Module 2a – Summary of Evidence – Week Two

Preliminary Issues

Evidence will not heard from former Chief Medical Officer for Scotland, Dr Catherine Calderwood, who has been excused participation due to ill health.

Caroline Lamb (Chief Executive of NHS Scotland and Director-General Health and Social Care)

From about mid-March 2020 until early May 2020, I was the delivery director for intensive care capacity expansion. I then led the delivery of contact tracing. From August 2020, I was the delivery director for the vaccination programme.

The Four Harms was about trying to provide advice to ministers that set out the broad context and enabled them to make the choices with advice around what some of the other impacts would be as well as just the health impacts.

At the outset, Harm 1 was our priority, but we became acutely conscious of the backlog that was building up. Ill health doesn't go away, and it gets more difficult to treat.

Test and Protect – appointed Delivery Director for Contract Tracing Element.

As soon as a test was available, we took measures to develop capacity. NHS Scotland was acutely concerned to get those tests ramped up.

I wasn't directly involved in the discussions around prioritisation of tests but I was aware of the approach that was being taken, which was prioritising treating people and knowing who had Covid-19, and then moving progressively towards protecting the vulnerable and then out into trying to break chains of transmission. The advice on prioritisation came through clinicians and was linked to advice from officials on how many tests we had and when we expected to be able to ramp up testing capacity. The advice then went to the Ministers and they made the decision.

Our Chief Nursing Officer was a huge advocate for social care and doing all we could to protect vulnerable. Some of the early decisions were around testing people who were being discharged from hospitals to care homes. The majority of deaths in Scotland in the first wave were in care homes. We would have data on people being discharged from hospitals, but not necessarily what setting they were being discharged to.

Some of the research that's been done since the start of the pandemic would demonstrate that there were a number of factors that influenced the extremely tragic death rate in care homes, and one of those was around admissions from hospitals, but actually there was a much stronger correlation around the size of the care home which was probably linked to the prevalence of Covid in the local community.

We absolutely recognised that the nature of a care home with people requiring very close intimate contact from staff, the sort of quite closed nature of the community, did present a heightened risk

The 4 CMOs worked up the shielding list. Clinicians also had the ability to add people if they felt they were missing. It formed part of our discussion from a pretty early stage, both in relation to identifying and categorising that shielding list, but also then what were we going to put in place to support those people. There was never an intention to ration support and to focus on the CEV. Our local authorities worked through their local resilience partnership. The shielding list was very much about those who were clinically vulnerable, but there were other support mechanisms put in place around people who weren't clinically vulnerable but would be vulnerable for other reasons.

Prof. Sir Gregor Smith (Chief Medical Officer for Scotland)

Appointed interim Chief Medical Officer on 5 April 2020 when the previous Chief Medical Officer, Dr Catherine Calderwood, resigned. Became the Chief Medical Officer for Scotland on 23 December 2020.

I attended SAGE as an observer. My role was to take account of the information that was being relayed and ask Questions on behalf of Government – generally they had to be signalled in advance of those meetings. There was some frustration that I wasn't able to participate in a deeper sense so at that stage we were still to see the full usefulness of the SAGE. The impact of that inability to be able to explore during the course of the meeting meant that you then had to, rather than be able to deal with a particular line of inquiry or interest at the time you had to chase down someone afterwards to try to find out more information, it expanded on the amount of work which was necessary to try to get a sense of an answer to your question. The questions were not particularly Scottish specific, just general epidemiology questions. This was corrected towards the end of March.

I didn't sit on NERVTAG, we had another representative sitting on those meetings namely Dr Jim McMenamin.

Harms 1 and 2 were the priority for me. It was for other people to give advice on harms 3 and 4.

Scottish Government advice in relation to informal communications was to not retain information for longer than it was necessary, to make sure that any information which was pertinent such as any discussions which ended up in a decision was captured within the corporate systems. My practice was to make sure that any information which was important was then captured in email form on the system, was formally recorded so there was an audit trail. And I would then delete that information from the phone. I would encourage others to do the same. My practice was to delete information when it was no longer useful as it shouldn't be retained.

Nike Conference

I know that Dr Calderwood in particular, was against any circumstances whereby she may be responsible for the release of confidential patient information. My own view is that whilst it was important to maintain patient confidentiality at all times, there was in this case, a legitimate public interest that meant that some information could be released, but it had to be very, very carefully thought through.

