Module 2a - Core Govt Decision making in Scotland, Summary of Evidence

The Module 2a hearings in Scotland continued last week with the First Minister Humza Yousaf giving evidence on Thursday. This week will see the former First Minister Nicola Sturgeon give evidence. No doubt she will be asked about her failure to retain WhatsApp messages amongst many other topics. At the end of this update is summary of the evidence heard last week. Please note some of this material has the potential to be upsetting.

The full timetable for next week is copied below.

Monday 29 January	Tuesday 30 January	Wednesday 31 Jan	Thursday 1 Feb
10:00 am	**10:00 am**	**10:00 am**	**10:00 am**
Ministerial Evidence **Michael Gove** (Former Chancellor of the Duchy of Lancaster and current Secretary of State for Levelling Up, Housing and Communities)	**Ministerial Evidence** **Kate Forbes** (Former Cab Sec for Finance and Economy – Scottish Minister) **John Swinney** (Former Deputy First Minister for Scotland)	**Ministerial Evidence** **Nicola Sturgeon** (Former First Minister for Scotland)	**Alister Jack MP** (Secretary of State for Scotland) **Closing Statements**
Jeane Freeman (Former Cabinet Secretary for Health and Sport)	**John Swinney** (Former Deputy First Minister for Scotland) *continued*	**Nicola Sturgeon** (Former First Minister for Scotland)	**Closing Statements**

Week One - Summary of Evidence

As set out above, please note some of this summary has the potential to be upsetting, particularly that of Dr Donald Macaskill who is the Chief Executive of Scottish Care and talks at length about the problems in care homes.

Day 1 – Tuesday 16th January

Jamie Dawson KC (Counsel to the Inquiry – CTI)

CTI Opening Statement

Aim of this module is to assess the decisions of the Scottish Govt.

The total number of Covid deaths reported in Scotland from the beginning of the pandemic up to 31 March 2022 was 14,130. Compared to the UK as a whole, Scotland had lower levels of excess mortality in the first and second waves in the pandemic, however in contrast throughout mid to late 2021, Scotland had higher levels of excess mortality. Mortality was 2.5 times higher in the most deprived than the least deprived areas of Scotland.

People from some ethnic minority groups had a significantly higher risk of being affected by Covid-19 and dying from it.

At the last preliminary hearing we shared that we had had some difficulty with accessing informal communications and that few, if any, had been made available to us. I am pleased to say that after a certain degree of political controversy over the issue, a large number of documents have now been made available to us. Around 28,000 messages have been disclosed to the Inquiry.

Relationships between the UK Government and the Scottish Government, in particular at ministerial level, were unusually poor in the lead-up to the Covid-19 pandemic.

Data from 2020 showed that for 2017 to 2019 both male and female life expectancy was lowest in the UK in Glasgow city. A new national body, Public Health Scotland was established as a result in 2020 as a national special health board within NHS Scotland. It has responsibility for providing evidence, analysis and intelligence to support public health and health inequalities, policy development nationally, and to support local activity.

Professor Nazroo identified a number of missed opportunities in the UK-wide response as regards the needs of elderly people. As far as social care was concerned, he stated that prior to the pandemic the fragile state of social care had been clearly documented, the failure to build resilience and equality into the social care sector including adequate rewards and security for the workforce was inevitably going to lead to crisis during a pandemic, thus robust infection control measures in his view in care homes were necessary.

Professors Shakespeare and Watson provided a similar report in relation to people with disabilities. In particular it was known that people with intellectual disabilities were more susceptible to severe outcomes from viral infections and other respiratory infections more broadly. In particular, Scottish research from 2018 had shown that people with intellectual disabilities have as many health conditions at age 20 and over as the rest of the population aged 50 and over and live 20 years less than their non-disabled peers.

