

Witness Name: Dame Sally Claire  
Davies  
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UK COVID-19 INQUIRY  
MODULE 1

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**FIRST WITNESS STATEMENT OF  
PROFESSOR DAME SALLY CLAIRE DAVIES**

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I, PROFESSOR DAME SALLY CLAIRE DAVIES, will say as follows:

## **Section 1: Background**

- 1.1. I am the former Chief Medical Officer (“CMO”) for England, having held the post from 1 June 2010 to 1 October 2019. I was initially appointed CMO on a twelve month interim basis, before my substantive appointment to the role in 2011. I was also Chief Scientific Adviser (“CSA”) to the Department of Health (hereafter “DH” or “DHSC” as appropriate, the department having been renamed in January 2018) and DH Director General for Research. I held both these roles from 2004 to 2016. As Director General for Research, I established the National Institute for Health Research (“NIHR”, now the National Institute for Health and Care Research) in 2006.
- 1.2. My qualifications include a Bachelor of Medicine, Bachelor of Surgery degree (MBChB) from the University of Manchester and an MSc in Immunology from the University of London. I am a fellow of several medical Royal Colleges or other health faculties,

including the Royal College of Physicians, the Royal College of Pathologists, the Royal College of Child and Paediatric Health, the Faculty of Public Health and the Faculty of Pharmaceutical Medicine. In addition, I am a fellow of the Royal Society, a fellow of the Academy of Medical Sciences and an international member of the National Academy of Medicine in the USA. I hold numerous other honorary fellowships from institutions around the world. I was awarded the Cameron Prize of the University of Edinburgh, the Jephcott Medal from the Royal Society of Medicine, and the inaugural World Health Organization (“WHO”) Nelson Mandela Prize for Health Promotion, amongst others. In addition to my positions in government set out above, I served as a member of the WHO Executive Board from 2014 to 2016 and was co-convenor of the United Nations Inter-Agency Co-ordination Group on Antimicrobial Resistance (“AMR”) from 2017 to 2020. On leaving my post as CMO, I took up the position of Master of Trinity College, University of Cambridge, and was appointed to act as the UK’s Special Envoy on AMR. In addition, I am currently a member of the UN’s Global Leaders Group on AMR.

- 1.3. I make this statement in response to a Rule 9 request received from the UK COVID-19 Inquiry (“the Inquiry”) on 8 February 2023. As a former CMO, I do not have access to all of my papers from when I was CMO but I have been assisted in obtaining certain documents by the Office of the CMO (“OCMO”). I am happy to provide the Inquiry with any additional evidence in respect of specific documents that are drawn to my attention should it be of assistance.
- 1.4. I have been assisted in the preparation of this statement by the legal team instructed on behalf of the OCMO. Except where I indicate to the contrary, the facts and matters contained in this witness statement are within my own knowledge. Where any information is not within my personal knowledge, I have identified the source of my information or the basis for my belief. The facts in this statement are true to the best of my knowledge and belief.

## **Section 2: Scientific Advisory Committees**

- 2.1. I have been asked by the Inquiry to set out my involvement in governmental scientific advisory committees and groups in the time period that is covered by Module 1 of the Inquiry.
- 2.2. I consider the most relevant committee in this respect to be the Scientific Advisory Group for Emergencies (“SAGE”). As set out in more detail in the OCMO’s corporate statements and DHSC’s Module 1 evidence, SAGE is an independent government

scientific advisory group, convened to provide scientific advice to support decision-making in the Cabinet Office Briefing Rooms (“COBR”) in the event of a national emergency. The secretariat for SAGE is provided by the Government Office for Science (“GO-Science”), who are therefore better placed to provide a full description of its roles, functions and responsibilities.