Risk

Scotland has an older population but it's also a sicker population. Not only is it more evident but it also tends to occur at a slightly earlier age, and a lot of that is influenced by the health inequalities. That is why the risk thresholds in Scotland was perhaps set slightly higher, because of the perceived additional risk to the population because of the increased burden of disease that existed within the population. My advice in terms of the health-related harms was that the risk to the Scottish population was greater because of the demographics and the burden of disease that existed within the country. These characteristics existed in March 2020 but Scotland did not introduce any restrictions earlier.

Prof. Sheila Rowan (Former Chief Scientific Adviser for Scotland)

The Scottish Government Covid Advisory Group was not re-doing SAGE's work, not duplicating SAGE's work, it was simply applying a Scottish lens to the advice that was coming from SAGE and adding in local information to help advise Scottish Government.

Prof. Jason Leitch, CBE (National Clinical Director for the Scottish Government)

The role was focused more on dealing with health boards than dealing with public health. During the pandemic the role evolved to briefing Ministers and communicated clinical matters to the public via the press conferences. I was part of the advisory structures, I was not the principal clinical adviser. I am not a doctor so did not provide medical advice. I provided clinical advice as part of a group of clinical advisors.

Informal Messaging

The record retention policy was that you could use informal messaging systems for Scottish Government business, but if you did, you should ensure that any advice or any decisions or anything that should be in the corporate record was then placed in that corporate record by email, briefing, et cetera and then you should then delete the informal messaging. That's the guidance I followed.

I have not retained any one-to-one informal communications in relation to the management of the pandemic in Scotland this is because I followed the policy. Some of my conversations have been recovered from other participants to the conversation. They potentially worked for other organisations so had different guidance to follow.

I was not deleting messages to avoid Freedom of Information requests.

AN area that could improve is the extent to which the communication strategy factored in disabled people and the degree of digital exclusion. A lot of our information was online, the nature of the speed of the response meant that it had to be online. We did a lot of translation work, we did a lot of engagement with disabled organisations, I spent quite a lot of time learning what it was like to receive that information. I agree with the premise of the question that that could of course be better. We were trying to make decisions for the whole population and that means that groups within that population would often feel that they weren't being listened to as much as they could be.

Prof. Devi Sridhar (Professor and Chair of Global Public Health at the University of Edinburgh)

It was a novel virus so we had to learn about it from the countries that were being affected by it. We had time, we had weeks to learn from not only countries but the Diamond Princess cruise ship where it was an elderly demographic. There was a lot of knowledge by mid to late February, the WHO was also doing daily briefings. There was a lot of information there about the response. But my sense is, high income countries as a whole hadn't faced anything like this so there was a sense of complacency that we will be fine and it won't come here. Whereas countries that had polio outbreaks, measles outbreaks, who were used to being hit with Ebola, were on high alert. They had had lockdowns on 2014 so they were not saying this was crazy. I think another issue was the swine flu pandemic where we had a near miss and if you have a near miss and you've lived through several near misses it's a bit like the boy who cried wolf so there was a fear of overreaction.

It wasn't until, March that suddenly when I started seeing the public announcements that I thought, oh, why are we doing something so different to other places and not trying to contain this. There were no real measures put in place by 12th March and that was why I started to speak publicly because it didn't make sense.

Some countries started really early in January so by mid-January they were contacting biotech companies and saying we have the sequencing out of China, can you make us a test, we need millions of tests so they started earlier. Then you had countries that were a little bit later into February who suddenly realised this is important and I think they moved immediately into the logistics. Britain got stuck and and spent a long time discussing whether testing would make a difference outside of hospitals and by the time the answer was yes, every other country in the world had already bought up the reagent that was needed to make the tests.

Other countries moved much quickly towards at least recommending to their public masks. In Britain we debated for too long whether masks work instead of saying they work in clinical settings where surgeons use them, they work on construction sites. The mask itself works, it's how it's used at a population level which affects whether it has an impact on transmission dynamics. I feel like that became a sticking point, wanting to have a standard of evidence that was incredibly high at a population level.

Modellers might say "I put it into my model and it made no difference," but models carry assumptions. Whereas for me, who is working on the ground and seeing it working in a local level and seeing it work in clinical settings then if a model says it doesn't work you have to reconcile two evidence sources.