The evidence suggests that there was a lack of account being taken by the Scottish Government of the needs of and effects of the pandemic on particular groups regarding the particular and disproportionate effects of the virus on them, the particular and disproportionate effects of the NPIs on certain groups, and the support or care which would normally have been provided to that group which could not be due to the pandemic, such as medical care, Social Services or social work

We will examine the powers that the Scottish Ministers had and their apparent decision not to make its own decisions and introduce suppression strategies before the national lockdown on 23 March 2020. In light of the emerging threat, why did the Scottish Government, the Scottish Ministers not take or seek to persuade the UK Government of the need to take swifter decisive action, including ramping up testing capacity, other surveillance systems and supplies of protective equipment?

On 25 March, the First Minister confirmed that the Scottish Government would establish its own Covid-19 Advisory Group to supplement the advice which it already received from SAGE. We will examine the role of this group in the overall divergence of the Scottish Government policy from the priorities and strategy of the UK Government, the reasons for that, and the reasonableness of such divergence in the context of a global viral pandemic.

On 10 May the UK Government updated its coronavirus message from "stay at home, protect the NHS, save lives" to "stay alert, control the virus, save lives." The leaders of the devolved governments in Scotland, Wales and Northern Ireland said they would keep to the original message. The UK signalling a move towards easing the lockdown and the Devolved Administrations sticking with the existing restrictions, in effect taking the view that the fight against the first harm, the harm caused by the virus itself, remained the priority.

The report from the University of Edinburgh said that 50% of the Covid-related deaths in Scotland between March and June 2020 involved care home residents.

Ms Claire Mitchell KC on behalf of Scottish Covid Bereaved

The vulnerable became more vulnerable, the poor, poorer, the sick, sicker. Life expectancy declined. The NHS was chronically underfunded. Preparations for Brexit replaced any work on pandemic planning, leaving the UK virtually defenceless.

Then PM BJ prevaricated, flip-flopped in the deadly days of delay during which action ought to have been taken as the disease quickly multiplied and overtook the UK.

Media reports have suggested that senior figures in the pandemic decision-making such as Nicola Sturgeon and Jason Leitch have failed to retain messages. If these reports are correct, the Scottish Covid Bereaved hope that whatever evidence may be gleaned from surviving WhatsApps, nothing of significance has been lost as a result of this apparently wilful deletion of messages.

Mr Daniel Friedman KC on behalf of Disability Rights UK and Inclusion Scotland

It is not enough to recognise the value of disabled people's lives. There must be redistribution of political resources in terms of the influence that disabled people can have upon the policies that affect them, and redistribution of economic resources, in the sense that if a society is serious about valuing the dignity and diversity of human life, disabled people will need more economic resources, not less.

the number of disabled people in Scotland may be as high as 35% of the population, compared to UK overall figures that range from 20% to 22%.

What planning was there for disabled people in Scotland going into the pandemic and thereafter? Going in, there was essentially nothing, and in that respect Scotland had violated an agreement under Article 11 of the UNCRPD (United Nations Convention on the Rights of Persons with Disabilities) to plan to protect disabled people in disasters just as the UK had done.

On core issues of clinical vulnerability, Scotland followed England such that the timing of placing those with Down's Syndrome on the CEV list being delayed despite the fact that they were three times more likely to die of Covid in Scotland and two times more likely to be hospitalised.

The pandemic has tested the validity of devolution both ways. It shows that Scotland does not have a fully determining government. However, as regards matters within its powers, Scottish Government does not always discharge the responsibilities that it wants to be judged by. Blaming UK Government for all shortcoming abdicates the power that Scottish Government enjoys.

Sam Jacobs on behalf of the Trades Union Congress and the Scottish Trades Union Congress

The evidence suggests that unlike the UK Govt, the Scottish Govt was willing to listen to the Scottish TUC about issues such as face coverings and financial support. However, there were many examples of the STUC being given little to no time to respond adequately to complex documents or to ensure that representatives with the right level of expertise about a sector were present for meaningful dialogue. There were also many occasions where the STUC raised serious concerns with Scottish Government ministers about decisions that, in the STUC's view, had lacked appropriate consultation.

