being taken in local systems ... that demonstrates  
17 this is being prioritised and driven forward ... The  
18 expectation being a material reduction in the delayed  
19 discharge figures across Scotland. In the immediate  
20 term, our requirement is to reduce the overall Scottish  
21 delayed discharge position from 1650 to 1250 by no later  
22 than 9 April -- efforts to achieve progressive  
23 reductions must continue thereafter."

24 Looking at the wording of that letter, do you have  
25 any reflections on whether that letter may have caused

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1 not transferred inappropriately but also that flows out  
2 from acute hospital are not hindered and where  
3 appropriate are expedited."

4 Looking back, Ms Freeman, do you think that that  
5 letter should have more explicitly set out the right of  
6 care homes to refuse admissions?

7 A. No, because I think care homes were perfectly clear that  
8 they had that right, and in some instances appropriately  
9 exercised that right. The key word in all of the  
10 paragraphs you've highlighted is "clinical". So an  
11 assessment as to whether or not someone is ready for  
12 discharge is a clinical assessment. It's not an  
13 assessment made by me or any of my officials, or even by  
14 a care home. But the care home has the right to see  
15 that clinical assessment and take a decision for itself  
16 as to whether or not it can appropriately manage the  
17 care of that individual in their setting. And they've  
18 always had that right and they had it throughout the  
19 pandemic.

20 Q. Dr Donald Macaskill of Scottish Care gave evidence in  
21 Module 2A and he spoke of care providers, from media  
22 publicity and also the public messaging that was going  
23 out, feeling pressured to take hospital discharges. And  
24 also that they felt that they needed to to help society.  
25 Was that something that you were aware of at the time,

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1 that care providers, even if they weren't being told  
 2 that they had to take discharges, that they were feeling  
 3 like they should or felt pressured to?  
 4 **A.** So I was aware that some may feel that, but you'll also  
 5 recall, and I think the Inquiry has sight of it,  
 6 Dr Macaskill's own letter to care home providers to his  
 7 members following his meeting with me on 18 March where  
 8 he urges them to continue to take hospital discharges,  
 9 and urges them in the strongest terms, I think.  
 10 So he was understanding of the situation, both the  
 11 need to free up hospital capacity, of which, as I've  
 12 said before, delayed discharge was a small component  
 13 cared to the other steps we took, affecting large  
 14 numbers of people, but also aware, as he rightly should  
 15 be, of the rights of his members to take a measured  
 16 decision as to whether or not they could adequately care  
 17 for someone coming to them from hospital.  
 18 **Q.** Dr Macaskill had in fact fed back on the draft guidance,  
 19 and his concern was that what was deemed to be  
 20 clinically safe, or the clinical screening process, was  
 21 not clear enough, and at a meeting with you on the 18th  
 22 it was agreed, wasn't it, that a mandatory isolation  
 23 period would be introduced, and that, in fact, was not  
 24 introduced until 26 March; is that right?  
 25 **A.** I believe so.

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1 done or did you ask for any data?  
 2 **A.** On what?  
 3 **Q.** To try to work out what the potential impact might be on  
 4 care homes of the discharge policy?  
 5 **A.** I'm not sure I understand. The discharge policy was not  
 6 new to the pandemic. I think I've made that clear. If  
 7 there were any concerns from care homes about their  
 8 ability to manage an individual discharge from hospital,  
 9 in terms of the advice and the guidance, they would  
 10 raise that and that would come to us from Dr Macaskill.  
 11 In terms of modelling and data, I'm still not quite  
 12 sure what it is you're asking me.  
 13 **Q.** Did you ask for any impact assessments to be carried  
 14 out?  
 15 **A.** No, we rested on Dr Macaskill's relationship with his  
 16 members, and also with COSLA, and any concerns to be fed  
 17 back to us in that way.  
 18 **Q.** Did you make any enquiries as to how many care homes had  
 19 isolation facilities? Could you have asked, for  
 20 example, for a list to have been drawn up of care homes  
 21 with isolation facilities?  
 22 **A.** So isolation was in the resident's own room. So there  
 23 wasn't a separate -- there wasn't a requirement for  
 24 separate isolation facilities, other than the resident's  
 25 own bedroom. So I didn't need such a list, if I'm

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1 **Q.** Why was there that delay? Because there was no  
 2 mandatory isolation requirement in the guidance that was  
 3 issued on 13 March. Having had the meeting with him on  
 4 the 18th, why did it then take until 26 March for that  
 5 mandatory isolation requirement to come in?  
 6 **A.** So on 13 March, from recollection, there was advice to  
 7 isolate, and to practice infection prevention and  
 8 control. The subsequent position was to make that  
 9 a requirement as opposed to advice. And also, from  
 10 recollection, to say that that period could be completed  
 11 either in the residential setting or in a mix of the  
 12 hospital and residential setting. And so the delay,  
 13 I presume -- I don't have it in front of me so I can't  
 14 recollect exactly, but I would presume that that was  
 15 around various toing and froing with Dr Macaskill but  
 16 also our relevant clinical experts on what might be the  
 17 right thing to do.  
 18 **Q.** Can we turn, then, to what protections were included and  
 19 what thinking was done ahead of the policy, please.  
 20 So, as you've pointed out, the guidance on the 13th  
 21 said that residents should be socially distanced and  
 22 that visits should be reduced to essential visits.  
 23 What, if any, consideration had been given at the time  
 24 to the potential impact of the discharge policy on care  
 25 homes? For example, did you ask for any modelling to be

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1 understanding your question correctly.  
 2 **Q.** Did you consider whether there are any alternatives to  
 3 direct discharges into care homes, so, for example,  
 4 step-down facilities where people being discharged from  
 5 hospital could go before going into the care homes?  
 6 **A.** So there are two -- yes, that was considered. There are  
 7 two difficulties with that. One, the availability of  
 8 step-down facilities, and two, the concern expressed,  
 9 particularly by our geriatrician expert advice, about  
 10 the impact, particularly on an elderly person, of being  
 11 moved more than once.  
 12 **Q.** Was that Mr Ellis? I think he was the Deputy Chief  
 13 Medical Officer; is that right?  
 14 **A.** He was from 12 March, but he had been our adviser prior  
 15 to that appointment.  
 16 **Q.** And did he also have a role in drafting guidance?  
 17 **A.** Yes, he did.  
 18 **Q.** Work was done on 6 March looking at hotel capacity. Was  
 19 that something that you looked at in terms of step-down  
 20 facilities?  
 21 **A.** Yes, it was. The difficulty with looking at something  
 22 like hotel capacity is how you would staff that. If --  
 23 you can't take staff out of care homes in order to staff  
 24 another facility, nor could we take staff from our NHS  
 25 to staff another facility. So there were practical

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1 difficulties in pursuing that, aside from whether or not  
 2 hotel capacity was available.  
 3 **Q.** Did you ask for the issue of staff capacity to be looked  
 4 into?  
 5 **A.** So our -- the part of our Health Directorate which is  
 6 concerned with staffing and people issues did consider  
 7 that, but at the same time, we were busy trying to  
 8 ensure that we were adequately staffed in both our  
 9 health and social care sector, in anticipation that our  
 10 staffing numbers would be reduced because staff  
 11 themselves would contract Covid or their family members  
 12 would, and therefore they would not be in employment.  
 13 And that is why we launched the portal in terms of  
 14 returners to adult social care and also to the NHS, but  
 15 also sought agreement from the regulatory bodies about  
 16 final-year medical and nursing students to be able to  
 17 operate to the limit of their competence in our health  
 18 settings.  
 19 **Q.** Forgive me, Ms Freeman, but can we focus, please, on  
 20 this period of time. I think the portal, for example,  
 21 came into -- it was established in April.  
 22 **A.** Yes, it was, but the work -- (overspeaking) --  
 23 **Q.** But just focusing on --  
 24 **A.** The work that led to the portal was happening at this  
 25 time.

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1 **Q.** Is there a reason why financial assistance wasn't given  
 2 at that stage, knowing that there were concerns about  
 3 the increased costs of self-isolation?  
 4 **A.** So there is a process to go through, even in a pandemic,  
 5 about the use of public funds that requires you to  
 6 adequately cost what might be needed, and where, and  
 7 then secure that agreement in terms of the proper way in  
 8 which government makes determination about the use of  
 9 public funds and then issues it. So that would be the  
 10 process that would be initiated at that point.  
 11 **Q.** The guidance did recognise that some people might find  
 12 it difficult to socially distance, for example people  
 13 with dementia --  
 14 **A.** Yes.  
 15 **Q.** -- and it was recommended that this may be best  
 16 addressed using volunteers or charitable organisations  
 17 to engage with those individuals. Did you think about  
 18 the risk that those individuals would potentially give  
 19 rise to, in terms of transmission?  
 20 **A.** Yes, and I think subsequent guidance removed that, as  
 21 that understanding increased. I think we were aware of  
 22 the difficulties in adhering to the guidance to the  
 23 letter in a setting which is essentially people's home,  
 24 and there was some flexibility available where it was  
 25 going to be far too distressing for a resident to be

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1 **Q.** So, focusing on this time, the PPE, because you have  
 2 just been discussing that, the Inquiry understands that  
 3 the submission dated 11 March, which first raised the  
 4 issue for the need of -- the need for guidance, had also  
 5 raised issues that providers were finding it  
 6 increasingly difficult to source PPE, that there were  
 7 issues about service and provider sustainability, about  
 8 the costs of self-isolation, and about staffing issues?  
 9 So when you issued the guidance, then, on 13 March,  
 10 did you make any provision for care homes to be given  
 11 extra PPE?  
 12 **A.** No, I would -- not specifically at that point. The  
 13 first triage helpline was 30 March. But we would have  
 14 asked NSS at that point to liaise with Scottish Care to  
 15 see exactly what was the extent of the problem. Was it  
 16 individual care homes or was it a general issue across?  
 17 At the same time asking COSLA to identify if they were  
 18 facing similar issues in local authorities' provision of  
 19 adult social care.  
 20 **Q.** And was it a widespread issue?  
 21 **A.** It emerged as one, yes, which is why we introduced the  
 22 additional routes for the supply and delivery of PPE.  
 23 **Q.** We understand from Ms Lamb's evidence that no funding  
 24 was provided on the guidance was issued on 13 March?  
 25 **A.** At that point, that's correct.

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1 socially distanced, and therefore you would err against  
 2 requiring that of them.  
 3 **Q.** So is it fair to say, then, that the main protection  
 4 that was put into place on 13 March from the risk of  
 5 hospital discharges was asking for residents to be  
 6 socially distanced, and the visiting restrictions?  
 7 **A.** No, the other protection was isolation in their own  
 8 room, and --  
 9 **Q.** That's what I meant.  
 10 **A.** -- and the application of infection prevention and  
 11 control.  
 12 **Q.** And do you think that from the submission on 11 March  
 13 and the guidance being issued on 13 March, was enough  
 14 time to give adequate consideration as to what  
 15 protections were necessary and what the potential impact  
 16 might be, taking into consideration what was known about  
 17 the vulnerability of care home residents?  
 18 **A.** So there's a balance to be struck. Care home providers  
 19 through Dr Macaskill, primarily, were asking for  
 20 guidance in order to help them maintain as safe an  
 21 environment for their residents as possible, and remain  
 22 open to admissions if they believed they could cope with  
 23 that in terms of what was required. We were always  
 24 clear that guidance that was issued would always be  
 25 iterative, recognising that that in of itself created

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1 additional demands on that sector.  
 2 So I think we struck the balance between responding  
 3 to a need expressed, quite strongly, for guidance, and  
 4 a recognition that if you produce guidance reasonably  
 5 quickly, albeit with a degree of consultation, including  
 6 with Dr Macaskill and his colleagues, that as your  
 7 understanding of the virus evolves, that you will  
 8 revisit that guidance.

9 **Q.** In the BBC podcast you said:  
 10 "We didn't take the right precautions to make sure  
 11 that older people leaving hospital going into care homes  
 12 were as safe as they could be, and that was a mistake."

13 Is that something that you stand by?

14 **A.** It was a mistake in the presumption that all our care  
 15 homes understood infection prevention and control and  
 16 were practising it.

17 **Q.** Sorry, forgive me. You said that you didn't take the  
 18 right precautions?

19 **A.** That's right. Because I presumed that all our care  
 20 homes were adhering to the national manual.

21 **Q.** So that wasn't referring to other things that you could  
 22 have done, like PPE provision? That was just in  
 23 relation to -- (overspeaking) --

24 **A.** At that stage --

25 **Q.** I see.

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1 a huge compromise of my ethical values. It was clear  
 2 that hospitals were becoming overwhelmed."

3 And then another, by a loved one of a care home  
 4 resident in Scotland:

5 "Two people that were discharged from hospital back  
 6 into care homes, having tested negative. Two days  
 7 later, turned out that they had Covid ... it was like my  
 8 worst fears had been realised. I just kept waiting for  
 9 the call to say she had Covid. I couldn't sleep.  
 10 I couldn't eat -- it was torture."

11 Ms Freeman, looking back, do you have any  
 12 reflections about the decisions that you made in  
 13 relation to the discharge policy, and do you think that  
 14 you could or should have taken a more cautious approach?