The Elimination plan was saying that we have a chance here to hold and wait for a vaccine in an optimal position and have a payoff from the sacrifices we all made and avoid a winter Lockdown. The Elimination plan I put together wasn't lockdown, it was for extensive testing as we had a lot of unused testing capacity in Scotland, my plan said to use borders, it addressed the issue of return to university. It was trying to capitalise on all that we had done to get to this point. The plan called for cohesion across the nations. Getting England to come along with this plan was the main area at that point. That's why when the winter wave came and the numbers went up, it was predictable. In January the vaccines were rolled out and you

just think how many of those people would have lived had they just been able to delay infection by two months, a month. That was how close it was at that time.

The countries that did have the best mortality did go for maximum suppression. if I'm honest I was really frustrated with not understanding England's strategy because we are linked together and so it does seem to me so clear that given the levels of immunity, given the level of death, given that we didn't want to have another lockdown which was catastrophic in terms of the harms that raised, why you wouldn't go for maximum suppression. Just going for simmering doesn't work when you have such a large susceptible population.

Prof. Andrew Morris (Professor of Medicine at the University of Edinburgh)

Was also chair of the Scottish Government Covid Advisory Group

My first attendance at SAGE was on 26 March 2020. That was in the capacity as the newly appointed chairman of the Scottish Government's Covid Advisory Group. Early on, January and February, Scottish colleagues were observers on some of these groups, and a need was identified to enable Scottish policymakers and ministers to have more direct access to expert scientific advice. From March 26th the relationship between SAGE and Scottish participants was excellent. I was a full participant

Over the course of the pandemic evidence emerged of the disproportionate impact on ethnic minority groups. We highlighted the need for data to highlight the differential. Even today we do not have sufficient capability and ability to differentiate the impact of covid on specific groups. There was insufficient data to be able to provide proper assessments of the way in which these disadvantaged groups should be dealt with.

Prof. Mark Woolhouse (Professor of Infectious Disease Epidemiology, University of Edinburgh)

Sat on SPI-M-O between January 2020 and early 2022 and Scottish Covid Advisory Group from March 2020. Did not attend SAGE. Provided advice through the CMO Catherine Calderwood.

I thought we were going to have a pandemic or it was very likely that we would have a pandemic from round about January 10th. I started to write emails in January. Prior to this chain of emails, I'd been in touch with Health Protection Scotland, and through him with Jim McMenamin. I didn't get the impression that it was treating the situation with the seriousness or the urgency that I felt it needed.

I was suggesting a programme of gathering data. The better informed we were the better decisions we could make. Dr Calderwood acknowledged my email and said that PHE and HPS were actively considering the novel virus. I don't regard ‘actively considering’ as sufficient. I was frustrated by the lack of action so I wrote to Sally Davies and basically asked her to get Catherine Calderwood to listen to me because she is not listening.

No one had thought about a lockdown before. it had never been contemplated. No work had been done on the impact of it. It was on the radar because at that stage the City of Wuhan had been locked down.

The realisation that something like a lockdown would have to be contemplated for Scotland took rather longer. When we went into lockdown, I don't think The Scottish Government had the faintest idea how long we would be in it for. My impression is that the Scottish Government had done absolutely no analysis of the effect of lockdown.

6th March met with Dr Calderwood again and discussed cocooning. There would be a subpopulation of very vulnerable people. We now had very good data that there was tremendous variation in the risk with age. This seemed to me to be the absolute number one, to protect this subset of the population that's at very considerable risk. The case fatality rate of 4% was high, but in the elderly and the frail, it's way higher than that. These people are very, very vulnerable. Elderly people, particularly elderly people with other risk factors, other comorbidities, need care, whether it's in the home or it's in a care home, some in hospital, this is a subset of the population that really couldn't socially distance. So how do we protect them? I had this idea of protecting people by protecting the people around them. So carers, family members, same household. That we had to pay particular attention to this. So that's what I was proposing.

What we got was shielding which was basically telling people to cut all contacts out. There's lots of evidence now that it didn't work particularly well, and I can give you chapter and verse as to why it didn't work if you want, but that didn't seem to me even at this stage to be a very good approach.

I don't think that those early SAGE meetings were doing a particularly good job of raising the alarm.

The Scottish approach was that no death from Covid was acceptable. This was problematic because it's empty rhetoric, it misleads the public, it gives an entirely false impression of what the future holds. The idea “no Covid death is acceptable" implies a world where no one dies of Covid. That possibility had gone. There seems to be no serious action so people are going to die of Covid. It also devalues non-covid deaths, somehow they are acceptable.

The whole message of not bothering the NHS meant that people who should have been in hospital were not. And that killed people.