Rory Phillips KC on behalf of the National Police Chiefs' Council

Police Scotland established a formal response to the pandemic at a very early stage, with the setting up of Operation Talla in January 2020. Compliance is the aim rather than enforcement. 88% of all encounters were resolved without the need to progress to enforcement.

Una Doherty KC on behalf of NHS National Services Scotland (NHS NSS)

The NHS in Scotland is and has always been separate from the NHS elsewhere in the UK. NHS NSS, it is a non-departmental public body accountable to the Scottish Government. Given that health is a devolved matter, the Scottish Government rather than the UK Government was responsible for core decision-making on the response to the pandemic in the health sector in Scotland.

Simon Bowie KC on behalf of Public Health Scotland

PHS is Scotland's national public health body. It's a young organisation, having only become operational on 1 April 2020, near to the start of the pandemic. The organisation is not involved in many of the practical aspects of maintaining public health at a community or local le

PHS's opening budget and staffing levels were not sufficient for PHS to delivery the health protection response required by the pandemic. Additional funding was helpfully provided by Scottish Government, but for a period there was a shortage of personnel within PHS trained and experienced in pandemic response.

The sharing of data across organisations was not straightforward because of variants in systems used. Routine sharing of data with and by trusted NHS authorities under updated information governance arrangements are essential. Progress was made during the pandemic, but there is a risk that it may slip back. The sharing of data between the four nations of the UK to support the management of incidence was challenging and continues to be.

During the pandemic PHS and Scottish Government agreed a process for issuing guidance which was known as the Policy Alignment Check Process or PAC for short. Although well intentioned, it's fair to say that there were challenges associated with it. The process was slow, resulting in delays such that the guidance was not always produced timeously. In consequence there was an impact on PHS's independent voice for public health.

Geoffrey Mitchell KC on behalf of the Scottish Ministers.

The Scottish Government acknowledges that certain decisions could have been taken differently. Whether alternative options were available and would have made a material difference are separate questions. With the benefit of hindsight, possessed with current knowledge as to the nature and effects of the virus the Scottish Government would have wanted to impose a lockdown earlier.

Day 2 - Wednesday 17th January

Jane Morrison obo Scottish Covid Bereaved

Lost wife Jacky Morrison-Hart who was in hospital where she caught Covid and died in Oct 2020. Because of liver failure she was told she was not a candidate for ITU as it would only delay the inevitable.

9% of our members experienced bereavement in care homes in Scotland.

25% of our members have lost someone to nosocomial infection

We all saw what was happening in Italy and I don't understand why we did not capitalise on the advance warning and provide IPC and PPE training and support in care homes. we even sent PPE to China in the early days. It was like we thought it would not happen to us.

I question whether Scotland should have taken an earlier autonomous approach rather than delaying as UK did as health was devolved.

Symptoms are poorly understood and are not well publicised outside of the usual 3. We wrote to UKHSA to ask if it could be extended and they declined to do that. We've got an awful lot of people who have been bereaved by Covid and those symptoms were not the primary symptoms, particularly in the early days when it only included fever and persistent cough, before they added loss of taste or smell. Particularly with older patients who didn't present with those symptoms. So it was a big concern.

Rozanne Foyer STUC

The engagement with the Scottish Govt was constructive. Easing lockdown over Summer 2020 and return to work was one area where we were not consulted. We did have issues with late engagement. There should be nothing about us without us. We felt we were able to influence a more cautious approach by the Scottish Government to opening up.

We were still very concerned about was the ability of workers to isolate and we felt that there was a real gap in provision across the economy, because the UK Government's statutory sick pay was not adequate to allow workers in low paid jobs to isolate.