15 **A.** In the circumstances at the time, with the resources  
 16 that I faced, and the understanding that we had of the  
 17 virus and how it transmitted, I don't believe I could  
 18 have taken a different decision from the one I took.  
 19 I have always said that if I had the capacity at the  
 20 time to test before discharge, I would have done so, and  
 21 did so as soon as that capacity was available but we did  
 22 not have it. And so -- and as I've also said, but  
 23 I think it bears repeating, that we were not making  
 24 binary decisions between a risk-free option and a risk  
 25 option. We were making decisions between relative

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1 **A.** -- no, but we very quickly did introduce PPE provision  
 2 but at that early stage we were not aware that there was  
 3 a consistent problem across the sector on securing  
 4 adequate PPE.

5 **LADY HALLETT:** If I may again, I'm sorry --

6 **MS JUNG:** Yes.

7 **LADY HALLETT:** When you told the podcast "We didn't take the  
 8 right precautions", appreciate that you say that you  
 9 didn't because it was based on a presumption, but what  
 10 precautions could you have taken?

11 **A.** So I think we could have introduced earlier, if that --  
 12 if I had not made that presumption, we could have  
 13 introduced earlier the wraparound support that we did  
 14 from directors of public health and nurse directors in  
 15 each individual board to provide greater clinical  
 16 support to the care home sector.

17 **LADY HALLETT:** Thank you.

18 **MS JUNG:** And before we end this topic, can I just quote to  
 19 you two accounts from Every Story Matters.

20 **A.** Mm-hm.

21 **Q.** The first is from a social worker in Scotland who says:

22 "At the beginning, people were discharged into care  
 23 homes without any testing in place, and also at times  
 24 without any real assessment to determine the views and  
 25 wishes of the older people involved. I found this

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1 degrees of risk.

2 **Q.** Can we move on, please, to visiting restrictions. The  
 3 first restrictions, as we've covered, came into place on  
 4 13 March in that guidance. And it's right, isn't it,  
 5 that they weren't fully lifted until 2021?

6 **A.** Yes, that's right.

7 **Q.** In a letter to CPAG, which was the -- is that the Covid  
 8 professional advisory group? -- on 18 June Dr Macaskill  
 9 put on record his growing concern about the lack of any  
 10 communication to the care sector to families and the  
 11 wider public about the restoration of visiting into care  
 12 homes, and he said this:

13 "Today marks the start of the 15th week of lockdown  
 14 for most of our care homes during which time there has  
 15 been minimal visiting other than for essential purposes  
 16 and end of life.

17 "Today is also when it looks as if the First  
 18 Minister will move the rest of the community to the next  
 19 stage of leaving lockdown. The complete lack of any  
 20 public messaging on care homes is causing a real loss of  
 21 confidence and distress in the sector."

22 One of the concerns raised by Dr Macaskill was that  
 23 care homes were being treated as one homogenous group.  
 24 Do you have a view, Ms Freeman, on whether it was right  
 25 to keep the visiting restrictions in place regardless of

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1 whether there was an outbreak in the home, for example,  
2 or whether the home provided residential or nursing  
3 care, or whether the home was located in a remote  
4 location such as an island community? Were those kind  
5 of factors taken into consideration in your decision  
6 making when it came to visiting restrictions?

7 **A.** They were taken into consideration in the clinical  
8 advice that I received, in terms of whether or not we  
9 could lift visiting restrictions, and if so, in what  
10 way.

11 **Q.** But did you raise any questions outside of the clinical  
12 advice that you received?

13 **A.** With whom?

14 **Q.** Were those questions in your mind?

15 **A.** Yes, yes, they were in my mind. So I didn't get  
16 clinical advice and just apply it. Clinical advice  
17 comes -- came to me and discussions were held  
18 practically daily with clinical advisers, who themselves  
19 were reaching out to their own counterparts elsewhere.  
20 So it was the product of a number of discussions that  
21 then reached a decision.

22 **Q.** And the conclusion was to keep a restriction in place  
23 across the board?

24 **A.** Yes, I believe that -- without it in front of me, yes,  
25 that would have been the case.

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1 risk of vulnerable adults acquiring the virus where  
2 their health was at a greater risk than perhaps others.  
3 **Q.** Thank you. And the Inquiry has also received, through  
4 the Every Story Matters project, accounts in relation to  
5 visiting restrictions. One care home worker in Scotland  
6 talked about challenging behaviour as a result of the  
7 visiting restrictions. Another care home worker in  
8 Scotland said this:

9 "There were no visits or anything for a very long  
10 time, which was quite sad. Some of them didn't even  
11 recognise who their family were because by that point  
12 they'd totally forgotten, which was really upsetting for  
13 the family."

14 Do you consider that the restrictions struck the  
15 right balance between the benefits and the risks, and do  
16 you think that anything could have been done  
17 differently?

18 **A.** So I think at the time, with the knowledge that we had  
19 at the time, and the clinical and other advice I was  
20 receiving, the restrictions struck the best balance that  
21 we could at that time.

22 That's not to say that I was unaware or unconcerned  
23 about the harms that were also being caused by those  
24 restrictions. The entire experience of the pandemic was  
25 about the balance of harms. There was no situation, at

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1 **Q.** Dr Macaskill went on to say:

2 "All in all, we are in an extremely challenging  
3 position. There is a real danger that the trust and  
4 confidence families have had in care services over the  
5 last 14 weeks ... will be lost unless we do not take  
6 action to at least give an indication of when things  
7 might change. We urgently need the Cabinet Secretary  
8 and First Minister to give such an indication of hope."

9 Was that indication of hope given and how important  
10 do you think it is to maintain the trust and confidence  
11 of families and those receiving care during a pandemic  
12 response?

13 **A.** So, first of all, I think it is important to maintain  
14 the trust and confidence of the public, including  
15 families, during a pandemic, because without that,  
16 people will not comply with the reasonable -- or with  
17 the restrictions, the quite unprecedented restrictions  
18 that we were asking them to apply with across the board.  
19 So yes, I do think that is really important.

20 At the same time, we have to exercise caution in  
21 terms of those individuals who are the most vulnerable  
22 to a severe impact of the virus on them and their  
23 health. So I was very conscious of, if you like, the  
24 social impact of the restrictions that we were requiring  
25 people to meet, but that had to be balanced against the

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1 any point, where you could make a decision that carried  
2 no harm.

3 **Q.** Can we move on to guidance, please.

4 It's right, isn't it, that at the beginning of the  
5 pandemic, Health Protection Scotland were issuing their  
6 guidance? Scottish Government also issued guidance.  
7 And then I think in June, you put into effect what's  
8 called the PAC process. And was that effectively  
9 a process by which Public Health Scotland had to have  
10 guidance signed off by you personally before it was then  
11 issued to the public?

12 **A.** Yes.

13 **Q.** And the Inquiry has received evidence that that led to  
14 some delays in guidance being published. Is that  
15 something that you accept?

16 **A.** There were a few delays, yes.

17 I should be clear that approval by me was not  
18 approval of the clinical aspects of guidance.

19 **Q.** What was your rationale for?

20 **A.** I wanted the guidance to be clearer than it had been  
21 previously.

22 **Q.** Can I ask for on screen, please, INQ000334871, page 2,  
23 please.

24 And it's tab 37 if you want to turn it up,  
25 Ms Freeman.

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1 This is a WhatsApp conversation between you and  
2 Mr Humza. And if we look at the last paragraph, you're  
3 giving him advice on him taking over the role, and you  
4 say, four lines up from the bottom:

5 "The other thing is [Public Health Scotland] -- do  
6 sometimes need [reminding] that they're an NHS board  
7 like any other and not a bunch of freelancers. They  
8 produced a list of forthcoming publications -- worth  
9 looking at to spot potential issues and worth querying  
10 some as to who commissioned the work!"

11 Do you have any personal reasons for implementing  
12 the PAC process? Was there any difficulties in the  
13 relationship between you and Public Health Scotland?

14 **A.** I don't believe there were difficulties in the  
15 relationship between me and Public Health Scotland, but  
16 I took the view that I would be accountable for guidance  
17 that was issued in any respect by any of our health  
18 bodies, and therefore it was responsible of me to ensure  
19 that I was content with the guidance that was issued.

20 **Q.** The Scottish Directors of Public Health have provided  
21 a health recommending that guidance should be specialist  
22 led and should be a streamlined process.

23 Do you think -- do you have any reflections on  
24 whether the PAC process was in fact necessary and  
25 whether it led to unnecessary delays?

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1 earlier than I did. The care sector is primarily  
2 a private sector. It is not part of our health service  
3 provision, and they guard that, perfectly reasonably, in  
4 quite a strong way. So it is for them to come to me and  
5 say, "We are struggling here", and as soon as that was  
6 clear, then we intervened, and took on the role of  
7 securing adequate PPE, both in volume and type, for not  
8 only the care sector, but also the care at home sector,  
9 and other areas, and introduced various improvements to  
10 the routes of both demand and supply.

11 **Q.** You've said a number of times today, and also throughout  
12 your statement, that issues were not brought to you, and  
13 when they were, you responded to them. To what extent  
14 do you think it's the responsibility of a minister,  
15 particularly dealing with a pandemic, to pre-empt issues  
16 that may arise, or think in advance, and provide support  
17 in advance of issues being raised?

18 **A.** I don't think any minister, and I include myself, is God  
19 like in that way. I think that the job of a Cabinet  
20 Secretary is to understand the sector as best as he or  
21 she can, to be open to improving that understanding as  
22 they go, to listen carefully to clinical and other  
23 advice, and to have a number of ways of hearing from  
24 individuals charged with the delivery of health and  
25 social care in pursuing those.

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1 **A.** I don't believe it led to unnecessary delays and I think  
2 where there were delays, there were very few.  
3 I completely agree that guidance should be specialist  
4 led and I don't believe the PAC process compromised that  
5 in any way. However, guidance needs to be written in  
6 language that is easily understood by the layperson.  
7 And so any interventions that I might have made was  
8 about trying to get clearer English as opposed to  
9 changing the clinical foundation of the guidance. I had  
10 no locus in that, nor did I have any expertise in that,  
11 and I was well aware of that fact.

12 **Q.** Can we move on, please, to PPE. When did you first  
13 become aware of the global issues with PPE?

14 **A.** I'm not sure I can give you a specific point in time.  
15 I think early on it was clear there were global issues  
16 with PPE because it was a global pandemic.

17 **Q.** And I think you say in previous modules' evidence that  
18 you were aware that care homes would not have had the  
19 bargaining power, for example, to compete against the  
20 NHS in being able to get -- to secure supplies of PPE.

21 Do you have any reflections on whether, with that  
22 knowledge, you should have made arrangements earlier on  
23 in the pandemic to ensure that the care sector were able  
24 to get access to PPE supplies?

25 **A.** I don't believe I should have made any interventions

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1 And I think my track record in all of that stands  
2 examination. I cannot be an expert in every field.  
3 What I can be is clear in seeking evidence and decisive  
4 in the decisions I make, and I do believe, overall,  
5 whilst not perfect, that I was both of those things.

6 **Q.** Thank you.

7 Just dealing briefly with the testing, is it right  
8 that a decision had been made to test GP surgeries for  
9 the purposes of surveillance? That would have covered  
10 up to 1.2 million people across all health boards, but  
11 it was set out in a briefing note that in fact that  
12 wasn't the most effective use of the testing because it  
13 would have required people to go into the GP surgeries  
14 to be tested.

15 With those 1.2 million tests, do you think that  
16 those could have been reallocated to the social care  
17 sector to allow testing of the sector to be carried out  
18 any earlier?

19 **A.** I'm afraid you've lost me a bit. I'm not quite  
20 understanding what you're saying. The testing capacity  
21 started out at 350 tests per day. And we scaled that up  
22 as rapidly as we could, both directly in terms of  
23 NHS Scotland, but also with our partners in the rest of  
24 the UK, through the Lighthouse initiative.

25 So I'm not quite understanding your question.

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1 Q. I think it was -- later on, there came a time when you  
2 did make a direction that the GP surgeries should be  
3 tested for surveillance reasons. But if you don't  
4 remember, perhaps we can move on.

5 A. Yeah.

6 Q. Can I ask you about inspections, please.  
7 Did you agree with the decision of the  
8 Care Inspectorate to pause regular inspections?

9 A. No, I didn't.

10 Q. What did you do in relation to that, then?

11 A. So I introduced a regular meeting with the Care  
12 Inspectorate and asked them to resume direct inspections  
13 focusing particularly on infection prevention and  
14 control, and also on the social aspects of residential  
15 care.

16 Q. Were you aware that one of the issues that they had was  
17 that they didn't have access to PPE?

18 A. I don't recall that but I am sure that if that had been  
19 an issue, they would have raised it with me and we would  
20 have acted to ensure that they did have access to PPE.

21 Q. We know that the enhanced oversight process came in in  
22 April, and you gave the Care Inspectorate some enhanced  
23 powers, is that right, in relation to reporting?

24 A. Yes.

25 Q. Did they have to report to you regularly on care homes

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1 Do you think that the various roles of the public  
2 bodies that were involved in the process were clear  
3 throughout?

4 A. Well, I was clear on their roles so I presumed that they  
5 were too.

6 Q. What do you think were the benefits of the enhanced  
7 oversight arrangements? We know that they required,  
8 from May, multi-disciplinary teams going into care homes  
9 and assessing the care homes on issues such as IPC and  
10 staffing levels. What do you think were the benefits of  
11 that support?