- 2.3. Typically, in any given emergency SAGE is convened by the government Chief Scientific Adviser (“GCSA”), who will also act as its chair. SAGE meets in advance of COBR and the GCSA then subsequently represents SAGE at COBR. Where there is a health component to the emergency, the DHSC CSA would normally attend SAGE. In an emergency where health is the (or a) major part of the emergency, the CMO would also be present and may co-chair. In major health emergencies, such as a pandemic, the CMO co-chairs SAGE along with the GCSA. This arrangement is a product of changes made to the structure of government scientific advisory committees following the H1N1 influenza pandemic of 2009-2010 (“swine flu”).
- 2.4. I was a participant in the following SAGE committees:
  - i. from 8 May 2009 to 11 January 2010, as DH CSA, the SAGE committees convened in respect of the the swine flu pandemic;
  - ii. from 16 October 2014 to 8 December 2014, as CMO, the SAGE committees convened in respect of the 2014 Ebola epidemic in West Africa;
  - iii. on 16 May 2019, as CMO, the pre-SAGE convened in respect of the Ebola outbreak in the Democratic Republic of Congo; and
  - iv. in 2018, as CMO, the SAGE committees convened in respect of the Novichok nerve agent poisonings in Salisbury and Amesbury.
- 2.5. The CMO’s role at SAGE is to provide technical insight and guidance. For instance, a particularly important aspect of the role was to bring the expertise of a clinician about the different perspectives of diverse sections of the community to discussions where scientific advice was formulated, as well as insight as to the practical implications of that advice and any policies on the health service and public health systems. It was necessary for me to elicit all the information I could from members and, where necessary, challenge their views. If needed, I would seek further information, and commission relevant research or further analysis so as to best advise ministers.
- 2.6. Information was provided to SAGE by members of the committee but could also be obtained from other expert committees or relevant experts in appropriate fields. Examples of these include the Advisory Committee on Dangerous Pathogens

("ACDP"), the Advisory Committee on the Safety of Blood, Tissues and Organs ("SABTO"), the New and Emerging Respiratory Virus Threats Advisory Group ("NERVTAG") and the Joint Committee on Vaccination and Immunisation ("JCVI"). These committees are comprised of experts in their respective fields, and whilst I was not personally a member and did not attend, they provided specialist advice which informed the wider discussions happening at SAGE. By way of further example, during the Ebola crisis in 2014 we learnt of the importance of the social sciences, particularly anthropology, in understanding outbreaks and how best to control the disease. Following this, a behavioural sub-group for SAGE was established to advise on the cultural and societal aspects of any emergency response.

## **Section 3: Performance of Advisory Committees**

### Structures and Effectiveness

- 3.1. When an emergency hits, it is essential to have structures and processes in place that are both familiar to those involved and effective. The CMO, GCSA and CSAs are all trained in COBR processes. While GO-Science provides the secretariat for SAGE, this all contributes to the resilience of the government's response. In my view, the SAGE system worked well during my tenure and could be activated at speed.
- 3.2. As DH Director General for Research, I insisted that best practice required that specialist questions be referred to the relevant expert advisory committees in government. I maintained this forcefully during the swine flu pandemic, so that the practice was gradually adopted as routine. Accordingly, our processes improved in later emergencies such as the Ebola outbreaks and Novichok poisonings. In my experience, this system of identifying the appropriate expert advisory committee, referring questions to them and accepting their response functioned well.

### Composition and Operation

- 3.3. SAGE was supported by GO-Science, drawing upon civil service resource in host departments and DH. Specific work was, on occasion, commissioned from academia. Each SAGE was set up for a new emergency with a core membership of government department CSAs.
- 3.4. Advice was expected to be evidence-based, with explanations as to the limitations of that evidence base, particularly where there were gaps in the information or evidence available. Where appropriate, advice given by SAGE would take the form of options for ministers to consider at COBR.

- 3.5. All committees, including SAGE, work best when they are broad-based both in expertise and diversity so that questions and answers are as comprehensive as possible. Participants in SAGE and its subgroups, with the exception of civil servants, take part voluntarily without remuneration.
- 3.6. I was consistently impressed by the willingness of academics to respond quickly and engage with SAGE committees in person, something which I understand has improved further since the adoption of video conferencing facilities such as Zoom and MS Teams since COVID-19. The input of such voluntary participants was essential and dependent upon their goodwill.
- 3.7. Membership of SAGE committees is usually subject to recommendation by the GCSA and GO-Science, with the CMO and DH having input when an emergency is health related. During my tenure, generalists were usually provided by government department CSAs and relevant agencies, for example Public Health England. We needed academics and other experts with relevant knowledge who could work at speed, with others, Cabinet-style and with sufficient discretion to maintain confidence until publication of the minutes. Small groups could be commissioned to work quickly and were particularly helpful when the questions were clear and the options grounded in the possible.
- 3.8. When there is a bad outbreak, epidemic or pandemic of influenza, there is a broad body of scientific evidence as well as experience to draw on in the emergency and longer term response. Many other infectious diseases, such as Ebola, are also well understood. However, when there is a new zoonosis, or a disease previously unknown in Britain arrives on our shores, then we have to develop new understanding and experience, sometimes through SAGE. SAGE performed this task well by providing a forum whose flexible membership meant that it could rapidly draw on the appropriate specialists from across academia.