The Scottish Govt definitely did listen, but they didn't always act. There were grave consequences for our members. There is definitely a link between the deaths and the sort of work they were carrying out. Certain occupations placed people in more danger. We had seen people in frontline services on very low pay really in the eye of the storm, and not receiving proper PPE, safety measures not being in place at the beginning. So we were very cautious and very aware of the fear of our members about getting up and going to work every day. We had real concerns that there weren't appropriate safety measures in place, and that workers could come under pressure to cut corners from unscrupulous employers. So there was a real caution there on our part. Our approach was very much safety first, that no worker should have their life put at risk in order to keep the economy going. Workers are not expendable.

If a person is notified by track and trace they need to isolate but they don't have the ability to follow that guidance because it would cause them severe financial hardship, then we have a situation where the UK Government's policy was undermining the Scottish Government's devolved policy and responsibilities. We know Scottish Government wrote to UK Government, they agreed with us that something should be done to improve statutory sick pay, but we didn't get any shift on that, unfortunately.

In the care sector you had workers on very low pay who were crucially in touch with some of the most vulnerable people when it came to the virus and providing personal care to them. These workers in many cases did not have access to appropriate levels of sick pay. The Scottish Government did very early on create a fund from their own budget, a social care fund that allowed social care workers, to access sick pay to cover their pay in order to allow them to isolate. So that was one example of where I feel they did act.

The public health data shows that, there is a clear link between worker occupation groupings and the likelihood to contract and indeed have fatal consequences with this virus, that we need to start looking at Covid as being an industrial injury in the same way as people who have asbestos related injuries.

The key workers put themselves and their families at risk to provide essential services at a time of real crisis. Many of those workers were on poverty pay rates, the majority were women, and disproportionately they came from black and ethnic minority backgrounds, and the sad reality is that too many of those workers lost their lives protecting us. But I don't think we protected them enough. Years of brutal austerity has fundamentally altered our public services with lethal consequences. Workers across our economy, especially in health and social care, were really dangerously exposed to the virus through a deadly combination of understaffing, PPE shortages, and poor pandemic planning from central government.

Dr Jim Elder-Woodward – Covid Convenor of Inclusion Scotland

Inclusion Scotland is a registered charity, it's a disabled people's organisation, and it is led therefore by people who are disabled themselves.

Going into the pandemic, disabled people did not enjoy the human rights set out in the UN Convention on the Rights of Persons with Disabilities. Instead, disabled people already experienced unequal outcome and lacked the support and resilience to deal with such an emergency. It was clear that this was compounded by the negative impacts of Covid-19 and core decisions taken by Scottish Government.

Our members say they felt abandoned, a number reported feeling suicidal, they talked of isolation and loneliness, the impact of the loss of essential social care supported by independent living, difficulties accessing foods and necessities, fears about being denied treatment, and the involuntary imposition of Do Not Attempt Resuscitation.

Roger Halliday: Former Chief Statistician and Joint Head of Covid Modelling and Analysis Team for the Scottish Government) and Scott Heald (Director for Data & Digital Innovation at Public Health Scotland)

information on disability relating to mortality was not available to begin with. In general it's because the data on disability wasn't recorded as part of the standard information on some of these death certificates so we had to bring that information in from the 2011 population census.

The Delta Variant the levels of infection are slightly higher in Scotland even though the levels of vaccination are broadly the same. It's difficult to quite understand this, I guess one factor in this may be something to do with the underlying health conditions of people in Scotland relative to other parts of the United Kingdom

Doctor Audrey MacDougall (Chief Social Researcher and Former Joint Head of Covid Modelling and Analysis Team for the Scottish Government)

We were not asked to model discharge into care homes. We were asked to look at what would be the impact on R and then the subsequent case numbers of the closure of schools. Care home modelling was done through SPI-M. It was not specific to Scottish people. There will have been analysis done of care homes, because modelling is a very particular tool, when actual data starts to become available you are getting some better estimation of what's happening rather than trying to model forward.

Day 3 – Thursday 18th January

Professor Paul Cairney (Expert)

Professor of politics and public policy. Specialise in research on UK and Scottish Government policy processes, including their public health policies and impact on inequalities.