12 A. So I think particularly in infection prevention and  
13 control, whilst it was part of a requirement of a care  
14 home provider that they would apply the national manual,  
15 it was clear that not all were able or had been doing  
16 that. So that enhancement was there to ensure that they  
17 were all doing that and they were given support to be  
18 able to practice the levels of infection prevention and  
19 control that we required them to practice, and in other  
20 areas, that they had direct access to local support  
21 where they required that.

22 Q. You say in your statement that you understood that the  
23 requirements might create additional burdens for the  
24 staff.

25 A. Mm-hm.

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1 and how they were doing, and did you find that to be an  
2 adequate replacement for them carrying out the regular  
3 in-person inspections?

4 A. So I don't believe it was a replacement, it was what was  
5 possible in the circumstances of the pandemic, and they  
6 reported -- from memory, I believe they submitted  
7 a report to the Scottish Parliament on a fortnightly  
8 basis on their inspections and their findings.

9 LADY HALLETT: When you told them to resume inspections and  
10 to deal with the matters you've raised, did they do so?

11 A. Yes, they did.

12 MS JUNG: Can I ask you about the enhanced oversight  
13 process, please.  
14 The Inquiry heard evidence from the Care  
15 Inspectorate that there were issues in relation to the  
16 carrying out of physical inspections because directors  
17 of public health were concerned about the risk that  
18 would be caused by inspectors going into care homes.  
19 Public Health Scotland has also provided a statement  
20 to the Inquiry saying that it was:  
21 "... becoming a very crowded pitch with an  
22 increasing number of players who were not all aware of  
23 what each [other] is doing and who is reported to whom."  
24 And forgive me, I think that may be actually in an  
25 email rather than in their statement.

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1 Q. And in fact a survey carried out later on by Scottish  
2 Care confirms that a number of care homes did in fact  
3 find it very burdensome.

4 A. Mm.

5 Q. What did you do to try to reduce that burden on staff?

6 A. Well, the support that they were offered and could  
7 receive from directors of public health in their local  
8 area and nurse directors in their local area was part of  
9 providing them with additional support.  
10 That sector was not the only sector that was under  
11 a great deal of pressure, but, as in everything during  
12 the pandemic, it was a balance of what we believed was  
13 required in order to minimise the spread of Covid-19, to  
14 care for those who acquired the infection, particularly  
15 those most vulnerable to it, and to minimise deaths as  
16 far as we possibly could. So there was never, as I said  
17 before, any risk-free decisions.

18 Q. Is the enhanced multidisciplinary support process  
19 something that you would recommend should be put in  
20 place in future pandemics at the start of the pandemic?

21 A. Yes, I believe so.

22 Q. Can we move on, please, to DNACPRs.  
23 You say in your paragraph 314 that there were  
24 concerns raised with the Scottish Government by third  
25 sector stakeholders, including Age Scotland, the public,

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and reports in the media, about the use of DNACPR forms.

Can you give us an indication, please, of the scale of the issue as indicated by the anecdotal accounts you were receiving?

**A.** So from recollection, it was not widespread by any means, but it was sufficiently concerning for those impacted by it for us to ensure that everyone was clear about the way in which that conversation should take place, which was -- which preceded the pandemic, and the level of support that should be in place in order to conduct those conversations, and who should conduct them.

**Q.** Based on what you were hearing, did you order any investigations to be carried out?

**A.** So I -- from recollection, I asked for some work to be carried out to try to identify the extent of this, whether it was widespread or not, and then to take steps to ensure that everyone understood exactly what the policy and the practice of those conversations should be, and the appropriateness of having them at any particular point.

**Q.** Could I ask for a document to be brought up on screen, please.

It's INQ000147441.

This is your letter again on 13 March. And if we

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the time, the presumption here would be that this was not new to anyone reading -- anyone appropriately reading that.

I think, as I say, with the benefit of hindsight, understanding that they were not widely applied, then the wording could have been different.

**Q.** I'd like to just read to you some extracts from Dr Macaskill's statement of Scottish Care. He says that:

"In response to a number of outbreaks of Covid-19 in care homes, on 5 May ... the then Cabinet Secretary Jeane Freeman said that she was concerned the guidance was not being followed by care homes. She said that the guidance for care home providers was 'really clear' and that 'private care home providers have not, in some instances, appeared to follow the guidance that we require them to follow'. Whilst the Cabinet Secretary referred to 'some instances', the media agreements to interpret this statement as criticism of sector as a whole. This perpetuated the negative narrative that was developing in relation to care homes and led to increased scrutiny of the sector."

He goes on to say that:

"The pressure on care home managers to ensure that they were following the most recent guidance was

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look at page 3, at the bottom of the page, can we see where it says, "Anticipatory Care Plans", it says:

"[They] should be in place for as many residents as possible (and ideally all residents) in these settings. Clear documentation of 'What matters to me' is helpful in the event of changing circumstances. In many cases the staff in the Residential or Nursing Home settings are able to start these conversations."

It goes on to say:

"Do Not Resuscitate paperwork should be in place where appropriate and communicated appropriately with patients or carers. It may be judicious to ensure that just-in-case medication is prescribed for high risk residents. Similarly verification of death paperwork for appropriate ill patients may help staff to anticipate and manage death and minimise [clinical] contacts."

Did you reflect at all on whether the wording of that may have caused some people to think that there was a suggestion that they should be issued on a more widespread basis?

**A.** So I think, with the benefit of hindsight, I can see how that may have been the interpretation by some. However, at the time, anticipatory care plans were not new. They had been a feature for some time pre-pandemic, and at

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compounded by the announcement by the then Lord Advocate in May 2020 that the death of any care home resident due to COVID-19 or presumed COVID-19 was to be reported to the Procurator Fiscal. The investigations associated with these reports became known as 'Operation Koper'. This decision and the subsequent reporting and investigation of such deaths has caused considerable trauma within the care home sector. Scottish Care recognises that this decision arose from a legitimate desire to provide assurance to the general public, however, its impact has led to many skilled and experienced managers and staff leaving the sector, which undoubtedly contributed to a less resilient response to the pandemic."

Have you reflected, Ms Freeman, on whether the public messages and media narrative, that perhaps you may have contributed to, in relation to care homes not following IPC guidance rather than it being framed as perhaps support that could have been given to them earlier on, have you reflected on what impact that had on the care sector during the pandemic?

**A.** So, first of all, it's important to be clear that Operation Koper, as it was referred to, was a decision by the Lord Advocate, and it would be completely inappropriate for me as the Health Secretary to

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1 intervene or comment on that decision by the  
2 Lord Advocate. So that was for him to make and, where  
3 it required the cooperation of government, for  
4 government to cooperate.

5 In terms of what Dr Macaskill is quoted as saying,  
6 I'm not entirely sure that I would agree with that  
7 quote. I think there is a wider context. I think  
8 a great deal of support was offered to the care home  
9 sector and, indeed, adult social care in its entirety,  
10 and on reflection, I think the approach that we took was  
11 the correct approach.

12 **Q.** And, finally, Ms Freeman, can I ask you about staff  
13 movement, please.

14 **A.** Yes.

15 **Q.** In your statement you say that there were issues in  
16 Scotland with staff moving between different places of  
17 work which resulted in the spread of infections between  
18 care homes. Can you give us an indication of the scale  
19 of that issue in Scotland, please?

20 **A.** Right at this moment I don't believe I can. I think you  
21 probably have material that would give you that. It was  
22 primarily where -- from recollection, it was primarily  
23 where a provider had more than one care home, and moved  
24 staff from one to the other in order to maintain  
25 staffing levels. And that clearly created a difficulty

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1 The first question I want to ask you about, a few  
2 questions, in fact, is about a report from Public Health  
3 Scotland titled "Discharges from NHS Scotland hospitals  
4 to care homes -- Between 1 March and 31 May 2020".

5 In your statement at paragraph 202, I don't need  
6 that brought up, you say that the report found that care  
7 home size was much more strongly associated with the  
8 risk of an outbreak than all other care home  
9 characteristics, including hospital discharge.

10 Now, you've fairly noted earlier on that you can't  
11 be an expert in every field, and there's a lot of  
12 wording in that report, such as "confidence intervals",  
13 "hazard ratios". What assistance did you receive in  
14 understanding and interpreting the statistical analysis  
15 contained in this document?

16 **A.** So, first of all, we asked for that work to be  
17 undertaken, and it was undertaken by the universities of  
18 Edinburgh and Glasgow. So it was an independent report.  
19 In terms of its overall remit and then understanding its  
20 conclusions, both its initial conclusions and,  
21 I believe, a subsequent report was then produced later,  
22 then I would receive advice primarily from the offices  
23 of the Chief Medical Officer and the Chief Nursing  
24 Officer.

25 **Q.** And was that in relation to understanding and

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1 in terms of the risk of infection spread.

2 **Q.** And I think you issued some guidance in relation to  
3 staff movement advising that staff should not work in  
4 more than one facility and that movement between care  
5 homes should be restricted.

6 Do you think that in the event of future pandemics,  
7 that the movement of staff is something that should be  
8 mandated? Do you think that's feasible?

9 **A.** So I'm not sure, with the current arrangements of how  
10 residential care is provided, ie, it is a mix of public  
11 and private sector provision, primarily private sector,  
12 that mandating that is feasible, but that's not to say  
13 that the overall nature of our provision of residential  
14 adult social care does not itself require some  
15 consideration as to whether or not the model that we  
16 currently have is the best model.

17 And again, that is something that the Feeley  
18 exercise and those recommendations considered.

19 **MS JUNG:** Thank you, Ms Freeman, those are all my questions.

20 **LADY HALLETT:** Thank you, Ms Jung.

21 Ms Mitchell, you may remember, that way.

#### 22 Questions from DR MITCHELL KC

23 **DR MITCHELL:** And indeed, you may remember I appear as  
24 instructed by Aamer Anwar & Company on behalf of the  
25 Scottish Covid Bereaved.

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1 interpreting the statistical analysis?

2 **A.** To a degree, yes.

3 **Q.** Did you have confidence in that regard that you  
4 understood what the report was saying to you?

5 **A.** Yes, I did.

6 **Q.** Moving on, then, there's a table -- again, I don't need  
7 it brought up, but there's a table in this report,  
8 comparing periods without a hospital discharge to  
9 periods otherwise without, in non-pandemic times, with  
10 discharge. And it talked about a risk and confidence  
11 interval. What it says is this:

12 [As read] "Compared to periods without hospital  
13 discharge, there was an increased risk of an outbreak  
14 observed in the period immediately after hospital  
15 discharge. The confidence interval includes 1.0 [that's  
16 a reference point, ie, the risk of an outbreak with no  
17 discharge] which means the risks in the period with  
18 a discharge is not statistically significant from  
19 periods without a discharge."

20 So that was saying, at that point, and this was the  
21 original report, that statistically they didn't see  
22 a difference. However, it went on to say:

23 [As read] "The confidence interval is relatively  
24 wide which means that there is uncertainty about the  
25 true risk, ranging from an 8% lower risk of care home

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1 outbreak in the period soon after a hospital discharge  
 2 to a 52% higher risk ..."  
 3 And the report goes on to say at that point:  
 4 [As read] "We therefore cannot rule out a small risk  
 5 from hospital discharge."  
 6 What did you understand that to mean when you  
 7 read it?  
 8 **A.** Precisely what it says: that they could not rule out  
 9 a small risk from hospital discharge.  
 10 **Q.** And what about the 8% to 52% risk? Did you realise and  
 11 understand that that was a wide uncertainty about the  
 12 true risk?  
 13 **A.** Yes, I did.  
 14 **Q.** Now, the reporting of the statistical modelling in  
 15 part 2, the part that we've been discussing, which  
 16 analyses the risk of care from care home outbreaks  
 17 associated with hospital discharge, was updated  
 18 following feedback from the Office for Statistics  
 19 Regulation, and in fact this Inquiry has a letter from  
 20 Ed Humpherson, who is the director general for  
 21 Regulation at the Office for Statistics, to Scott Heald,  
 22 the Head of Professional Statistics for Public Health  
 23 Scotland, regarding the findings from the discharges of  
 24 NHS Scotland hospitals to care homes.  
 25 Were you aware of that letter?  
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1 of his statement. He was a member of the DHSC's adult  
 2 social care policy from April to October of 2020, and  
 3 was officially responsible for creating the Vivaldi  
 4 project. Were you aware of the project at the time?  
 5 **A.** I don't believe so, no.  
 6 **Q.** Were you aware of its findings later?  
 7 **A.** I can't recollect them.  
 8 **Q.** In his statement, and simply for the purposes of the  
 9 Inquiry, that's at paragraphs 31 and 32 of his  
 10 statement, he discusses how politicians in England used  
 11 the Vivaldi data in relation to discharge in care homes,  
 12 and he states the following:  
 13 "But, again, the study suggested how the disease was  
 14 being spread within and between ... homes in May. Our  
 15 data was not able to give definitive insight into how  
 16 the virus got into many homes in the first place back in  
 17 March, for the simple reason that there had been little  
 18 or no testing back then."  
 19 And I pause to say: there was little or no testing  
 20 in Scotland; is that correct?  
 21 **A.** That's correct.  
 22 **Q.** "Indeed, staff movement between homes would not have  
 23 been so dangerous if the homes themselves had been  
 24 genuinely protected in the first place, rather than full  
 25 of the virus."  
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1 **A.** Yes.  
 2 **Q.** That letter came on 14 January 2021, and when discussing  
 3 the data contained in another table, table 11,  
 4 Mr Humpherson stated:  
 5 [As read] "When looking at the different types of  
 6 discharge, we see adjusted hazard ratios of 1 for tested  
 7 negative, 1.7 for untested, and 1.45 for tested  
 8 positive. Although the confidence intervals again  
 9 suggest these findings are not significant, the observed  
 10 and 'dose response pattern' in the adjusted hazard  
 11 ratios is consistent with a causal relationship between  
 12 positivity and outbreak."  
 13 What did you understand that to mean?  
 14 **A.** So my understanding of both the earlier report and that  
 15 subsequent one, is that it was not possible to discount  
 16 the risk of hospital discharge in terms of infection in  
 17 care homes, but it was not the most significant risk.  
 18 The most significant risk was, from memory, the size of  
 19 the care home.  
 20 **Q.** So you accept that the data was consistent with a causal  
 21 relationship between positivity and outbreak in care  
 22 homes?  
 23 **A.** To the extent that I've said that, yes.  
 24 **Q.** Moving on, we have heard evidence this morning from  
 25 Alasdair Donaldson, and the Inquiry also has the benefit  
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1 "32. I believe this is very important because --  
 2 perhaps in a psychologically understandable effort to  
 3 absolve themselves of their responsibility for the  
 4 original decision to discharge thousands of people from  
 5 hospitals into homes without quarantine or tests, our  
 6 study has been used to suggest that such a policy was  
 7 not dangerous -- when in my view, as a matter of basic  
 8 epidemiology and simple common sense, it probably was  
 9 very dangerous indeed. Absence of evidence cannot be  
 10 claimed to be evidence of absence, and there is no good  
 11 data for the period when the main hospital discharge  
 12 occurred for the same reason it was potentially so  
 13 reckless: because there was no testing."  
 14 Reflecting on what he has said about the fact there  
 15 was no testing, do you consider that the Scottish data  
 16 contained in the Public Health Scotland report is not  
 17 able to give a definitive insight into how Covid-19 got  
 18 into many Scottish care homes in March 2020?  
 19 **A.** I think it gives as good an insight as it could at that  
 20 time. I think there are other factors to be considered.  
 21 For example, from my recollection, 843 individuals were  
 22 discharged from hospital to care homes, and 348 were  
 23 involved in -- care homes were involved in an outbreak.  
 24 So, for example, a number of care homes who received  
 25 a discharge from hospital did not have an outbreak of  
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1 Covid.