I didn't understand the Scottish Government's strategy over the summer of 2020. The emphasis was on a very, very cautious relaxation from lockdown, and it seemed to be important to the politicians that it was more cautious than the one in England, so they were emphasising that. They didn't articulate in any way that I understood what they thought the public health benefit of this caution actually would be.

If I had been listened to early on, I think the lockdown could have been avoided. If we had gone earlier and with measures we would have seen it wasn't necessary to close schools. The strategy of Patrick Vallance led to the closure of schools, my strategy would have seen them stay open.

Prof. Stephen Reicher (Professor of Psychology, University of St Andrews)

My primary interest is in how humans interact with one another and in a social setting. It is for the medical scientists to tell us what sort of behaviours are likely to spread the virus. I can then begin to think about how we might be able to change those behaviours to reduce transmission.

I think we made a huge mistake early on in the pandemic when we talked about social distancing, what we had to do was physically distance because physical proximity led to the transmission of the virus that could kill you. We didn't put enough effort into asking the question: how can we keep people socially together particularly marginalised social groups

Vaccine Hesitancy

There are two broad ways in which you can deal with vaccine hesitancy. One is to say people don't take the vaccine because they are too stupid or too immoral to care, they're selfish, there's something wrong with those individuals. The problem with that is that when you look at the statistics on vaccine hesitancy they are much larger amongst certain groups, more deprived groups, ethnic minorities, in particular black British people, much less likely to get vaccinated. So one route might be that black people are either less intelligent or less moral than others, and hopefully none of us want to go down that route.

An alternative approach is to say it's not about the information itself, it's about our social relationship to the source of that information, do we trust those who are giving us this information? And there is good reason to understand why certain groups have less trust in government, because historically they have been treated differentially.

So the key issue becomes not the intellectual or moral values but about building trust. My feeling very strongly was we should focus on engagement, we should focus on working with those communities, on listening to people. Once you understand the different communities, what matters to them and wait for them to go to you, you have a hugely effective intervention, and that to me was the way to go

The issue of support time and time and time again was absolutely critical and time and time and time again we weren't given enough support. If I ask you to do something which you can't do because of your practical circumstances all it does is alienate you. You say these people don't understand our lives, they tell us to do these things and we can't do them. It undermines that social relationship fundamentally. The key issue here was self-isolation. The whole point of the testing system, the billions spent on it was not to test people, not to trace contacts, but to get people to self-isolate. And if you didn't get them to self-isolate, you were wasting your money.

Dr. Pablo Grez (University of Strathclyde)

Lecturer in public law. Worked on a project called the Pandemic Review Rights and Accountability in Covid-19.

In my view the Covid-19 pandemic is a textbook of legitimate use of emergency powers, including delegation of emergency law making powers to the executive.

The vaccination certificate scheme was announced in Parliament by Nicola Sturgeon on 3 August 2021. on 9 September 2021 the chamber in the Scottish Parliament debated for around two hours a motion on the Covid vaccine certification scheme. The debate was a clear indication that the proposal was fraught with difficulties, because the Scottish Conservatives, Scottish Labour and Liberal Democrats all voted against the motion. However, despite that Scottish Government used the Made Affirmative Procedure on 30 September 2021, and the regulations came into force on 1 October 2021.

So what we have here is a policy announcement made on 3 August 2021, there seems to be quite a lot of political controversy, and then the regulations are introduced using Made Affirmative Procedure without an ability for the Scottish Parliament to debate the details of the policy.

It is hard to understand why those regulations containing the details of that policy that had been controversial had not been shared in advance with the Covid committee and other members of the Scottish Parliament.

Prof. Susan McVie (Professor of Quantitative Criminology at University of Edinburgh)

Became a member of the independent advisory group on police use of temporary powers related to the coronavirus crisis in Scotland, from the inception of the group in April 2020.

Principal investigator for a project titled Policing the Pandemic in Scotland. Our terms of reference were specifically to look at the police emergency powers that had been issued, so the powers of enforcement, and we were asked to examine the policing of the pandemic in the context of human rights and also to ensure that enforcement had been administered in line with policing values and principles in Scotland.

Fixed penalty notices are most suitable for a clearly defined objective offences that involve minimum discretion on the part of police officers such as speeding. Being used to enforce public health restrictions was a departure from this traditional model.

The types of behaviour that they might be issued for was not necessarily always clearly defined, it changed a lot over the course of the pandemic as the regulations changed. So it was problematic from the point of view that neither the individual nor the police officer might have a clear view of whether an offence had actually been committed. Police were frustrated at the amount of changes to the regulations and the lack of consultation. Some of the regulations were absolute gobbledegook.