The Four Harms was not a decision-making tool. It is mostly a statement of the problem, it's not a statement of the solution. It essentially says there are four main harms that we need to take into account, and there will always be trade-offs between trying to reduce one harm in relation to the other. The classic was a lockdown would reduce Covid-19 harm, but it would also have a knock-on effect for the other three harms. There would be less access to the NHS, there would be more social isolation, there would be a problem of economic activity. So it was essentially a way to describe the four key harms that they wanted to pay attention to at any one time. It helped define the problem but didn't propose a solution.

In Scotland everything is compared with the UK Government. The Scottish system may be less top down than Westminster but to say that something is better does not make it good, and to say that it's less top-down does not make it not top-down. I think that the reference point is useful, but it can also distract us from what governments actually do.

Both the First Minister and Deputy First Minister talk about learning from the previous experience in the sense that it would inform their future decisions. But what I can't then do is reconcile that with the fact that they appear to have made exactly the same mistakes twice. The first one was understandable because the virus was novel. Lockdown in March was something that was profoundly different from what anyone had been used to. By the time of the second lockdown they clearly had data on how much people would adhere to the guidelines and suchlike. They state time and time again that we have learned a lot about what this virus is, and yet they appear to have produced the same delays in the second lockdown as the first.

That does not exhibit pandemic preparedness in relation to continuously learning. What I would like clarity on from the Scottish Government is, do they think that the virus was so different that they could not prepare for it and therefore it's very difficult to prepare ever for a novel virus? Or is there some other explanation for the fact that they learned so much and yet acted, so late?

The Scottish Government documents talk much more about learning than they demonstrate learning feeding into action. There's a rhetoric of learning that does not match reality.

I use the word "blurry" to describe the boundary between UK and Scottish Government responsibilities. When disaster comes along like the pandemic, which affects all areas of society and life, and therefore all policy areas, this blurriness starts to become a bit of a problem. The existence of these blurry lines may also make it easier for decision-makers in the Scottish Government to attribute blame for bad policy outcomes to the UK Government and vice versa, thereby potentially creating an accountability deficit in Scotland.

The Scottish Government could have initiated legislation in the Scottish Parliament to impose a lockdown before Westminster because this was clearly a public health responsibility, so there were no issues of it being challenged, but it made a decision not to legislate in the Scottish Parliament in favour of a four nations approach built on legislation in Westminster. The feedback from the Scottish Government is that they thought this was the quickest way to do it.

Finances

The history of Scottish Government finance has been that the Treasury provides the budget, the Scottish Government decides how to spend it. The Scottish Govt did not have the means to borrow to finance

the lockdown itself. The SG needed the UK Government to allocate additional funds, that the Scottish Government did not have the means to provide those funds themselves, because almost all of this additional funding came from borrowing and the Scottish Government does not have those powers. It needed the certainty of how much it would receive so that it could allocate that funding quickly.

Relations between the two governments at the time the pandemic struck were particularly poor. The devolved governments can't successfully demand meetings with the UK Govt so they're sort of subordinate partners. So their relationship was already bad. The SNP has been highly dissatisfied with the UK Government. The UK Government has portrayed the SNP government as not to be trusted. So there was a lack of trust between ministers. It was exacerbated by key personalities, and exacerbated by Brexit, which was famously rejected by most people in Scotland. Up to the point of Brexit it's hard to imagine a worse relationship between the UK Government and devolved government.

Doctor Donald Macaskill (Chief Executive of Scottish Care)

Scottish Care is a membership organisation representing the independent care sector in Scotland. We represent charitable, not for profit, employee owned and private providers of older people's care in care homes and in the community in care at home and housing support.

We know that a large number of patients were transferred from hospital to care homes without being tested for the virus in the early stages of the pandemic, and it was not until 21 April 2020, when it became mandatory for hospital patients to have two negative Covid-19 tests before being discharged, and for all new care home admissions to be isolated for a period of 14 days.