2 So I think this is a complex and complicated  
3 question, and an area we've not touched on is the risk  
4 to those individuals of remaining in hospital when they  
5 were clinically able to be discharged.

6 **Q.** I think the Chair has already heard evidence in that  
7 regard, so the Chair is already aware of that situation.  
8 But do you agree, as a matter of basic epidemiological  
9 and simple common sense that discharge of untested  
10 patients from hospitals to care and nursing homes in  
11 Scotland was probably, and I quote, "very dangerous"  
12 indeed?

13 **A.** No, I don't agree that it was very dangerous indeed.  
14 I believe that that decision, like many others, carried  
15 a degree of risk. As I've said earlier, there were no  
16 risk-free decisions in any of this at any point, and  
17 I believe that the mitigation measures that we put in  
18 place were there precisely because we did recognise the  
19 level of risk involved.

20 **Q.** But you've accepted in your evidence earlier that part  
21 of the mitigation process or procedures that were put in  
22 place you thought was happening when it wasn't?

23 **A.** That's true, and was subsequently addressed.

24 **Q.** So the decision taken to have the discharge was taking  
25 place on an understanding which wasn't correct, about

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1 **Q.** Therefore, how could it be that you considered that  
2 a proper clinical analysis could be carried out before  
3 deciding to send someone to a care home if you knew that  
4 there was no testing?

5 **A.** I'm genuinely not sure I understand your question.  
6 I certainly knew at that point, in the early stages of  
7 the pandemic, we did not have sufficient testing  
8 capacity to undertake those tests. Whether or not  
9 someone was clinically able to be discharged from  
10 hospital was a clinical assessment. Whether or not the  
11 care home accepted them was a care home decision. And  
12 what we put in place to mitigate against the absence of  
13 testing were the measures that you're aware of.

14 I'm not suggesting that they were fully adequate,  
15 but they were the only measures available to us at that  
16 point, and the alternative was to leave someone ready  
17 for discharge in hospital, which was a high-risk  
18 environment, given the level of Covid patients, and an  
19 environment that, prior to the pandemic, was widely  
20 understood as one that would carry a serious risk of  
21 physical and mental deterioration.

22 **Q.** I'll perhaps simply try the question a different way.  
23 What did you consider the purpose of requiring tests and  
24 getting tests into hospitals as soon as possible for  
25 people being discharged was? What was the point of

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1 the risks?

2 **A.** It was taken on an understanding that proved itself to  
3 be incomplete, but that does not answer the question as  
4 to why some of our care homes that received discharge  
5 from hospital did not have an outbreak, and some did.

6 **Q.** Well, given the lack of testing, how could it be that  
7 a proper clinical analysis could be done before deciding  
8 to send someone to a care home?

9 **A.** So that is for clinicians to answer, not me, as  
10 a non-clinician, I believe. No one is discharged from  
11 hospital without a clinical assessment as to whether or  
12 not that is appropriate. That clinical assessment is  
13 then for the individual care home to determine whether  
14 or not they wish to accept that discharge.

15 **Q.** And I understand that, but I wonder if my Lady would  
16 allow me to ask a follow-up question?

17 **LADY HALLETT:** In fact, and if you want to -- the point of  
18 the question was the point about the testing. Clinical  
19 assessment is obviously not for you but I think the  
20 point -- so follow it up.

21 **DR MITCHELL:** I'm obliged, my Lady.

22 The question, as my Lady has identified, is about  
23 the testing. You knew, as minister, there was not the  
24 ability to test.

25 **A.** Yes.

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1 them?

2 **A.** It was an additional mitigation measure.

3 **Q.** An additional mitigation measure. Do you not think it,  
4 with respect, would be the primary mitigation measure?

5 **A.** No, I don't, because, as you'll know, there were, in the  
6 early stages of testing, concerns around the validity of  
7 test results. That improved over time, of course, but  
8 the test itself was not the silver bullet.

9 **Q.** We had people going from hospitals into care homes  
10 without being tested, which is one procedural  
11 mitigation, as you've described it, and then also going  
12 into care homes which did not or were not able or, for  
13 some reason, you say, weren't carrying out the tests  
14 that were required. So both of those procedural  
15 safeguards were not sufficient; is that correct?

16 **A.** So the care home procedural safeguard was a practice of  
17 infection prevention and control as required by their  
18 contract and set out in the manual. That, as experience  
19 demonstrated, was not universally practised in all care  
20 homes.

21 **Q.** Moving on, if some GPs were refusing to visit care  
22 homes, as this Inquiry has heard, and not going into  
23 care homes meant that residents were not being tested,  
24 what if any impact do you consider that had on the data  
25 contained in the Public Health Scotland report?

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1 A. I'm not sure I'm equipped to answer that. There  
 2 certainly were concerns around GPs being unwilling to go  
 3 into care homes that we sought to address directly.  
 4 Whether or not that had an impact on the data that --  
 5 the independent report from Edinburgh and Glasgow  
 6 produced, I don't believe I am equipped to comment on  
 7 that. I do believe, if those two universities had felt  
 8 that they did not have adequate data to undertake the  
 9 work, they would have raised that and made that clear.  
 10 Q. I think, in fairness, in that report they do make clear  
 11 the relative limitations --  
 12 A. Mm-hm, they do.  
 13 Q. -- in that report; do you recall that?  
 14 A. Yes, I do.  
 15 Q. Mr Macaskill has also indicated that there were feelings  
 16 of what he described as clinical abandonment in relation  
 17 to care homes. Now, when taken alongside the lack of  
 18 testing to care homes in March 2020, would that cause  
 19 you to reconsider your views of the impact of discharge  
 20 of untested patients into the care homes?  
 21 A. I think the only difference it would make is that  
 22 I would have introduced the engagement of directors of  
 23 public health and nurse directors sooner than we did.  
 24 Q. And you say earlier on, it's one of the questions  
 25 I think has already been answered, that you were aware

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1 than I to say whether they believe the data they drew  
 2 that from was adequate or not.  
 3 Q. And was that something you considered at the time? When  
 4 you were looking at the number of Covid deaths, did you  
 5 think: if there's not testing, how are we able to get  
 6 this number?  
 7 A. No, I don't believe I did consider that at the time.  
 8 Q. Moving, then, on to my final question. It relates to  
 9 evidence that we heard earlier this morning from  
 10 yourself about the data system for adult social care,  
 11 which I think you called Centennial; is that correct?  
 12 A. Sentinel.  
 13 Q. Sentinel, sorry?  
 14 A. It's the surveillance system.  
 15 Q. The surveillance system. And that is a surveillance  
 16 system for adult social care?  
 17 A. No, it's a surveillance system for health in Scotland.  
 18 Q. Okay, which --  
 19 A. Not confined to adult social care.  
 20 Q. Okay, but includes adult social care?  
 21 A. Yes, it does.  
 22 Q. Yes. So you said, and I'm not quoting exactly here, but  
 23 broadly, you said that it relied on GP practice to  
 24 provide data on infection and other data around the  
 25 provision of care, the quality of care, and the adequacy

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1 of GPs being unwilling or refusing to attend care homes  
 2 and there was an intervention. Can you explain to us  
 3 when you took the steps to address it, when you became  
 4 aware of it, and when you took the steps to address it.  
 5 A. I'm afraid I don't have those specific dates in mind.  
 6 What I do recall is that, in circumstances like that --  
 7 and this is purely an assertion on my part, I believe  
 8 the dates, if we check them, will back this up -- but as  
 9 soon as I was aware of issues like that, then I acted as  
 10 quickly as I could to address them.  
 11 Q. And we'll be able to look at the evidence of  
 12 Mr Macaskill in that regard.  
 13 Again, moving back to Mr Donaldson, who gave  
 14 evidence this morning, in his statement to this Inquiry,  
 15 he said that the reason why so many thousands of excess  
 16 deaths in care homes in England were not reported was  
 17 the result of there not being enough tests to establish  
 18 that these were Covid infections in the first place.  
 19 Do you consider there is the possibility that many  
 20 deaths in care homes in Scotland were not reported as  
 21 Covid deaths because there was a lack of testing?  
 22 A. I don't believe that I am qualified to answer that  
 23 question. I think the body in Scotland that produced  
 24 the data on deaths because of Covid or where Covid is  
 25 mentioned in the death certificate is better placed

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1 of staffing via the Care Inspectorate, when you were  
 2 talking about care homes; is that correct?  
 3 A. Not quite. The Sentinel exercise is simply around the  
 4 prevalence of infection, and that comes -- that was --  
 5 pre-existed pre-Covid and comes through GP practices.  
 6 The other matters are around the Care Inspectorate,  
 7 and their inspections, and the information that they  
 8 provide from those inspections.  
 9 Q. I see. So the former only relates to the GP practice --  
 10 A. Yes.  
 11 Q. -- and infection --  
 12 A. Yeah.  
 13 Q. -- and the latter about care relates to the Care  
 14 Inspectorate?  
 15 A. Yes.  
 16 Q. Given that the Inquiry has heard of the limited contact  
 17 with some care homes of GPs, you've touched on it  
 18 earlier yourself, and also the cessation of contact with  
 19 the Care Inspectorate, this means, it would appear, that  
 20 you weren't getting the provision of data on infection,  
 21 and also the provision of care, the quality of care, the  
 22 advocacy -- the adequacy of staffing, and the Care  
 23 Inspectorate was also not there. Does this mean that  
 24 the data system wasn't -- or does this mean that this  
 25 system wasn't fit for purpose to give you the

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1 information about adult social care?

2 **A.** So I think there's no question that the system, at that

3 point, was not as useful as we would have wished it to

4 be. However, the Sentinel system does not rest on every

5 single GP practice. As I recall it, it is a system that

6 statistically takes what the individual practices

7 involved say and projects that to give you

8 a Scottish-wide position. And during the pandemic, we

9 increased the number of GP practices that were engaged

10 in providing data for the Sentinel system. The

11 inspections from the Care Inspectorate, as you rightly

12 say, on 13 March, they paused their inspections, and

13 you'll also know that as soon as possible thereafter,

14 I required them to recommence their inspections.

15 **Q.** Does that mean that the system, for a time, wasn't fit

16 for purpose?

17 **A.** So there would be a period when the information coming

18 via the Care Inspectorate was not as adequate as

19 I wished it to be.

20 **Q.** Or indeed at all, because there was a cessation in

21 the --

22 **A.** Well, no, there was a cessation of their in-person

23 inspections, and they moved to, I suppose, Teams or

24 Zoom-type inspections which I did not consider adequate.

25 **DR MITCHELL:** My Lady, that's my time and those are my

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1 **LADY HALLETT:** Sorry about that.

2 **THE WITNESS:** That's okay.

3 **Questions from COUNSEL TO THE INQUIRY**

4 **MS JUNG:** Can you confirm your full name, please.

5 **A.** Yes, Caroline Sarah Lamb.

6 **Q.** Thank you for coming again for your sixth time to assist

7 the Inquiry. You've produced two witness statements for

8 this module. The first is the corporate statement for

9 the director general of Health and Social Care, which is

10 at INQ000614179, and the second one is on behalf of the

11 Chief Nursing Officer Directorate; is that correct?

12 **A.** That's correct, yes.

