Module 1 of the UK Covid-19 Public Inquiry ("the Inquiry")
Request for Evidence under Rule 9 of the Inquiry Rules 2006
Reference for Request - M1/SAGE/01/TE

STATEMENT

Expertise and Background

1. I am Professor Thomas John Evans, Professor of Molecular Microbiology in the University of Glasgow and an Honorary Consultant Physician in Infectious Diseases and Acute General Medicine for Greater Glasgow and Clyde Health Board. I have a first-class MA degree in Natural Sciences (Biochemistry) from the University of Cambridge, a PhD in the molecular biology of interferon from the University of Cambridge, and a medical degree (MBBChir) from the University of Cambridge. I am a fellow of the Royal College of Physicians (London and Glasgow) and of the European Society for Clinical Microbiology and Infectious Diseases. I trained in medicine in Cambridge and London. My substantive career posts were as Reader in Infectious Diseases at Imperial London (1996-2003), before moving to Glasgow in my current post. I am a clinical academic leading a research group investigating innate immune responses to bacterial infection as well as analysis of genomic sequences of invasive bacteria. I have published widely in these areas, as summarised at this web site: (https://scholar.google.com/citations?user=aueF2PkAAAAJ&hl=en)

2. In my clinical work, I am a Consultant in Infectious Diseases with inpatient responsibility and leading outpatient clinics. I am also a Consultant in acute general medicine, with responsibilities in immediate management of acute admissions of patients with medical problems. I am on the specialist register of the General Medical Council for Communicable (Infectious) Diseases (Registration number 3358524). During the COVID-19 pandemic I have seen and treated hundreds of patients with this infection. I chair the Advisory Committee on Dangerous Pathogens (2016 – current), a scientific advisory group to the Department of Health and Social Care, and co-chair the High Consequence Infectious Diseases (HCID) subgroup of the Scottish Health Prevention Network (SHPN), a part of Public Health Scotland (2018 – current). I also was a member of the precautionary SAGE to advise on Zika from February to August 2016.

Involvement with Advisory Groups

3. I applied to be Chair of ACDP in response to advertisement and was appointed initially as a member following interview according to regulations regarding government scientific advisory groups. In my first meeting in 2015 I was a member and thereafter I was appointed as Chair, following Chris Whitty relinquishing the post as he moved to be Chief Scientific Advisor to the Department of Health. Over the time period covered, I attended all 12 meetings

of the ACDP, 4 of the 5 pre-SAGE Zika meetings, and all of the 4 meetings of the HCID subgroup of the SHPN. My role in all of these meetings was to ensure important matters of concern for the different committees were brought forward for discussion, to provide expert insight into the areas reviewed by these bodies, and to help shape explicit advice to government on these matters.

Advisory Groups Constitution and Ways of Working

4. For all these different groups, I felt the diversity of expertise was very well suited to the terms of reference given. Members included those with expertise in epidemiology and modelling of infectious disease, public health, clinical and laboratory expertise in microbiology and virology, clinical infectious diseases, high consequence infectious diseases, veterinary medicine, and international health. The ACDP has in addition a lay member. Members were all UK nationals. ACDP is a scientific advisory committee to the UK Department of Health and Social Care (DHSC), the Department of the Environment, Food and Rural Affairs (Defra), and the Health and Safety Executive. Matters to be considered by the committee were either directly introduced by these sponsor bodies, or as chair I would bring forward specific items for discussion which I thought were important for the committee to consider. The pre-SAGE Zika group was commissioned to provide advice on the 2016 Zika outbreak by the Department of Health and the Government Office for Science. The HCID subgroup of the SHPN was commissioned by the SHPN to provide advice on management of HCID within Scotland.

5. Membership of ACDP is by application, according to the guidelines set out by government for scientific advisory bodies. It is important to note that members must be independent of government. Members are not remunerated, but can claim necessary travel and subsistence expenses for attending meetings. Membership of the Zika pre-SAGE group was by invitation; again there was no remuneration, but provision of necessary expenses. The HCID subgroup members were invited by the co-chairs as those representing key stakeholders in formulating advice for management of HCIDs; again, there was no remuneration, but provision of necessary expenses.

6. The ACDP and the HCID subgroup continue to be active, and the frequency of meetings is recorded in the submitted documents. ACDP meets in general 3 times a year. The pre-SAGE Zika advisory group met 5 times in 2016 during the Zika outbreak. At times, extraordinary meetings were held to address specific issues, facilitated by the use of telephone or video conferencing. In my opinion, these different groups worked exceptionally well together to fulfil their different remits. Secretarial support was provided for all the groups, to record meetings and to make necessary administrative arrangements. I would highlight, however, that ACDP lacked a permanent secretariat from January 2018 to July 2018, from July 2019 to November 2019, and from January 2021 to October 2021. In my opinion, this seriously impacted on the work of the committee, and in open recording of all committee

business during this time; it accounts for why records of some meetings are not available. In addition, when posts on ACDP became vacant, there were often lengthy delays in the process of recruitment, which was organised by DHSC.