Data shows that between 1 March and 21 April 2020, 82% of the 3,595 patients discharged from hospital to care homes were not tested and 752 care homes took in untested patients between 1 March and 21 April 2020.

Initially the guidance was that care providers should not admit new residents unless they were assured about the robustness of the clinical assessment. We challenged that and said it should include the testing of those being admitted. We were told this was not possible and that a robust clinical assessment should be sufficient to enable somebody to be admitted. We were cautious about being the sector which stopped that flow of patients from the NHS to stop the NHS from collapsing but we were aware that the population most at risk was the population over 80 and that tended to be a population that lived in Scotland's care homes.

Guidance was issued on 13 March. We were only consulted on the draft guidance on 12 march and only given a matter of hours to comment. The Guidance said “social distancing, essential visits only, accept admissions to the care home if safe. Close the home if resident tests positive”.

Only someone with no experience of care home would include social distancing in guidance. It became hugely problematic for care homes to keep social distancing, particularly in the lives of people with dementia, and it became really traumatic for residents in particular, who were used to social interaction. It became a massive challenge for most operators and providers to adhere to guidance which was not fit for purpose.

Staff working in care homes were likely to pose the greatest risks to those being supported in care settings. Because the majority of residents in the care home weren't going anywhere. They were a static population. The population which was moving was staff coming from their own homes, living in communities. That's one of the reasons why we said it is really important that we start to test staff in a preventative manner, and unfortunately in many instances what happened was that we started to use tests after an outbreak occurred.

There was a virtual overnight withdrawal of support for individuals in their own home. Services which did continue meant that on a typical day, staff were visiting 12, up to 20 individuals. So that was different households engaging in different levels of care and support. This workforce was the forgotten frontline because all the focus had been placed on care homes, both in terms of testing and other intervention including PPE.

There was a sense of despair and there was a degree of resignation, "Well, of course they're going to prioritise the NHS", but there was also a growing sense of anger, that: why should we be putting ourselves at risk without the level of protection which we as experienced professional clinical staff in care homes and in communities need even if we're not employed by the NHS?

Life is not just the ability to draw breath in and out, it's also the relationships, the purpose that you have in continuing to live. We were hearing from frontline staff as early as April in 2020 that people were turning their face to the wall, that they were losing a desire to continue, they were losing a sense of purpose, because they didn't have contact with their family or their wider community.

The burden of that upon staff who were depleted in number, who were having to manage Covid risk, who were having to manage under a guidance system and an infection prevention and control methodology which was not fit for a social care environment, was massive. When most of them would have wanted to spend time with individuals, some of whom they had known for years, they could see the deterioration right in front of their eyes.

Infection control measures that might be appropriate in an acute setting just aren't going to work in a care home. When you're talking about an environment with free flow of individuals, with individuals who might remember for a minute what you've said to them but then will forget why they shouldn't touch that or why they shouldn't go into that room.

The care home sector was literally hung out to dry on failing to achieve these standards. Residents living with dementia had articles of significance in their room, articles of memory, items which are important to them, items which were often described as "clutter which risk infection and should be removed". Care staff were told by IPC specialists "get rid of that stuff" and yet these objects were intrinsic markers of identity for that person, they were things that rooted them to their self, to their family and their story, and yet they became for IPC specialist objects which were a risk of infection.

I think we failed to balance the rights, the individuality of individual care home residents in guidance which was developed by people who had no contextual understanding and to be blunt, showed no interest in gaining that understanding from people like me and other practitioners. That guidance treated people as a group, as a blanket entity, instead of as individuals with rights and autonomy.

The guidance also caused care homes to believe that there was a form of blanket ban on transferring residents who tested positive for Covid-19 into hospital. They arrived at that belief because it was their

experience, in numerous instances. The presumption that that should be the result and the end decision and clinical assessment for all is simply wrong. The framework which was developed by the CMO at the time had used age as a proxy for decision-making, should we get to a situation where there were limits on resources available for clinical intervention. It wasn't Covid that was preventing somebody being transferred, it was other conditions. I have absolutely no doubt that individuals whose lives could have been saved were not saved because of the nature of that uncertainty caused by this guidance.