## **Section 4: Responses - Domestic Planning**

- 4.1. I have previously expressed the view that whilst the WHO has said the UK was well prepared for a pandemic, those preparations assumed a pandemic of influenza. This reflected a longstanding bias in our preparations in favour of influenza and diseases that had already occurred, with, we now know, an underestimation of the impact of novel and particularly zoonotic diseases.
- 4.2. I have also expressed the view that the UK underestimated our lack of resilience compared, say, with Germany or Scandinavia, both in respect of our public's health,

e.g. obesity, and the fact that the NHS has been known for more than a decade to 'run hot', i.e. at full capacity, every winter. I have previously remarked that COVID-19 demonstrated a number of problems which were not addressed by our pandemic planning; including poor data linkage and the absence of an industrial and manufacturing base.

- 4.3. I still hold those views. To respond effectively in a health emergency, we need not only background planning and agility at the time, but also resilience in the health of the public, the NHS, public health systems and research. We also need to consider issues of resilience in respect of supply chains and manufacturing.
- 4.4. I have been asked by the Inquiry to comment on how we might build resilience within the public health system. The UK public's health has limited resilience due to high levels of obesity, diabetes, heart disease and so on. It is essential that we take cross-government action to support the public in reducing obesity and improving their general health. We have to address the inequalities in health purposefully. In my view this should include measures to promote healthy lifestyles through taxation, as we already do for alcohol and tobacco.
- 4.5. We also need to improve the resilience of the NHS by running at lower levels of bed occupancy whilst having more clinicians and equipment, and by rebuilding our local Public Health Services. International comparisons, including with OECD countries, show the UK to be relatively poorly provided for in terms of numbers of clinicians (doctors, nurses, physiotherapists, laboratory physicists, radiographers etc.), beds and ventilators. We know that every winter we run the NHS 'hot' with long waits in A&E and cancelled operations showing that we have no spare capacity and poor resilience.
- 4.6. In my view, our public health system has suffered as a result of many years of funding cuts. This was something I raised with ministers during meetings that were convened when the NHS was facing particular difficulties, for example during the winter in 2010. Ultimately, however, issues of funding are a matter of political decision making and prioritisation which properly fall to elected politicians. Nevertheless, it is to my mind not controversial to say that the capacity of our public health and healthcare systems to respond to a pandemic has been and remains constrained by its funding. The UK is however not alone in disinvesting in public health over the last decade; it has also happened steadily in Europe and the USA.

- 4.7. With regard to manufacturing, we do not manufacture a lot of health products including vaccines, PPE, ventilators and many drugs domestically. We have moved in the health system to just-in-time ordering with some national stockpiling, with most products coming from abroad because of the lack of manufacturing in the UK. The result is that in the event of a pandemic, when there is competition for products, other countries can put in place export bans meaning we cannot import to satisfy our needs. We need to encourage an active bioscience industry in this country and to consider what manufacturing is needed in an emergency, including for PPE, other medical countermeasures and vaccines.
- 4.8. As I have also stated above, the capability and capacity for data collection, linkage and analysis is vital to respond effectively to an emergency. This requires not only the necessary hardware and software but also the employment of top data scientists. One solution would be for government to fund joint appointments with top academic departments. In addition to giving the government access to top academics, such an arrangement would promote the government's capabilities by building links between government and academics who are at the forefront of current advances in their field.
- 4.9. Domestic horizon scanning for new threats can be undertaken routinely by experts. The process however relies in particular on reviewing reports to multilateral organisations such as the WHO, European Centre for Disease Prevention and Control ("ECDC"), Africa Centre for Disease Control and Prevention and the Nigerian Centre for Disease Control and Prevention. This activity can benefit from strong interpersonal networks between infectious disease and public health experts across the world. In my view, we need to develop a public health global infectious disease specialty consisting of doctors who have worked both in the multinational organisations and infield in Africa and Asia who can support and advise on the UK response to new disease outbreaks. We have no present scheme for this.