7. The recommendations and advice given by these different groups is recorded in the submitted documents. Minutes were distributed to members and stakeholders. In addition, as chair of ACDP, I sent letters directly to various recipients to highlight the committee's advice or recommendations on a particular issue; these are also captured in the submitted documents.

Pandemic preparedness

8. In considering the work of these different advisory bodies in terms of pandemic planning, it is important to differentiate such planning from that relating to High Consequence Infectious Diseases. ACDP and the HCID subgroup have provided quite extensive advice on management of high consequence infectious diseases over the years. This work is framed around possible introduction of a HCID from an endemic or outbreak area, to ensure systems are in place to allow rapid identification and diagnosis, optimal patient care, prevention of community spread, and safety of healthcare staff. I note that these considerations led to commissioning of a HCID network by NHS England, and ongoing consideration of such a network in Scotland. This is not designed to be a pandemic response; it is predicated on very small number of patients presenting with a HCID at any one time. It has worked well when the UK has had HCID introductions such as viral hemorrhagic fevers, or more recently Mpox. ACDP was never specifically commissioned to provide advice on pandemic infection.

9. I am aware of some of the planning that was specifically made for a future pandemic through exercises such as Cygnus, and in Scotland specifically, Silver Swan. I was not involved in either of these exercises but in view of my expertise I feel I can comment on some aspects of the pandemic planning. The views set out below are my personal opinions and do not necessarily reflect those of DHSC or any other government or advisory body. Firstly, all such planning in the period before COVID-19 was based on pandemic influenza. There was no consideration given to other agents. In the event, SARS-CoV-2 was indeed a respiratory virus that shared some properties with influenza, but also with important differences in e.g. the effects on different age ranges – COVID-19 generally extremely mild in children but for influenza significant cause of morbidity and mortality in the very young; additionally children are an important group in dissemination of influenza but much less so for COVID-19. This focus on influenza led in my opinion to a suboptimal response to COVID-19, even when accumulating evidence highlighted such differences. In addition, I can see no evidence of consideration of diagnostic capacity for a novel pathogen. Asymptomatic infections with COVID-19 are significant (perhaps up to 30% of cases) and have been shown to contribute to transmission (actually also known for influenza as well). Lack of accurate diagnostic testing in

the early stages of the pandemic seriously impacted on the ability to identify all cases of infection and thus to limit its spread.

10. In these planning exercises and associated documents there is consideration of utilising capacity in social care to alleviate the burden on acute NHS facilities. However, there does not seem to be any consideration on health security in care homes and other aspects of social care. This was a major failing, resulting in the spread of COVID-19 through many care homes where the most vulnerable were living, and with the result that there was a high number of excess deaths due to COVID-19 in this setting. In addition, none of the planning considered the likely disproportionate effect of a pandemic on ethnic minorities or more deprived communities; such inequalities in health have been recognised since the 1980 Black report and subsequent similar analyses. The planning exercises did consider acquisition and distribution of personal protective equipment (PPE) in event of an influenza pandemic. However, there is no real evidence of consideration of training requirements in the use of PPE, which is as important as its provision, and vital when many more front-line healthcare staff will be required to manage infected patients. No consideration is given to the inevitable limitation of PPE supply and increase in cost in the event of a pandemic, which was exactly what was seen in COVID-19.

11. The positive aspects of national planning for a pandemic were very much those embedded in our national health and public health services, and robust academic capacity in clinical trial design and implementation. These are of course not specific to a pandemic, but did provide a high level of care for those hospitalised with COVID-19 and in providing healthcare advice and, when they became available, administration of vaccines on an unprecedented scale and adoption of evidence-based therapies. However, while planning did acknowledge the need for focussing healthcare resources on those infected in a pandemic, there does not seem to have been any consideration of the secondary harms of limiting healthcare in all other areas, which is an inevitable corollary. Sadly, the longer term effects of reduction of healthcare for non-COVID-19 illness during the pandemic are now very clear, with large increases in waiting times for routine procedures and deterioration in care of chronic diseases.

12. It is of course easy to be wise after the event, but at least some of the areas where UK planning was sub-optimal as set out above were predictable. I am encouraged that many of these shortcomings are being addressed in future pandemic planning – a UK Emergency Preparedness and Countermeasures Advisory Group (of which I was a member) has been convened and will report shortly, with many recommendations that will I believe improve our response to a future pandemic. The Scottish Government has also commissioned a Standing Committee on Pandemic Preparedness (of which I am a member), which will report at the end of 2023, and again will improve our pandemic readiness. There is a danger that as time

passes, consideration of future pandemic planning will be perceived as less important, so it is vital that planning measures are refreshed on a regular basis and that novel technological developments in diagnostics, vaccines and therapeutics are exploited as much as possible.

Documentary Submission

13. I am submitting with this report all documents that are currently available relating to the work of the advisory bodies in which I am part. There are some submitted papers to ACDP which provide background for members to consider which in some instances are not part of the collated papers. In addition, there are other electronic communications which relate to some of the areas considered by the different committees. All advice, however, is captured in the documents submitted, but if required these additional sources can be supplied.

Statement of Truth

14. 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: April 13th 2023