The restrictions on visiting was an invidious position for staff but much more traumatically it was a devastating experience for residents, their families and undoubtedly caused a harm which whilst it may not have been brought about by the virus, was certainly brought about by the protective measures. We continually said they needed to adopt a human rights approach and we were never listened to. If there had been sufficient trust and regard to the professionalism of frontline care staff and clinical staff in the care sector, if that had been heard and listened to at all periods of the pandemic, then I'm quite convinced that we would have withdrawn visiting restrictions much earlier. We took too long and as a result we limited the lives of people.

Nicola Dickie (Director of People Policy of COSLA)

National associations of Councils – all 32 local authorities are members.

I think colleagues in government always listened, I think they tried their best to understand what we were saying, I think it becomes more difficult to understand how that was factored into the decision-making process because those decision-making processes were for Scottish Government and therefore, we were not necessarily party to how that evidence was then weighed up.

The 4 harms were discussed but we didn't know how they were weighted.

We had many ministers and civil servants who had never worked with COSLA or local government closely, and a failure to understand our democratic mandate.

I did not form the view that only lip service was being paid to us in decision making.

We were regularly feeding back that our members were being told about decisions at the same time as the public, but things were moving quickly.

Day 4 – Friday 19th January 2024

Lesley Fraser (Director-General Corporate of Scottish Government)

Responsible for all aspects of record keeping.
Ministers are directly accountable to the Scottish Parliament, so it was critical throughout the pandemic that we had a record of who, what, why, when, how. We were regularly sharing that with Parliament, and Parliament was therefore able to hold ministers to account in live time. It's a legal responsibility on the government to maintain a proper record, and to be able to account for decisions and how those were reached, and to be able to demonstrate that through the public record. There are policies and

guidance for civil servants so they understand records management. We also have guidance on ensuring there are full records for inquiries like this. I am responsible for those policies.

I am sorry if it has appeared to the Inquiry that it has been difficult to get disclosure from us. That has not been our intention. We've endeavoured throughout to give the Inquiry as well and as quickly as we can precisely the documents that you've been looking for. Our understanding of the focus of the Inquiry had developed over time as your requests have become more specific. The documents provided earlier this week is because of a different set of searches that we had undertaken in relation to a freedom of information request. My understanding is that we had provided the record management policy in good time to the Inquiry. I would have expected that it would have been provided last year alongside my statement.

The Records Management Policy says that employees of the government have to retain evidence of transactions or decisions carried out on or on behalf of the government. Things done on behalf of government may include making decisions, taking action, and the forming of a rationale behind those decisions. It also states that messages should be deleted as soon as they are no longer needed.

Messages are not the official record so they need to be written into the record. The policy doesn't state explicitly that it needs to be written into the written record before messages are deleted but it is implied. I do think it is clear to experienced civil servants. Ministers are not subjects to our records policy. Ministers don't have access to our electronic records management system directly, they could not write information on to the record. Civil servants have the responsibility for record keeping not the Minister. The rules do not apply to Ministers but provide good guidance and advice for how messages for example will be treated.

Nicola Sturgeon’s statement says that her messages were not retained, they were deleted in routine tidying up of inboxes or changes of phones. She is unable to retrieve the messages.

Ms Sturgeon would have worked with her private office in order to ensure that her views and instructions were clearly understood. My experience is that we've been able to find the relevant information and to demonstrate how those decisions were made and to evidence that through emails and other exchanges on our corporate records system.

I would expect material that related to an FOI to be retained.

I would not accept that the Scottish Government's document retention policies were not fit for purpose. I think that's evidenced by the sheer number of documents that we've been able to provide and the end-to-end story that that sets out. I would accept that there is some learning. I also understanding the frustration that we have not been able to retrieve all the WhatsApp messages.