13 **Q.** And that's at INQ000614180?

14 **A.** Yes.

15 **Q.** You are currently the director general of Health and

16 Social Care; is that right?

17 **A.** That's correct.

18 **Q.** And also the chief executive of the National Health

19 Service in Scotland?

20 **A.** Yes.

21 **Q.** And you've been in that dual role since 21 January 2021?

22 **A.** Yes. I think it might have been 11 January, actually.

23 **Q.** 11 January, thank you. And is it right that the

24 director general of Health and Social Care is

25 responsible for the Health and Social Care Directorate

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1 questions.

2 **LADY HALLETT:** Thank you very much, Ms Mitchell, very

3 grateful.

4 That completes the questions we have for you, and

5 I gather from making enquiries that it's the last time

6 that we'll be asking you to assist us, so I appreciate

7 it's been quite a burden. Five times -- is this the

8 sixth time?

9 **THE WITNESS:** Sixth.

10 **LADY HALLETT:** That's quite a lot to ask of you and I'm

11 really grateful for the help you've provided to the

12 Inquiry.

13 **THE WITNESS:** Not at all. Thank you, my Lady, I appreciate

14 it.

15 **LADY HALLETT:** I shall return at 2.00.

16 **(1.04 pm)**

17 **(The Short Adjournment)**

18 **(2.00 pm)**

19 **LADY HALLETT:** Ms Jung.

20 **MS JUNG:** Thank you, my Lady. The next witness is Caroline

21 Lamb.

22 **MS CAROLINE LAMB (affirmed)**

23 **LADY HALLETT:** Ms Lamb, Ms Freeman told me it was the sixth

24 time she's given evidence. What is it for you?

25 **THE WITNESS:** Sixth as well.

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1 within the Scottish Government --

2 **A.** That's correct.

3 **Q.** -- also referred to as the "Director General Health and

4 Social Care family"?

5 **A.** That's correct.

6 **Q.** And can I call it the DGHSC family for short?

7 **A.** Yes.

8 **Q.** Thank you. The Health and Social Care Directorates have

9 responsibility for health policy, social care policy,

10 public health, and the administration of the NHS, and

11 this includes setting the standards for governance in

12 NHS Scotland.

13 **A.** That's correct.

14 **Q.** Could you very briefly set out a summary of your

15 relevant professional career prior to your appointment

16 as the director general of Health and Social Care

17 please --

18 **A.** Yes.

19 **Q.** -- in particular focusing on any experience that you

20 have in adult social care, please.

21 **A.** Yes. So I qualified as a chartered accountant.

22 I worked for a while in the profession. My first job

23 out of the profession was director of finance in

24 a housing association, which was also involved in the

25 provision of adult social care to residents in its

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1 accommodation.

2 From there, I moved to the University of Abertay,

3 where I was director of finance and then university

4 secretary.

5 I then moved to NHS Education for Scotland as --

6 initially as director of finance and then became chief

7 executive there, before moving, on a secondment, to

8 Scottish Government in December 2019, and I took up my

9 current role, as you said, in January 2021.

10 Q. Thank you very much.

11 Do you have a view on whether there should be

12 a permanent adult social care directorate?

13 A. So I think that's what's really important is that we

14 recognise the connections across health and social care.

15 It's a single system. No bit of that system functions

16 really well without all bits of the system working well

17 together. And so the director general (sic) that I head

18 up is director general of Health and Social Care, and

19 within that group of directorates we have a directorate

20 that is focused on social care as well as directorates

21 that are focused more on the performance of the NHS, for

22 example.

23 Q. What about whether there should be a permanent minister

24 for adult social care only?

25 A. So we do have a minister whose responsibility is for

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1 A. I think any position where you're trying to balance

2 competing demands is difficult but I think the advantage

3 of having a director general responsible for health and

4 social care is that you have within your purview

5 officials who can advise you both on health and -- on

6 matters relating to the NHS, but also on matters

7 relating to the social care system, and that through the

8 interactions that we have, not just with NHS chief

9 executives but with the chief officers of our integrated

10 joint boards, we're also linked in to the system.

11 So the systems are different but I think that we

12 have good mechanisms for understanding what the issues

13 are, and therefore trying, as well as we can, to balance

14 out those priorities.

15 Q. So is the answer that you don't think there needs to be

16 a separate ...?

17 A. I think that there are disadvantages in separating out.

18 I think that could lead to a more siloed approach where

19 you were really just looking, if you were just

20 responsible for one element, then I think it would be

21 easier to be siloed and blinkered to some of the issues

22 in other parts of the system.

23 Q. Thank you.

24 The Inquiry understands that various working groups

25 were set up during the pandemic, in particular the

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1 adult social care.

2 Q. Sorry, I mean Cabinet Secretary.

3 A. So the Cabinet Secretary encompasses health and social

4 care, and again I think that's because of the

5 "whole system" nature, and the fact that in Scotland we

6 have integrated joint boards and health and social care

7 partnerships, so there is very much an attempt to see

8 the system as one and to ensure that what we're doing

9 works across the whole of the system.

10 Q. Could I ask you to slow down just a little bit, please.

11 A. Sorry.

12 Q. It's probably my fault for asking the questions very

13 quickly at the beginning.

14 Can I ask you this, please, Ms Lamb: during the

15 pandemic there were times when there were competing

16 demands between the NHS in Scotland and the care sector,

17 for example, in relation to discharge policy or access

18 to PPE or access to testing.

19 Given the NHS-facing role of -- the other part of

20 your role, which is as chief executive of the NHS, do

21 you think it could be challenging in future, during

22 a pandemic, for someone occupying that dual role to

23 ensure that adult social care receives equal focus and

24 priority, particularly when decisions involve competing

25 demands?

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1 Clinical and Professional Advisory Group from

2 April 2020. However, in relation to the rest of the

3 care sector, I think the CPAG originally only covered

4 care homes, it was expanded later on to cover the wider

5 sector in February 2021; is that right?

6 A. I'm not sure I can remember the exact dates, but the

7 advisory groups were put in place so the -- the Clinical

8 and Professional Advisory Group for social care I think

9 did actually look at -- look across the whole of the

10 sector. Initially there was quite a heavy focus on the

11 care home sector but I think it was also looking at

12 issues and concerns from the whole of the social care

13 system.

14 Q. Do you think that unpaid carers or the care at home

15 sector were overlooked in comparison to care homes?

16 A. I don't think that they were overlooked. I think

17 that -- you're right that there was a focus on care

18 homes, particularly in the early parts of the pandemic,

19 but I do think that Scottish Government was also very

20 aware of issues being raised by the care at home sector,

21 and also by unpaid carers. So again, I think, as a

22 result of the Carers Act 2016, we had well developed

23 mechanisms for consulting with representatives of unpaid

24 carers, and in fact we were pretty early -- as we

25 expanded our provision of PPE, we expanded that not just

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1 for the care home sector but the care at home sector and  
 2 also to unpaid carers, as well.  
 3 **Q.** Thank you. Just very quickly on that point, how were  
 4 you able to identify, I think you expanded the PPE  
 5 provision to personal assistants and services that  
 6 weren't registered. How were you able to identify them?  
 7 **A.** So that was one of the challenges in being able to  
 8 identify, because personal assistants, you'll be aware,  
 9 can be employed in many different ways. They might be  
 10 self-employed, they might be employed by an individual.  
 11 So one of the challenges was actually identifying those  
 12 people, but one of the things I think we did was to try  
 13 and make it clear in the guidance that we were putting  
 14 out to -- not just to health boards and to our  
 15 integrated joint boards, our health and social care  
 16 partnerships, but also to GPs and others, that what were  
 17 the mechanisms for people being able to come forward and  
 18 to be able to sort of accredit themselves as being  
 19 personal assistants.  
 20 **Q.** Thank you. We understand that adult social care in  
 21 Scotland is delivered by a wide range of partners. Do  
 22 you think that the government had sufficient oversight  
 23 of all of that during the pandemic?  
 24 **A.** I think that from a Scottish Government perspective we  
 25 had a good understanding of the structure of the adult  
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1 legislation coming into force insofar as relevant to the  
 2 staffing of the adult social care sector is concerned,  
 3 and whether those powers would have been helpful to have  
 4 had during the pandemic, please?  
 5 **A.** So the staffing -- the legislation that you refer to  
 6 covers both health and social care.  
 7 **Q.** So just focusing on the --  
 8 **A.** So focusing on social care, the legislation requires  
 9 providers of social care to ensure that they have  
 10 adequate staffing levels, having due mind to the nature  
 11 of the service, the size of the service, the people who  
 12 are receiving care from that service, and the nature of  
 13 their needs, as well. And it also requires the  
 14 providers to make sure that those staff members are  
 15 adequately trained, as well. It provides powers for the  
 16 Care Inspectorate to set out staffing methodologies, to  
 17 assist providers in establishing staffing ratios as an  
 18 example. And it requires reporting to Parliament around  
 19 staffing levels on an annual basis.  
 20 So as you've said, that Act was legislated for in  
 21 2019 and implemented in 2024.  
 22 I think that had that Act been in place earlier, it  
 23 might have improved our understanding of the levels of  
 24 staffing and indeed the variance in relation to levels  
 25 of staffing between different care providers as well.  
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1 social care system, obviously through our integrated  
 2 joint boards, health and social care partnerships,  
 3 through our interactions with COSLA --  
 4 **Q.** Can I just ask you to slow down a little bit, please.  
 5 Thank you.  
 6 **A.** Sorry -- through our interactions with COSLA and also  
 7 through, you know, representative people like Scottish  
 8 Care and also the Coalition of Care Providers in  
 9 Scotland. I think probably in terms of oversight, our  
 10 oversight in relation to the NHS is stronger because  
 11 ministers are directly accountable for the NHS, whereas  
 12 local authorities are -- have a statutory responsibility  
 13 with regards to social care. And as you've said, there  
 14 are multiple providers in the social care system. So  
 15 I think that having oversight of those multiple partners  
 16 was much more challenging, and having the data that  
 17 would enable us to really understand that was more  
 18 challenging we well.  
 19 **Q.** Thank you.  
 20 Can I ask you, please, about one particular aspect  
 21 of -- the issue of levers. You say in your statement  
 22 that the Health and Care (Staffing) (Scotland) Act 2019  
 23 received Royal Assent in June 2019 but it didn't come  
 24 into force until April 2024. Can you just briefly  
 25 explain what levers have been conferred by that  
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1 **Q.** Can I just ask you, when you say there's a requirement  
 2 also to ensure that staff are adequately trained, does  
 3 that include in IPC measures?  
 4 **A.** I don't think the Act is that specific but I think we  
 5 would certainly expect that, given that the National  
 6 Infection Prevention and Control manual is mandated,  
 7 that that would be one of the areas that is covered.  
 8 **Q.** Thank you.  
 9 The Inquiry has heard evidence from Ms Freeman that,  
 10 in Module 2, she said that the Scottish Government's  
 11 knowledge of and complete understanding of how the  
 12 sector operated was not as adequate at the outset as  
 13 they needed it to be. In your statement, you say that  
 14 the Scottish Government had a deep understanding of the  
 15 sector, both prior to and during the pandemic.  
 16 Can you help us as to what you meant by that,  
 17 please?  
 18 **A.** Yes. I think that partly relates to what I said  
 19 earlier, is that I think that in Scottish Government we  
 20 had a number of mechanisms through dedicated policy  
 21 officials whose role was to provide advice to ministers  
 22 around social care, professional and clinical advisers,  
 23 so our Chief Social Work Officer, as an example, and to  
 24 our links into local government through COSLA, our links  
 25 into the integrated joint board through chief officers,  
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1 so we had a lot of structures in place to enable us to  
2 gather intelligence and to understand the adult social  
3 care sector.

4 I think that what Ms Freeman referred to in her  
5 evidence is that within a sector that is as diverse as  
6 the adult social care sector, there is a lot of  
7 variability in relation to -- I think the example she  
8 quoted was around the use of the national manual on  
9 infection prevention and control. So there was a lot of  
10 variability, and I don't think that we had fully  
11 understood the extent of that variability.

12 **Q.** Thank you.

13 In your statement you refer to the four harms  
14 approach, harm one being direct health harms as a result  
15 of Covid, and harm two being broader health harms,  
16 primarily the impact on the effective operation of the  
17 NHS and social care associated with large numbers of  
18 patients with Covid-19 and it's knock-on effects on the  
19 treatment of illness.

20 Do you think that enough data was gathered on harm  
21 two, as opposed to harm one during the pandemic, so the  
22 indirect impact on social care, including people  
23 receiving it?

24 **A.** I think that probably our data gathering improved as the  
25 pandemic went on, and certainly as we sought to use that  
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1 of, daily or even weekly or monthly basis, and there was  
2 quite a time lag between the collection of that data and  
3 then being able to report on it, none of which was what  
4 we needed when it came to the pandemic.

5 **Q.** We know that you engaged with a range of stakeholders  
6 which included, for example, provider organisation  
7 representative groups. In terms of the breadth of  
8 information sources available, do you think that the  
9 voice of care home residents and their loved ones and  
10 also unpaid carers and personal assistants was loud  
11 enough within government?