There is no evidence that more enforcement led to less spread or fewer deaths.

Elizabeth Lloyd (Former Chief of Staff to Rt Hon Nicola Sturgeon MSP)

There is a special advisers code of conduct. The role of a special adviser as adding a political dimension to the advice and assistance available to ministers, and the code notes that one of the reasons for the role is to reinforce the political impartiality of the permanent civil service so that the political advice can come from the special advisers as opposed to the permanent civil servants.

Sometimes the scientific advice was proposed in the abstract and didn't seem to consider what real life was like and how people function so that is what I would sometimes address with Nicola Sturgeon. I would take into account issues like the broader societal impact and things like mental health.

Note from meeting: “Political tactics – calling for things we cant do to force the UK “

The Scottish Government couldn't provide financial support if we wanted to go for a circuit breaker. What we needed was the UK Treasury to open up additional funding, to extend furlough, to enable us to take actions to do that. We were setting out very clearly what we wanted to do in public health terms but what we couldn't do, so we had to build pressure on the UK Government who were not amenable to this discussion in private, by calling for it publicly to force a change of position.

You have to say to the people you represent why you are not able to do something that you are being advised to do. That means going public on the fact that you can't afford it, that means going public on the fact that you may have asked the Treasury for money, and they were not providing it. It's not a "we are doing this to stir up political contest", it's "we can't do what we're trying to do, and we need to tell you why".

Ultimately the furlough scheme was extended. There was significant public pressure placed on the UK Government. Ultimately it did it because it did it for England, and this was the issue, finance decisions that related to mitigating public health measures were not co-ordinated with the decisions each of the four nations might make on those public health measures, they were only triggered, when England took a decision

Humza Yousaf MSP (First Minister for Scotland)

During the course of the pandemic, I held two Cabinet Secretary roles. I was Cabinet Secretary for Justice from 26 June 2018 to 19 May 2021. In May 2021 I took over the health and social care portfolio. Took that over from Ms Jeane Freeman, who had held the role during the earlier stages of the pandemic.

There were occasions on which the First Minister either with or without the benefit of discussions within gold command took decisions without the delegated authority of the Cabinet. I think those times would be very rare, very rare occasions, often the former First Minister would seek Cabinet's delegated authority, but I think there was an understanding in exceptional cases where the epidemiology of the virus had changed, if there had been a sudden spike in cases in 24 hours and therefore a decision had to be made there and then, there was an understanding that given this was not normal times that such decisions could be made by the First Minister.

Gold command was a tighter cast list of Cabinet secretaries that were necessary to make a particular decision. Cabinet meetings are minuted and published. My understanding was that Gold Command meetings should have been minuted. If that was not the case that would have been unusual. I agree that the public was entitled to see those minutes to understand how decisions were made.

My View is that any messages should be handed over. I apologise for the Govts poor handling of the various Rule 9 requests for informal messages. We should have done better. There is clearly a gap that

exists in relation to how material in informal communications should be retained in relation to a statutory public inquiry, and that's why I've instructed an externally led review to look at this issue. Our record management policy will make it clear that it is not just the decision that needs to be recorded but also the salient point of the discussion leading to the decision.

Where I was deeply frustrated at the fact that either information coming to us, and it was usually information from the JBC, the Joint Biosecurity Centre, or other sources was coming to us at the absolute last minute before a meeting, five, ten minutes before a meeting was to start, or we were reading about an announcement of a decision already being made by the UK Government, such as a decision about what countries were on what list for England, but that undoubtedly had an impact on decisions that we were then going to have to make.

As the person who was Cabinet Secretary for Health and Social Care Harm 1 was always the one that was at the forefront of my mind, harms 1 and 2. For me there was never any dilution, diminution of harm 1, it was at the forefront of our minds as a government constantly throughout the course of the pandemic. There's no doubt at all that when you cancel elective surgery people waiting on a waiting list is not a benign act.

I think the issue around possible asymptomatic transmission of the virus was known as a possibility early on, through various international journals, through various academic articles, and there will be a number of things that we could have done better. It is in my view as the current First Minister that we should have been testing those who were leaving hospitals going into care homes who were asymptomatic sooner than we actually did. I was aware of the possibility well in advance of 21 April. Our thinking was that we needed to prevent the NHS from being overwhelmed and we also had to consider the testing infrastructure.