Ken Thomson CB (former Director-General for Strategy & External Affairs in the Scottish Government)

I supported the First Minister, Deputy First Minister and Cabinet including on cross-government work.

The mobile messaging policy, the instruction to us was to transfer salient points to the official record and then to delete the messages.

WhatsApp Covid Outbreak Group
Ken Thompson: J*ust to remind you (seriously) this is discoverable under FOI. Plausible deniability are my middle names, now clear it again.*
I was not encouraging people to delete messages in order to defeat FOI requests. These messages contained personal disclosure. This channel is discoverable under FOI which I believe to be correct. That doesn't mean these messages that are not important needs to be kept under the Records Management Policy. What I'm saying is unless material is salient and relevant to the public record, in which case it should be transferred, and then all of the material should be deleted.

At the start NS was optimistic that the relationship with BJ would become productive but it did not. The meeting of 7 May Was the first point at which I was concerned that the relationship was going to diverge in terms of their ability to work together. The First Minister was concerned about some media reports which had suggested that the UK Government was going to drop its stay-at-home message, and that she was keen to try to impress upon others at the meeting, in particular the former Prime Minister, that she would not be prepared to drop that message for Scotland. NS view was that a change in the message would be catastrophic. The PM response was he understood stay at home remained an important part of the message, but the message was actually 'stay at home unless you need to go to work', and he thought that too many people were interpreting that as just stay at home. BJ said in that conversation he wasn't going to release anything publicly but the same day it was in the papers about freedom beckoning. Their relationship wasn't built up during peacetime. I do think that affected how, whether the decisions were the best they could have been.

Doctor Jim McMenamin (Head of Infections Service, Strategic Incident Director at Public Health Scotland) and **Doctor Nick Phin (Current Director of Public Health Science for Public Health Scotland, previously Deputy Director at Public Health England's National Infections Service)**

PHS received policy decisions from the Scottish Government and assisted by providing advice on the medical side of those.

There were issues with the formation of PHS and delaying it would have been helpful but everything was addressed but the speed at which that could happen was interrupted by the pandemic. The timing of the creation of the organisation was unfortunate but important we went ahead with it.

PHS had minimal opportunities to provide ministers with a first-hand account of the thoughts of senior staff in PHS or to make them aware of the practical implications of policy decisions.

Some of the things that we love to do was constrained simply by the fact that there wasn't the resource, there wasn't the infrastructure, and indeed as the pandemic evolved in those early months into 2020, supply chains were stretched, we ended up not having enough sample kits because everyone was trying to get their hands on them. So there were multiple factors here that delayed the introduction of testing, which I think we all accept now was an important part of our control response.

Care Home Guidance

As increasing appreciation about what steps would need to be in place, particularly across the month of March, very rapidly we were trying to come to a conclusion about what initial guidance might be provided.

Often we are giving completely unacceptable timelines to colleagues to rapidly contribute to information, recognising that you'll do the best that you can for the maximum good within the time available to you. But also knowing that you may have an opportunity to come to it later and identify any further wording changes or incorporate any of the new information that had come available.

The testing challenge was the number of tests that were available per day. Talking about the most good that you could make of those tests was something which was incredibly clinically challenging.

The Guidance on 13 March did not mention testing before being moved to a care home.

My understanding was about availability of the tests that would be able to support such an approach, not just about discharge from hospital or admission from home to a care setting, but also what would we need to be able to test, not just those individuals who were in that care setting but potentially the staff who would be involved too? There was significant pressure on test availability. There had to be a triage and concentration on where we thought the maximum benefit would be derived from the tests.

A consensus statement issued on 26 May 2022. This was commissioned by the Department of Health in England. It acknowledges that at least some care home outbreaks were caused, partly caused or intensified by discharge from hospital to care home. However, the conclusion was that hospital discharge was not a prominent feature of transmission in the healthcare setting. Instead, that care home staff and visiting professionals were probably the cause of many of the introductions and promulgation of infection within the care homes.