12 **A.** I think that the ministers were always very keen to  
13 understand issues from the perspective of the people  
14 receiving services and their loved ones. But were those  
15 voices loud enough, particularly at a time when things  
16 were developing very quickly and we were having to make  
17 decisions very quickly? I think there's probably always  
18 improvements that you can make in terms of engaging with  
19 those groups, but that said, there were regular  
20 meetings. Scottish Care and others were represented  
21 around the table at many of the groups that were set up  
22 to provide that sort of input into decision making. And  
23 like I said, we had linked into -- links into unpaid  
24 carers and a network through that as well, but I'm sure  
25 there is always more that can be done in that respect.  
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1 four harms methodology to assess policy decisions, but  
2 I think at the outset of the pandemic, and again, down  
3 to the sort of diverse and diffuse nature of the social  
4 care sector, it was far easier for us to assess the  
5 indirect impact on health services through, for example,  
6 the stepping down of planned care than it was to assess  
7 that indirect impact on social care services.

8 **Q.** You've talked about, perhaps, knowledge of the variance  
9 not being adequate. Do you think that the information  
10 sources available to ministers and the government during  
11 the pandemic of matters on how the sector was operating  
12 on the ground was sufficient?

13 **A.** No, I don't. I think at the outset of the pandemic,  
14 there were a number of data gaps that we identified, and  
15 sought to address those by putting in place additional  
16 data collection measures, for example the Safety Huddle  
17 Tool and I think a clear example I could quote there was  
18 around staffing and staff absences.

19 So whereas for NHS services, there's a single  
20 payroll, a single time-recording system, we were able to  
21 get daily details on staff absences, there was nothing  
22 comparable to that in the social care system and one of  
23 the things the Safety Huddle Tool was used to collect  
24 was that data on staff absences. So staffing data was  
25 collected in the social care sector, but not on a, sort  
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1 **Q.** So the answer might be obvious, but do you think, on  
2 reflection, that had you had a broader cross-section of  
3 the sector in those meetings, that the government would  
4 have been assisted in its decision making?

5 **A.** I think -- so I think that we did have quite a broad  
6 cross sector in those meetings. I think it was also not  
7 the case that there was always a consensus in those  
8 meetings, and that -- and, you know, I'm sure a lot of  
9 the decisions that were made, as you will have heard  
10 already, were about balancing up different levels of  
11 risk and trying to reach the right decision.

12 So, certainly we were hearing a number of different  
13 voices, and those voices were not always in agreement,  
14 and so I think that the process of decision making was  
15 helped by understanding those range of agreements, but  
16 there was never a single sort of definitive source that  
17 you could use.

18 **Q.** Can I ask you about the discharge policy, please.

19 **A.** Yep.

20 **Q.** We know that guidance was issued on 13 March 2020, which  
21 accompanied the Cabinet Secretary for Health and Sport's  
22 letter to the sector. Do you know whose decision it was  
23 that care homes or the residents in the care homes  
24 should be socially distanced? And by that I mean that  
25 visits would be restricted to essential visits only and  
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1 that residents would be isolated in their rooms.

2 **A.** So I'm not sure -- so that guidance, the 13th -- the

3 guidance that was issued on 13 March, I believe, was

4 issued by -- that was -- is that the Scottish Government

5 clinical guidance, you're talking about?

6 **Q.** So there was guidance commissioned by Health Protection

7 Scotland on 12 March --

8 **A.** Yeah, and then the 13th.

9 **Q.** -- and then on 13 March the Scottish Government issued

10 guidance, which is based on the Health Protection

11 Scotland guidance but issued the next day, along with

12 a letter from Jeane Freeman?

13 **A.** Yeah, so that's the clinical guidance. So HPS, Health

14 Protection Scotland, issued guidance which was around,

15 sort of, health protection aspects, and then it was

16 recognised that there was additional clinical guidance

17 needed.

18 In terms of what was in that guidance, that was

19 based on the best evidence and the best advice from

20 clinical advisers within Scottish Government, including

21 the Chief Medical Officer, who was in discussion with

22 other chief medical officers across the UK. So the

23 advice came together based on, you know, all those

24 clinical factors being taken into account.

25 **Q.** Do you know what was intended by the definition of

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1 information, share concerns, share intelligence around

2 what was then the developing Covid pandemic.

3 And in early March as well, COSLA held the first of

4 their national contingency group meetings. So I think,

5 both of those, the thinking then was starting to emerge

6 about the best way in which to protect people, and

7 certainly I think, perhaps inevitably -- I'm not

8 a clinician, but I think inevitably, when you have a new

9 infectious disease, one of the measures that you can use

10 to try to protect people from that is ensuring that

11 they're not in -- that their close contact with people

12 who may be infectious is limited.

13 **Q.** Did the government carry out any investigation to see if

14 they could establish whether care homes could in fact

15 isolate residents in their room or whether there was any

16 suggestion of drawing up a list of care homes with

17 isolation facilities?

18 **A.** So this wasn't about separate isolation facilities.

19 This was about the advice being provided to isolate

20 people, as you've said, in their own rooms.

21 We didn't carry out any research as to what -- which

22 care homes had what sort of facilities. But -- and it

23 was always a choice for care homes in relation to taking

24 admissions.

25 **Q.** Do you know if any enquiries were made for assurance

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1 essential visits in that guidance?

2 **A.** So my understanding is that the definition of essential

3 visits was in line with the definition that we'd adopted

4 for hospitals, which was around end-of-life visits being

5 deemed essential. But also, if residents were

6 distressed, then that would be deemed an essential visit

7 as well, if that could alleviate their distress.

8 **Q.** I think it was slightly broader than that on 13 March

9 then it was narrowed down to those on 26 March. Can you

10 help us any further with that?

11 **A.** I'm sorry, without having it in front of me, I can't.

12 **Q.** Thank you. Your statement explains that the guidance

13 was issued urgently following a submission on 11 March

14 about care homes closing their doors to hospital

15 discharges. Do you know whether any thinking had been

16 done by the government in advance of 11 March about

17 social distancing measures or about visiting

18 restrictions in care homes?

19 **A.** So I think that -- so there were a couple of things that

20 happened in the run-up to that guidance being issued.

21 In February, there was a resilience meeting that

22 involved social care providers that had originally been

23 set up to deal with resilience issues that we thought

24 would come around as a result of Brexit, but then was

25 sort of rapidly repurposed to be a meeting to share

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1 purposes that the -- about Care Inspectorate ratings of

2 care homes? So was any thought given to the risks of

3 discharging patients into care homes that had had less

4 adequate ratings, for example?

5 **A.** So my understanding is that standard practice at an

6 individual health and social care partnership level

7 would be to consider the ratings of care homes before

8 making decisions about where to place residents who are

9 needing to be placed in care homes.

10 **Q.** Are you able to help us, please, as to why the guidance

11 advised that all care home residents should be isolated,

12 regardless of whether the care home was accepting

13 admissions from the hospital or the community, and where

14 they were located or what types of care homes they were?

15 **A.** So my understanding, I think, would be that the advice

16 to isolate residents would be to recognise that the

17 risk -- there was a risk of infection coming in not just

18 from new people being admitted but from staff coming in

19 and out of the care home as well. And that's why

20 infection prevention and control measures were so

21 important.

22 **Q.** Do you know how long it was anticipated that those

23 measures would be in place for?

24 **A.** No, I don't, because that would depend on how long it

25 was before the pandemic eased, before we had

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1 a vaccination, and I don't think any of us knew any of  
2 that at that point.

3 **Q.** Do you know if any impact assessments were ordered or  
4 carried out in relation to the measures?

5 **A.** So I would imagine that, at that point, there was simply  
6 not the time to carry out impact assessments.

7 **Q.** Do you know if any work was done prior to the guidance  
8 being issued on alternatives to those measures? So for  
9 example, step-down facilities? So, for hospital  
10 discharges, whether they could have spent some time  
11 isolating in step-down facilities before they went into  
12 care homes?

13 **A.** So I think that -- you know, standard practice would be,  
14 when people are being discharged from hospital, if those  
15 people are unable to be discharged back to their private  
16 individual home, that there would be consideration of  
17 whether a step-down facility is the most appropriate  
18 place for them to go to, and -- taking into account  
19 availability. I don't recall us having particular --  
20 I think there was some discussion at some point of  
21 whether we could provide additional capacity, through  
22 hotels or anything else, but I think that was  
23 discounted, both in terms of the additional disruption  
24 to individuals, but also in relation to having to staff  
25 additional facilities and make sure that those

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1 consideration given to providing care homes with PPE  
2 supplies or asking the NHS to provide PPE alongside  
3 patients who were being discharged into care homes?

4 **A.** Yes, so early in -- so, as you heard in Module 5,  
5 I think it was, National Services Scotland procures PPE  
6 on behalf of the whole of the NHS in Scotland, and also  
7 managed the pandemic stockpile, and so from early March,  
8 possibly earlier than that, there were discussions with  
9 National Services Scotland about releasing stock from  
10 their pandemic stockpile, but also, a memorandum of  
11 understanding was signed with NSS so that they could  
12 take on the distribution of PPE stock to social care, as  
13 well. I think that was around about 15 March. And from  
14 then on, we set up -- NSS established a social care  
15 helpline so that social care organisations who were  
16 experiencing difficulty, particularly where they had  
17 suspected or confirmed Covid cases, were able to get  
18 rapid deliveries, and then we went on to establish the  
19 PPE hubs working with the local authorities so that not  
20 just social care organisations but unpaid carers, care  
21 at home organisations, everybody, could get access  
22 through those.

23 **Q.** Thank you, and if you could just focus on the time  
24 period we're looking at, which is when the guidance on  
25 13 March was published.

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1 facilities complied with, you know, everything you would  
2 require to see when you're looking after older or  
3 vulnerable people.

4 **Q.** In your statement you say that no financial support was  
5 offered directly to care homes at the time that the  
6 guidance was published. Do you know why that was?

7 **A.** Well, at the time the guidance was published, as I say,  
8 that guidance was being published rapidly to respond to  
9 a rapidly developing pandemic. Any financial decisions  
10 have to go through a process of establishing what it is  
11 that we're offering assistance for, how we ensure that  
12 that represents best value for the public purse, how we  
13 make sure that the money is distributed appropriately.  
14 So there was financial assistance to care homes, but --  
15 and that was backdated, but we had to work through all  
16 the mechanisms of setting that out and working with  
17 COSLA because that assistance was provided by local  
18 authorities.

19 So that process did -- was worked through, but it  
20 couldn't be done at exactly the same time as the  
21 guidance was issued.

22 **Q.** The Inquiry understands that supplies of PPE were low at  
23 this stage but bearing in mind that the submission of  
24 11 March had indicated that some care providers were  
25 finding it difficult to source PPE, was any

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1 **A.** Yes.

2 **Q.** You make the observation in your statement that whilst  
3 not complete isolation, the guidance advised that  
4 communal activities should be reduced by 75%. In  
5 Ms Freeman's statement she says that the mandatory  
6 isolation came in on 26 March, I think it may actually  
7 have been a bit later than that. Do you know when it  
8 came in, the hospital discharges for mandatory  
9 isolation?

10 **A.** My recollection is that it was in the 26 March guidance  
11 but I'm -- I'll stand corrected.

12 **Q.** Do you know why, in that case, on 13 March, there was no  
13 requirement for all hospital discharges to be isolated  
14 on arrival, or at hospital before they came to the care  
15 homes?

16 **A.** So I think that the 13 March guidance was focused around  
17 social distancing. I don't know why that wasn't -- why  
18 the mandatory isolation wasn't included at that point.

19 **Q.** Do you think it ought to have been, considering there  
20 was no testing of the hospital discharges and given what  
21 was known about the vulnerability of care home  
22 residents?

23 **A.** So I think that yes, I would accept that we probably  
24 should have been clearer about isolation as at -- in the  
25 guidance of 13 March, and I think it's important, as

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1 well, because isolation continued to be really important  
 2 even after we had testing, because of the possibility of  
 3 false negatives.

4 **Q.** In the time between 13 March, when the guidance was  
 5 first issued, and 26 March, when it was updated, did the  
 6 Scottish Government receive any feedback about  
 7 difficulties that care homes were having in implementing  
 8 the isolation requirements or in accessing PPE?

9 **A.** So I think Donald Macaskill from Scottish Care met with  
 10 Ms Freeman, I think on about 18 March, and she would  
 11 have had, and officials would have had feedback from  
 12 other areas, as well, but I think Mr Macaskill was in  
 13 that meeting able to be clear and we would have had  
 14 feedback from COSLA and others that -- both around the  
 15 difficulties that social care organisations were having  
 16 in accessing PPE, which I've explained what we did to  
 17 try to address that, and also around challenges of  
 18 isolation, as well.

19 **Q.** And what exact steps were taken by the government to  
 20 ensure that it had oversight of the impact of hospital  
 21 discharges on care homes, and that's focusing on this  
 22 particular period in time, so between 13 March and  
 23 26 March?

24 **A.** So I think in that period between the 13th and 26th, we  
 25 were very reliant on the guidance that had been issued,

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1 that are not required by the people who are in those  
 2 beds, many of whom will be going home rather than into  
 3 care settings.

4 I think if we were to think about what we would do  
 5 differently, I think we need to maybe be even clearer  
 6 than we were about the limitations of testing, the  
 7 likelihood, the importance of maintaining a focus on  
 8 infection prevention control and all the other  
 9 mitigations you can put in place to try and ensure that  
 10 people are kept safe in care settings.