## **Section 5: Industry Preparations**

- 5.1. I have previously expressed the view that the UK's laboratories in the NHS, generally but particularly around genomics, were essentially a cottage industry, and that the UK has broadly speaking not moved to large, more factory-effective scalable laboratories. This remains my view, and the result of that position is that we did not have the laboratory capacity that was required to carry out testing on a sufficient scale.
- 5.2. Some pathology laboratories servicing the NHS are privately run, for example the University College London Hospital Halo laboratory that services much of North

Central London. Most however are run by the NHS for their local hospital trust. Larger laboratories can have shorter management chains, are generally better funded, and can offer state of the art tests as well as ultimately being cheaper per test performed. The NHS has been trying for some years to reform laboratory services, which has worked better in some parts of the country than others.

- 5.3. I understand from conversations with academics that PHE took time to develop large factory laboratories rather than working with university research labs who understood and practiced genomic technology. PHE may of course have considered size more important than speed. The first big lab was built in Milton Keynes based on an NIHR investment, again demonstrating the value of research investment to deliver resilience.
- 5.4. In addition, the UK benefits from an active life-science industry and it is also important that government takes advantage of its strength. For instance, NIHR managed clinical research networks can help deliver trials quickly and efficiently by providing access for industry in the form of government funded infrastructure from NIHR.

## **Section 6: International Responses**

- 6.1. I have previously stated that the UK was poor at learning from others during the COVID-19 pandemic. In addition to preparedness and system resilience, I expressed the view that comparator countries in Asia had more doctors, beds and ITU facilities than the UK.
- 6.2. In particular, I was referring to those countries that had experienced, and learnt from, the SARS outbreak including Singapore, Hong Kong and South Korea. These countries (and Vietnam, Thailand and Taiwan) have learnt the value of non-pharmaceutical interventions in breaking the infection chain in SARS - a coronavirus - including for instance facemasks, PPE, isolating at home and reducing travel, as well as testing and contact tracing. South Korea also learnt from their MERS outbreak in 2015. I know this from direct experience, having later visited South Korea.
- 6.3. A particular feature of both MERS and SARS is that a proportion of cases can be traced back to a relatively small number of index cases (i.e. some cases transmit the virus to many more individuals than others do, so called 'super-spreaders'). The relevance of this is that it underlines the importance of having good contact tracing systems and non-pharmaceutical interventions, such as facemasks. Countries such as South Korea were better equipped to contain outbreaks due to efficient and developed contact tracing systems.



- 6.4. I have also previously observed that other respected international public health institutes that deal with infectious disease outbreaks are professionally led by a clinical scientist and that I thought that the UK needed such leadership. I recall expressing this view to the panel overseeing the Tailored Review of PHE, a DHSC led review which took place in 2016/17. The report into PHE did not recommend such a change when it was published, however, it did recommend more structured monitoring and supervision of the PHE executive, which I believe occurred (SD1/01 – INQ000182707).
- 6.5. Examples of organisations which are led by clinical specialists include the US Centers for Disease Control and Prevention (“US CDC”), the ECDC, the Robert Koch Institute in Germany and the Swedish Institute of Public Health. A clinical scientist has the advantage of a knowledge and understanding of infectious diseases. There is evidence that the public trusts doctors in communication, so that is also a big advantage given the importance of public communications in a pandemic. The only possible disadvantage is that not all professional doctors or scientists are good managers, so such a leader is likely, in the absence of managerial expertise, to need support from a Chief Operating Officer. The UK Health Security Agency has now adopted this position (and Dame Jenny Harries is in fact both a clinical scientist and an excellent manager).

## **Section 7: Lessons Learned**

- 7.1. Following the 2009-2010 ‘swine flu’ pandemic, my predecessor as CMO, Professor Sir Liam Donaldson, commissioned an independent review of the United Kingdom’s response. This review was undertaken by Dame Deirdre Hine (“the Hine Review”) and was published in July 2010. It made a total of 28 recommendations covering: i) the central government response; ii) scientific advice; iii) the role of containment; iv) treatments; v) vaccines; and vi) communications during a pandemic.
- 7.2. The review described the UK’s preparedness as generally impressive. In my view, the Hine Review resulted in improvements in relation to pandemic planning, preparedness and resilience during my tenure. These are covered in greater depth in the corporate witness statements provided by the OCMO and DHSC for Module 1, but in summary, the Hine Review shaped the 2011 Influenza Strategy, which further drew on consultations with experts across the country. Aspects of this strategy were then advanced by the Pandemic Influenza Preparedness Programme (“PIPP”), a DH-led programme to develop pandemic preparations.