11 **Q.** Can we look at the visiting restrictions that are set  
 12 out in the guidance, please. On 25 March there was an  
 13 email discussion involving the Chief Nursing Officer,  
 14 and she was advised that most European countries had  
 15 banned visits to care homes, and she was asked what she  
 16 thought about the definition of essential visits only.  
 17 I think in the 13 March guidance it had included named  
 18 family contact, consideration in end-of-life situations,  
 19 and suggested a risk assessment be carried out.

20 The Chief Nursing Officer at the time, I think that  
 21 was Fiona McQueen --

22 **A.** Yeah.

23 **Q.** -- said it was her preference that essential visiting  
 24 should be restricted to end of life and that was in  
 25 accordance with what was being applied in hospitals. Do

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1 and, you know, the activities of our local health and  
 2 social care partnerships, but there wasn't anything else  
 3 that we were able to do at that point in terms of  
 4 oversight.

5 **Q.** In the event of a future pandemic, would the Scottish  
 6 Government make any different decisions about the  
 7 discharge of patients from hospitals to care settings?

8 **A.** So I think when we talk about discharges, I think we  
 9 need to be really mindful of the fact that, first of  
 10 all, it's really well established that being in hospital  
 11 is not the best place for somebody who no longer has  
 12 a clinical requirement to be in hospital. People  
 13 decondition, they get confused, they deteriorate while  
 14 they're in hospital. I think we also need to remember  
 15 that -- and I think it's in the PHS report -- that quite  
 16 a significant number of those people, about 46%, from  
 17 memory, of the people who were discharged from hospitals  
 18 to care homes were discharged back to the care home that  
 19 had been their place of residence before they went into  
 20 hospital, and so I think, you know, it remains really  
 21 challenging, when you're facing a pandemic that is  
 22 likely to require you to use all of your hospital  
 23 capacity to the extent that you're having to stand down  
 24 other areas of care that are very important for people,  
 25 obviously it's important that we free up hospital beds

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1 you know if that was a unilateral decision by her to  
 2 narrow the definition of essential visits, because you  
 3 say in your statement that updated guidance was then  
 4 issued on 26 March, so the next day.

5 **A.** I don't think there were any unilateral decisions.  
 6 I think there was always a debate around some -- you  
 7 know, weighing up different aspects of every decision,  
 8 and I don't think either that we would have been unduly  
 9 influenced by what other countries were doing, that we  
 10 were always looking at what the situation was in  
 11 Scotland, and what the assessment was based on a range  
 12 of clinical and other professional advisers, including,  
 13 as I said, the Chief Social Work Officer.

14 **Q.** Do you know whether anyone in the sector was consulted  
 15 on that change of definition?

16 **A.** So I'm ... I'm sorry, no, I can't say for certain.

17 **Q.** Do you know if any impact assessments or equality  
 18 assessments were carried out?

19 **A.** Again, I think at that point we were -- the pace at  
 20 which we were issuing guidance made it very, very  
 21 difficult to carry out those sort of impact assessments.

22 **Q.** And can you just help us, please, as to what  
 23 Ms McQueen's professional experience was in the care  
 24 sector as opposed to in the NHS?

25 **A.** Yeah, I'm sorry, I think I'd need to go back to that.

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1 But she was a very experienced nurse.

2 **Q.** It's right, isn't it, that in June 2020, guidance was

3 issued which outlined a staged approach to supporting

4 indoor visiting, however a full return was not promoted

5 until February 2021?

6 **A.** That's correct, yeah.

7 **Q.** Did you have any accounts at the time that care homes

8 were not opening their doors in accordance with the

9 staged approach?

10 **A.** Yes, we did. And one of the ways in which we tried to

11 address that -- there were two ways, really. One is we

12 used the Safety Huddle Tool to gather information about

13 the extent to which individual care homes were or were

14 not allowing visitors and what they were doing, and that

15 was then -- the data from all of that fed into

16 the health and social care partnership, so they could

17 actually, sort of, contact the care homes and ask the

18 questions.

19 There was also a survey that we carried out to try

20 to understand what the barriers were to allowing

21 visiting, so to try to understand what were the things

22 that were making care homes anxious, what were the

23 things that were preventing them from allowing more

24 visiting.

25 **Q.** So some residents in care homes were effectively locked

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1 I think, you know, in some cases, guidance would --

2 the changes that were formalised in the guidance would

3 have already been well trailed, so they might have been

4 announced in Parliament by the Cabinet Secretary or the

5 First Minister. Where there were more substantial

6 changes we also tried to put out additional guidance to

7 support those needing to implement the guidance. So

8 there were, you know, videos, webinars, and more

9 information, but I accept absolutely that there were

10 times when guidance landed probably on a Friday

11 afternoon and that that wasn't a particularly helpful

12 time for people to be receiving it.

13 **Q.** The Inquiry has also received evidence that some of the

14 staff are finding the guidance itself confusing. We've

15 heard that there was guidance also issued by Health

16 Protection Scotland or Public Health Scotland, as it

17 became, on the one hand, and then Scottish Government

18 guidance which was based on the Health Protection

19 Scotland guidance.

20 Do you accept that that could have been confusing

21 for the sector and do you think that the quality and

22 timeliness of guidance improved with the increased input

23 of the sector, through the working groups and wider

24 engagement?

25 **A.** Yes, yeah, absolutely. I think that -- you quote an

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1 down for a year or longer. We know that Anne's Law was

2 consulted on in 2021. Is it right that that is still

3 not in force? And could you give us an update on the

4 progress of that, please.

5 **A.** Yes, so Anne's Law is part of the Care Reform (Scotland)

6 Bill, which was passed unanimously in the Scottish

7 Parliament in June just gone, June 2025, and is now

8 waiting on Royal assent.

9 **Q.** The Inquiry has heard that it was a common complaint

10 that guidance was often issued on a Friday, and there's

11 a balance to be struck between issuing guidance as

12 quickly as possible in a rapidly moving pandemic and

13 also not causing an unnecessary burden on an already

14 strained workforce. Were you aware of the concerns in

15 the sector?

16 **A.** Yes, we were. We had a workforce leadership group that

17 met really regularly, and through that we were advised

18 that issuing guidance, probably particularly on

19 a Friday -- I mean, obviously guidance was being issued

20 rapidly and there was a lot of it, but that particularly

21 on a Friday that that was difficult.

22 I think, for us, we had to balance the need to get

23 guidance with changes out as quickly as possible, with,

24 you know, the understanding that that was going to be

25 challenging for those receiving it.

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1 example earlier where Health Protection Scotland issued

2 guidance on 12 March and we issued clinical guidance on

3 13 March, and we moved quite quickly to having all that

4 guidance issued by what was then Public Health Scotland,

5 and the Scottish Government just then retained the

6 responsibility for issuing guidance and things like face

7 coverings that was more general.

8 So, yes, I do accept that -- I think that our

9 processes by which we issued guidance, our processes for

10 consulting with the sector and therefore being able to

11 adapt that guidance and make sure that the language was

12 understandable and was appropriate for the sector,

13 I think we improved all of that.

14 **Q.** Can I ask about PPE, please.

15 In Scotland, is it right that social care providers

16 received PPE support from the government in two ways?

17 First, by recouping pandemic-related PPE costs from the

18 local authority via funding from the Scottish

19 Government. And was it right that when that came into

20 force it allowed backdating of funding requests?

21 And the second way was, from March 2020, the

22 national stock was provided free of charge for top-up

23 and emergency provision where normal supply routes were

24 unsuccessful.

25 **A.** Yes, that's correct, yeah. Both those methods of

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1 support were used.

2 **Q.** The Inquiry has received evidence from multiple sources  
3 about some of the challenges that people had in  
4 obtaining PPE, also about the quality of the PPE that  
5 they were able to access, and also issues regarding the  
6 fit of PPE. Was the government aware of those issues?

7 **A.** So I think we were aware that there were issues with  
8 the -- with the social care sector being able to use the  
9 supply methods that they'd used pre-pandemic, and that's  
10 why we asked National Services Scotland to step in there  
11 and ensure that the PPE that the social care sector were  
12 getting was sufficient, of appropriate quality, and  
13 appropriately fitting as well.

14 So essentially we moved from pre-pandemic  
15 arrangements, whereby local authorities would source PPE  
16 for their social care sector through the Excel contract,  
17 and other independent private providers would have their  
18 own supply routes, we moved from that to a position  
19 where National Services Scotland was supplying the whole  
20 sector.

21 **Q.** And if there was a pandemic tomorrow, how would the  
22 sector be supplied with PPE?

23 **A.** We would take exactly the same approach.

24 **Q.** Thank you.

25 Can I ask you about the enhanced system of assurance

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1 like staffing levels, they'd look at training around  
2 infection prevention control measures, how infection  
3 prevention control measures were actually being applied  
4 in reality, the amount of PPE and other things and the  
5 general wellbeing of residents.

6 So I think it worked well in that it gave ministers  
7 greater assurance in the areas that they'd accepted that  
8 they were limited in their assurance because of that  
9 variability across different providers.

10 I think that we also recognised that there were some  
11 challenges in that approach, as well. So there were  
12 challenges around whether this was -- whether the visits  
13 were about improvement and supporting the care homes to  
14 be able to be as good as they possibly could be, or  
15 whether they were inspection visits, and therefore how  
16 that sat and rubbed up against the Care Inspectorate's  
17 role.

18 And I think there was also different professional  
19 groups coming together, it's really powerful, but also  
20 they have different roles, different responsibilities,  
21 and different views.

22 So there was further work done, and a guidance  
23 framework laid out for how to actually -- best practice  
24 in terms of that whole approach, and I think that, you  
25 know, if we were to be faced by that situation again,

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1 or oversight that came in in April 2020, please. Could  
2 you tell us, please, what you think went well with that  
3 process and what you think could have been differently  
4 or can be improved in future?

5 **A.** Yeah, so the enhanced system of assurance was set up,  
6 led by directors of public health in every NHS board  
7 area but with a really strong focus on bringing together  
8 multidisciplinary teams, so bringing together teams  
9 across nursing, across social care, across allied health  
10 professionals, GPs, and others, to provide -- start  
11 the -- the initial ask was for them to do a review of  
12 every care home within their geographical area, to bring  
13 together all the information and intelligence -- sorry,  
14 the Care Inspectorate was included on that, as well --  
15 that they had, and then do a risk assessment and to then  
16 carry out a series of visits based on that risk  
17 assessment.

18 So in terms of what worked well, I think it was  
19 a really good way of bringing together a range of  
20 different professionals. Sometimes, again, with  
21 different views on things, but bringing them together to  
22 reach a consensus around the care homes that needed to  
23 be prioritised for visits. I think it gave Scottish  
24 Government ministers greater assurance that when the  
25 teams went to visit care homes they would look at things

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1 then I think that guidance would stand us in good stead  
2 in terms of actually being able to understand what were  
3 the things that created the difficulties in the early  
4 phases of that last time and how we would approach that  
5 differently.

6 **Q.** There was a varied approach amongst the health boards as  
7 to whether they took an inspection-type approach --

8 **A.** Yes.

9 **Q.** -- or a more supportive role. Did you find that the  
10 ones that took a more supportive role were better  
11 received and had better outcomes?

12 **A.** I think that certainly some of the feedback and I think  
13 Scottish Care carried out a survey of their members, and  
14 I think they felt that where that system worked really  
15 well, it was actually incredibly helpful, and where more  
16 of an inspection-focused approach happened, then that  
17 became quite confusing for the care homes to be able to  
18 understand what the difference was between what the  
19 oversight team were saying and what the Care  
20 Inspectorate was saying to them.

21 So I think that, again, going forward, we need to be  
22 really clear about that role and that it is about  
23 support to improve, rather than an inspection.