- 7.3. I have previously expressed the view that whilst the UK had prepared well for a pandemic, there is a difference between preparing well and delivering well. I have also stated in the past that I considered there to be a need for greater challenge to our system and to our accepted assumptions in order to ensure the system as a whole was considering the variety of diseases we might get exposed to in any potential pandemic. These remain my views.
- 7.4. In my view, as a system we need to open ourselves up better to challenge, including from external experts such as the Royal Society or other public health experts from abroad. This may need to be done in private in order to be as robust a challenge as possible. We know that for instance the WHO often produce reports that satisfy politically but do not provide the necessary challenge to the status quo.
- 7.5. I have previously stated that such challenge can come from many places. The Royal Society has in the past set up groups to bring challenge in to our systems. By way of illustration of the need for challenge, at the start of the COVID-19 pandemic our modelling was 13 years old. Public health and epidemiology have, in general, been either influenza focused or not particularly digital and forward looking. In contrast, mathematicians perform modelling in different ways and bring an artificial intelligence capacity which often the public health establishment lacks. During the COVID-19 pandemic, some Cambridge mathematicians asked me how they could assist. I suggested they came together under the sponsorship of the Royal Society. They approached the GCSA with different methodologies for modelling and thinking about the problem, thus giving our response greater depth.
- 7.6. I have previously stated that whilst it is desirable for biomedical experts to confine their advice to biomedical matters, ministers also need advice from economists and anthropologists and people from other points of view who can help balance the issues.
- 7.7. Again, I can confirm to the Inquiry that I still hold those views. I would further add that I now think ministers need a balance to the biomedical input from SAGE and to look at the health emergency/pandemic from the perspective of the economy and well-being of society. This could for instance include contributions from the CSA at the Department for Education or the Chief Economist at the Treasury. There needs to be an institutional framework to ensure that there are a full range of opinions from each discipline. Other factors the government needs to consider to a greater extent include behavioural science input, high quality digital maths and data input and social geography expertise looking at the impact on inequalities. Government also needs to take account of the latest on diagnostics and bioscience and health manufacturing.

- 7.8. In addition to the experts outlined in the paragraph above, all systems, including the NHS and public health infrastructure need engineers to design the contact tracing, moving of patients etc. This involves, at a minimum, experts in logistics, good design and queuing theory. In my view, as a country we do not currently value and involve engineers sufficiently in the public sector

#### Successes of Preparation

- 7.9. The Inquiry has asked me to reflect on what was done correctly in relation to pandemic planning, preparedness and resilience during my tenure.
- 7.10. We need to continue practices and exercises on a regular basis including both tabletop and larger scale like Exercise Cygnus. Cygnus was a DH commissioned cross-government simulation exercise which aimed to assess the UK's preparedness for, and response to, an influenza pandemic close to the UK's worst case planning scenarios. It was based around four simulated COBR meetings which were run by the CCS and which I attended as CMO. In advance of those meetings, the then Secretary of State for Health and I were briefed by DH and then simulated pre-COBR meetings in which I advised the Secretary of State prior to meeting with other ministers. DH also convened four nation CMO meetings at which the CMOs could discuss and coordinate their response.
- 7.11. I considered Cygnus to be particularly valuable because it led to: the drafting of the Pandemic Influenza (Emergency) Bill (discussed below); the development of measures to address a possible surge in demand on the health service; discussions with community and religious leaders around the ethics of a pandemic response; and it provided an opportunity to test all the different components of the health and governance system from the very top to the grass roots.
- 7.12. Nevertheless, whilst exercises such as these were effective, and in my experience gave rise to no concerns about the sustainability of an emergency response over a few months, it is now apparent to me that government preparedness exercises could have done more to prepare for long-term emergencies that went on for more than a few months. This is important given the need for government to balance the biomedical model with economic factors and societal well-being in the context of a longer term crisis such as COVID-19. In respect of COVID-19, there were plans in place to respond to an initial outbreak. From there, scaling up the response was obviously challenging but doable. What had not been fully considered was how to sustain the response once scaled-up and mitigate the impacts for those working on the front line.

- 7.13. Another success of our preparation was that following swine flu, I ensured that NIHR put in place sleeping contracts for influenza research that would be needed in a pandemic. I also worked on developing a public health emergency ethics system, whereby an ethics committee opinion could be provided within 48 hours - in order that essential research was not delayed. As a result of a cross-government exercise, we developed a draft emergency bill with all the clauses and provisions we thought might be necessary in the event of a pandemic. This was ultimately adapted at the start of the COVID-19 pandemic and formed the basis of the Coronavirus Act 2020. The draft bill was developed at my request and led by the CCS as part of our response to the lessons learned during Exercise Cygnus.
- 7.14. One consequence of COVID-19 being a wholly novel pathogen was that other aspects of our pandemic preparations for influenza could not ultimately be relied upon. For instance, advance purchase agreements for pandemic specific vaccines and pre-pandemic vaccine contracts could not be activated as COVID-19 required the development of new vaccines in response to a novel pathogen. The National Pandemic Flu Service, which played a useful role in response to the swine flu pandemic, was not activated as there were no useful community treatments to be distributed for COVID-19. I believe some functions of this service were however replicated by advice provided by NHS 111 during COVID-19. As these topics are covered in greater detail in the OCMO's Module 1 Corporate Statement, I cover them only briefly here.

#### Potential Improvements

- 7.15. I am asked by the Inquiry to reflect on what changes could have been made to the specialist structures, systems and processes of the UK Government to better prepare it for a pandemic.
- 7.16. Firstly, it is important to acknowledge that we were lucky that the COVID-19 death rate was low and that, with the extraordinary efforts of scientists, regulators and manufacturers, we were able to develop effective vaccines quickly. When we consider potential improvements it must be within that context and within the knowledge that we may not be so lucky next time.
- 7.17. Overall, Government budgets have been constrained since 2008 and have not been big enough to provide the assurance and insurance needed to respond to a major pandemic. We also need to think about how to bring together a better laboratory service and bring in both universities and the life sciences industries into Government planning and emergency response.

- 7.18. There has been long-term concern about the capacity of social care in any pandemic and the ability of local authorities to cope with a large number of excess deaths. Just-in-time ordering can be a problem in a pandemic because of either illness in factories or export ban by other countries, because they place their national needs above ours.
- 7.19. In addition, just-in-time ordering raises risk to both production and the delivery of food and fuel, thus increasing the risk of runs on products in shops and panic buying during an emergency. The same problems can be found in the health services' supply chain, for instance with respect to PPE, pharmaceuticals, and other medical equipment.
- 7.20. Despite generally good uptake of the COVID-19 vaccine, there is still a big problem with vaccine hesitancy and misinformation. This needs to be addressed through careful explanation and long-term public communication. A big program should be in place to inform the public about immunisations and their safety during normal (non-emergency) times so that public confidence is built up in advance of the need for an emergency vaccination programme.
- 7.21. We also need to build other campaigns such as 'catch it, bin it, kill it' every winter in order to ensure that the public are aware of the role they can play, including the importance of face masks to protect others from you if infected (even with a cold) or you from others.
- 7.22. I would also comment that in terms of our preparations, whilst the 2011 Influenza Strategy represented a strong plan for the time, in retrospect it should have been subject to challenge every five years. It would have been helpful had we looked at the basic principles afresh e.g. do we let flu pass through the population? The Government should also have reviewed the state of the art of diagnostics and use of data etc, updating practices as required as technology and practice moved on.
- 7.23. Lastly, I believe it is necessary to establish a new expert committee that could act as SAGE's equivalent for social and economic advice. Where SAGE provides scientific advice to the government, this new committee could provide expert advice on the social, economic and educational aspects of responding to an emergency. I believe this would fill a lacuna that was exposed during the COVID-19 pandemic and help ensure that the scientific response is better joined up with the social and economic response.

## Section 8: Conclusion

8.1 I hope that the above is of assistance to the Chair. A draft of this witness statement was provided to the Inquiry on 24 March 2023. Whilst I have not been asked any follow up questions by the Inquiry, I have considered whether there are any further matters that I should address. I am aware that the Inquiry has received Module 1 corporate statements from DHSC and the OCMO. Given that and having not yet considered the evidence of other witnesses, there are no immediate matters that I have felt it necessary to add. I am however happy to continue to assist the Inquiry either before the oral hearings or during my oral evidence (or at any other stage) and address any matters pertinent to Module 1 that the Chair or Counsel to the Inquiry considers would be of benefit.

### Statement of Truth

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

Signed

**Personal Data**

Dated: 4 May 2023