24 **Q.** Another issue that was raised about that process is that  
25 care homes were providing a lot of information that went

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1 into data analysis for public bodies and the government,  
 2 but they weren't being shared that data themselves. So  
 3 for example, if there was an outbreak in their area,  
 4 they didn't have a forewarning about that. Is data  
 5 sharing with care homes something that you would  
 6 recommend should happen in future if there is  
 7 a pandemic?  
 8 **A.** Yes, I think -- so I think that -- I appreciate that  
 9 a number of -- many care homes probably felt that there  
 10 was an additional data burden imposed on them, and I've  
 11 explained why that was necessary because we didn't  
 12 have -- there weren't other systems through which we  
 13 could get that data. What we tried to do was to make  
 14 it -- that data collection as quick and easy as  
 15 possible. It was a web-based system so it didn't  
 16 require lots of analysis, it would produce graphs and  
 17 everything else straight away, and it was certainly used  
 18 through the health and social care partnerships and  
 19 I would agree yes, it should have been shared back with  
 20 care homes, as well, so that they could see what was  
 21 happening in their area and that is certainly, you know,  
 22 our approach with regard to social care data now: is to  
 23 try to make that as visible as possible.  
 24 **Q.** Thank you.  
 25 Can I ask you about staff movement, please. Did the

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1 advice, to people working across the sector, because  
 2 it's an incredibly stressful time for people.  
 3 Scottish Government has also, consistently, since  
 4 2016, met the costs of ensuring that social care staff  
 5 are paid the real living wage rather than just the  
 6 minimum wage --  
 7 **Q.** Just focusing on staff movement and what funding was  
 8 considered in relation to that issue, is there anything  
 9 else you'd want to add?  
 10 **A.** I can't think of anything else that I'd add to that.  
 11 **Q.** Thank you. And just very quickly, do you think that  
 12 legislating staff movement is feasible? I think you  
 13 described it as being very complex.  
 14 **A.** I think that that would be very difficult, but I'm not  
 15 a legal expert either.  
 16 **Q.** We understand that the Scottish Government or Scotland  
 17 in fact had a central register of care workers. Do you  
 18 think that benefited Scotland in terms of the adult  
 19 social care sector's response? And if so, how?  
 20 **A.** Yeah. So, in Scotland, care workers are regulated by  
 21 the Scottish Social Services Council, so we do have  
 22 a register, and I think one of the ways in which that  
 23 benefits the sector is that there are training  
 24 requirements associated with being registered, and  
 25 therefore I think that encourages people working in the

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1 government ever consider legislating about staff  
 2 movement, and what consideration did it give, if so, to  
 3 funding for the workforce?  
 4 **A.** So I don't recall that there was ever consideration of  
 5 legislation, and so there were lots of things that we  
 6 put in guidance that would have taken a very long time  
 7 to get through legislation and obviously there was  
 8 a requirement to act very quickly. And I think  
 9 legislation of that sort would be incredibly complex as  
 10 well.  
 11 In terms of funding and support for the workforce,  
 12 we did a number of things. So, one of the things  
 13 I think was that we recognised that terms and conditions  
 14 across the social care sector are variable, and are not  
 15 always as good as we would want them to be. We  
 16 recognised that some employers would only pay  
 17 statutory -- if people were off sick, they would only be  
 18 entitled to Statutory Sick Pay, so we put in place  
 19 arrangements to ensure that they could receive an amount  
 20 equivalent to their normal pay, so they weren't  
 21 suffering financially if they were off sick or indeed if  
 22 they had to isolate because a member of their family was  
 23 off sick.  
 24 We also put in place a number of wellbeing supports.  
 25 We had a national wellbeing hub to offer support,

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1 sector but also employers to support their staff in  
 2 training as well.  
 3 **Q.** Thank you.  
 4 And before we end with what your top recommendation  
 5 is, just one more short topic, please. Do you think  
 6 that enough was done during the pandemic in relation to  
 7 the issue of inequalities in Scotland?  
 8 **A.** No, I couldn't possibly say that. I think that Scotland  
 9 has -- in common with other parts of the UK, has  
 10 a persistent issue with inequalities. I think that all  
 11 the evidence would show that the pandemic has worsened  
 12 rather than ameliorated those inequalities and therefore  
 13 I couldn't possibly say that there isn't more that we  
 14 could have done.  
 15 **Q.** And your top recommendation, please, in the event of  
 16 a future pandemic?  
 17 **A.** Just one?  
 18 **Q.** Well, how many top recommendations --  
 19 **A.** So, I think that -- first of all I'd say that I think  
 20 there's a number of things that we have done. We've  
 21 talked about Anne's Law. We've -- within that same  
 22 legislation we've made additional provisions around data  
 23 sharing and information standards, which I think will  
 24 really help us going forwards. And we've also  
 25 legislated for breaks for unpaid carers. So I think

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1 there are a number of things that have already happened.  
 2 I think that probably, though, we need, as the UK,  
 3 really, to look at the underlying resilience of the  
 4 social care system. When you look at the demographics,  
 5 this is a really important system for us, and I think  
 6 it's hard to escape the fact that it's a sector that  
 7 needs additional funding.

8 **MS JUNG:** Thank you very much, Ms Lamb.

9 My Lady, those are all my questions. I understand  
 10 that there are some questions from the Core  
 11 Participants.

12 **LADY HALLETT:** There are. Thank you very much, Ms Jung.  
 13 Ms Mitchell, who is that way, as you may remember.

14 **Questions from DR MITCHELL KC**

15 **DR MITCHELL:** I appear, as instructed by Aamer Anwar &  
 16 Company, on behalf of the Scottish Covid Bereaved, which  
 17 you may remember from I was asking you questions before.

18 Just touching on the last point that you were asked  
 19 there by my learned friend about recommendations.

20 As we know, the chair can make recommendations and  
 21 it's for politicians to implement them. Do you have any  
 22 suggestions which would be low cost but high impact in  
 23 relation to planning for the next pandemic?

24 **A.** Low cost but high impact.

25 I actually think that a lot of the -- and I've  
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1 could use usefully.

2 **Q.** So really using the data to either assure yourself that  
 3 things are working properly or where they aren't,  
 4 identify there you can implement change?

5 **A.** Absolutely.

6 **Q.** The next question I want to ask is probably just as  
 7 broad, and it may be one that you've thought of before,  
 8 certainly other witnesses have given an indication that  
 9 this is something that they've thought of. If you were  
 10 given the opportunity to go back and change one thing  
 11 that was done that would make great impact, what would  
 12 that be and why?

13 **A.** So I think that's a very broad question and it's also  
 14 an incredibly difficult one to --

15 **LADY HALLETT:** Is it a bit like when did you stop beating  
 16 your wife?

17 **A.** Yes.

18 **DR MITCHELL:** It was premised on the basis that a number of  
 19 witnesses have said, "This is one thing that could have  
 20 been done" or "We think this was the most important  
 21 thing." I'm not suggesting that you discount all the  
 22 rest but I'm just seeing if there is something that you  
 23 think, "This could have been done differently and here's  
 24 how it would have been better had it been done  
 25 differently."

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1 explained that we've already done quite a lot around  
 2 data but, actually, I do think that having a better  
 3 understanding, a more up-to-date understanding of what's  
 4 actually happening across the social care system and  
 5 being able, therefore, to identify where there are  
 6 variances and to understand whether those are warranted  
 7 variances or whether there is additional support that  
 8 could be provided to improve some services, is  
 9 a relatively low cost, but I think it could be an  
 10 incredibly high impact.

11 **Q.** And what would you be looking for there, when you're  
 12 seeing the differentials? What sort of things would you  
 13 be looking at?

14 **A.** So I think there's a number of things. If you look at  
 15 our national -- the performance indicators for social  
 16 care, which is a balance of, you know, what are the  
 17 things that people can expect to receive. So I think  
 18 it's looking at eligibility so ensuring that people are  
 19 getting the care packages and the support that they  
 20 need, ensuring that they're being treated with dignity  
 21 and respect, looking to see that, you know, the care  
 22 packages are the right sort of size for people, looking  
 23 to see that staff are valued and well trained and well  
 24 supported to do the best job that they possibly can.  
 25 There's a whole range of indicators that I think we  
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1 **A.** I think that, so I wish that we had had more testing  
 2 capacity earlier and I think also that we could have  
 3 been much clearer in our guidance earlier, as well.

4 **Q.** And why would that be?

5 **A.** Because I think that there was still -- I think there  
 6 was still confusion and I think -- maybe I'm wrong,  
 7 maybe that's the wrong way to describe it in being  
 8 clearer. I think, I think we could have provided more  
 9 support to ensure that guidance was fully implemented in  
 10 the way that it was intended to be.

11 **DR MITCHELL:** My Lady, those are my questions.

12 **LADY HALLETT:** Thank you very much, Ms Mitchell.  
 13 Ms Jones, who's over there.

14 **Questions from MS JONES**

15 **MS JONES:** Thank you, my Lady.

16 Ms Lamb, my question follows quite well from the  
 17 answer that you have just given. I'm asking questions  
 18 on behalf of John's Campaign, Care Rights UK and The  
 19 Patients Association, and our question is about the  
 20 confusion that arose from the guidance that was  
 21 published.

22 You were asked by Ms Jung earlier what you  
 23 understood the term "exceptional circumstances" to mean  
 24 in the visiting guidance, and you referred to end of  
 25 life being an exceptional circumstance in which visits  
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1 should have been permitted under the guidance, but we  
2 know that there were real problems and inconsistencies  
3 with how different settings understood that term.

4 So, for example, the organisations I represent are  
5 aware of some care homes taking a more liberal approach  
6 to that, but others interpreting end of life to mean the  
7 last days, the last hours, even, in some cases, the last  
8 minutes of someone's life, so that very often family  
9 members were not able to make it in time to be with  
10 their loved one when they died and were not there to  
11 provide support in the period leading up to that. And  
12 we even know of some cases where, extremely upsettingly,  
13 family members were let in and then were kicked out  
14 again when their loved one did not die as quickly as had  
15 been expected.

16 So, given these real inconsistencies and  
17 unpredictabilities in how the guidance was interpreted,  
18 can you clarify for the Inquiry what you thought the  
19 definition of the end-of-life period was under the  
20 guidance, what was it intending to refer to and who  
21 should have been allowed in.

22 **A.** So, my understanding was that -- if you read the  
23 guidance alongside the, sort of, person-centered  
24 approach to care, that that should be -- the end of  
25 life -- essential visiting at end of life should be an

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1 **MS BEATTIE:** Thank you. I ask questions on behalf of  
2 Disabled People's Organisations and my questions also  
3 concern the visiting restrictions.

4 You were asked some questions and answered them  
5 earlier about restricting those visits to essential  
6 visits and you said that you understood that that was in  
7 line with the definition for hospitals, which again, as  
8 just mentioned, was around end-of-life visits and also  
9 if residents were distressed.

10 How did the Scottish Government ensure that that  
11 restriction, those visiting restrictions, didn't prevent  
12 the continuation of vital health and clinical services  
13 to people in residential care settings, including, for  
14 example, visits by GPs?

15 **A.** Yes. So I think in -- there was a letter that was sent  
16 from the Chief Medical Officer to our GPs and it was  
17 a follow-up around some of the concerns that had been  
18 raised with us about the inappropriate use of DNACPRs,  
19 but there was a follow-up letter went out from the Chief  
20 Medical Officer which also, I think, stressed the  
21 importance of GPs in providing care and support to the  
22 care homes in their locality.

23 So there was that letter that went out, I think it  
24 was about the end of March, it might have been April,  
25 but also then when, once that system of enhanced

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1 individual assessment based on the individual in front  
2 of you, that provides the time and the space for them to  
3 be able to -- for them and their loved ones to be able  
4 to spent time together as they approached the end of  
5 their life.

6 **Q.** But did you consider that any time period was being put  
7 on that by the guidance?

8 **A.** I don't think so, no.

9 **Q.** So, in circumstances, then, where it is a series of  
10 individual interpretations under the guidance applied to  
11 a particular person, what do you think would have been  
12 the way around the extremely unhelpful inconsistencies  
13 that arose in interpretation?

14 **A.** So I think if you -- if you sort of take a step back  
15 from that and -- what I explained about what we've done  
16 in Scotland around Anne's Law is to make sure that there  
17 is always, you know, a nominated essential visitor,  
18 which would avoid you having to get into the "Is it  
19 days, is it hours, is it" -- which is an incredibly  
20 difficult position to put not only those individuals in,  
21 but also care home staff trying to manage that.

22 **MS JONES:** Thank you, my Lady.

23 **LADY HALLETT:** Thank you, Ms Jones.

24 Ms Beattie, who is just behind, I think. Yeah.

**Questions from MS BEATTIE**

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1 monitoring was put in place, that was -- under the  
2 oversight of directors of public health, that was also  
3 very much intended to ensure that care homes were well  
4 supported by general practitioners, by geriatricians in  
5 their local hospitals, and others as well.

6 **Q.** I think in your statement you say that initially the  
7 guidance said that essential visits might have to  
8 include visits by health and social care staff --

9 **A.** That's right, and that was then corrected -- sorry, that  
10 was then adjusted in the next version of the guidance.  
11 I think that was felt to be a bit tight.

12 **Q.** Right. And so obviously you weren't intending to  
13 prevent those kind of considerations?

14 **A.** No, absolutely not.

15 **Q.** Is it the case, though, that concerns and reports that  
16 GPs and others weren't getting into care homes continued  
17 really right up until and throughout 2020 such that  
18 a letter was still being sent, even in April 2021,  
19 stressing to care homes that GPs can and should visit?

20 **A.** Yes.

21 **Q.** So did that remain a concern, despite that early  
22 correction --

23 **A.** Yes.

24 **Q.** -- more than a year earlier?

25 **A.** Yes, so we had, I think, attempted to correct the

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1 guidance. We had issued a letter, but yes, it did --  
 2 again, it's about the variability across -- across the  
 3 country that it was felt necessary to issue that further  
 4 letter.  
 5 **Q.** Are you aware of any checks or any auditing of whether  
 6 that -- and those gaps perhaps in residents receiving  
 7 that kind of ongoing routine care in circumstances where  
 8 there had been stops on visiting, whether those kind of  
 9 clinical care visits had caught up?  
 10 **A.** I'm not aware of that, no.  
 11 **MS BEATTIE:** Thank you, my Lady.  
 12 **LADY HALLETT:** Thank you, Ms Beattie.  
 13 That completes the questions we have for you,  
 14 Ms Lamb, and -- I'm pretty confident in saying -- that  
 15 completes the demands we're going to make upon you for  
 16 this Inquiry, although I suspect there are other  
 17 inquiries that there will be demands placed on you. But  
 18 thank you for your help and I'm sure the help of members  
 19 of your team, who helped provide the statement.  
 20 **THE WITNESS:** Thank you.  
 21 **LADY HALLETT:** So thank you, and safe journey back to  
 22 Scotland.  
 23 **THE WITNESS:** Thank you very much.  
 24 **LADY HALLETT:** Very well. I think that completes the  
 25 evidence for today, and so I shall return at 10.00 am  
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1 tomorrow.  
 2 **(3.06 pm)**  
 3 **(The hearing adjourned until 10.00 am the following day)**  
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