Witness Name: Professor Dame Jenny Harries
Statement No.: 2
Exhibits: JH/M1 001-009
Dated: 4 August 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF PROFESSOR DAME JENNY HARRIES

I, Professor Dame Jenny Harries will say as follows: -

1. This statement is provided to the inquiry in response to the Rule 9 request received by UKHSA dated 13 July 2023. The matters in my statement rely on a combination of my own experience, the records of UKHSA and its predecessor organisations and the input from colleagues within UKHSA, who were employees of PHE or HPA.

2. During my oral evidence, I was asked to confirm if the document **[Exhibit: JH/M1 001 - INQ000206659]** was provided to DHSC by PHE and to comment on its contents. Whilst I was familiar with that document, the document itself did not contain the full information required to address the question posed to me, so I suggested I check this and confirm to ensure the inquiry has the most accurate information. I can now confirm the provenance of that document having reviewed the relevant associated documents and e-mail trail. On 23 November 2017, PHE received a commission from DHSC to assist with completion of the 2018 National (Security) Risk Assessment (N(S)RA) template for emerging infectious diseases. The corporate record shows that PHE received the N(S)RA template from DHSC pre-populated with existing information from the 2016 N(S)RA. PHE was specifically asked to provide input to: the reasonable worst-case scenario (RWCS); background information supporting this; the variations to the worst-case scenario and any modelling of impacts which had been done by the team. DHSC also provided Civil Contingencies Secretariat (CCS) guidance on information to include

on the template. The commission noted that this would be a collaborative process between PHE and DHSC. I have exhibited an e-mail chain documenting this activity **[Exhibit: JH/M1 002].**

3. PHE returned a draft version of the template to DHSC on 8 Dec 2017 and received comments back from CMO. PHE returned the final version of the template, which was the document shown to me, to DHSC on 11 January 2018 **[Exhibit: JH/M1 001 - INQ000206659]**. The document describes that the primary reasonable worst-case scenario is based on an outbreak of a respiratory infection in the UK which is similar to the MERS-CoV outbreak in the Republic of Korea in 2015. The document also includes several variations of health threats upon which the "Emerging Infectious diseases" risk scenario within the N(S)RA could be based, including: "Range 1" a viral haemorrhagic fever; "Range 2" a vector-born infection; and "Range 3" which includes HIV, antimicrobial resistant Gonorrhea, and variant Creutzfeldt-Jakob disease (vCJD).

4. The specific details relating to the estimated number of casualties and fatalities was provided by PHE and was based on the number of casualties that occurred during the MERS-CoV outbreak in the Republic of Korea (the basis for the primary RWCS for this risk). The rationale for these figures is described under heading 19e (Page 10) of the document **[Exhibit: JH/M1 001 - INQ000206659**]. The proposed scenario was based on the 40 fatalities that occurred during that outbreak, but the 40-70 range was included to account for the case fatality rate of MERS-CoV of 34.9% recognizing that a greater number of deaths could reasonably have occurred. The rationale also notes that the number of casualties and fatalities could be higher or lower than that based on the speed of identification of the outbreak, and implementation of control measures.

5. During the hearing I was also shown and asked to comment on a Cabinet Office document **[Exhibit: JH/M1 003 - INQ000185135].** I have confirmed with my legal Counsel that I was not directly referred to that document by the inquiry in advance, and therefore felt it appropriate to review the document in more detail, which I have now done. The comments I made at the Inquiry remain extant and in particular the observation that the differences in case and fatality numbers reflected in this

document compared to the previous one above, are entirely consistent with the differential known case fatality rates of MERS and SARS respectively known at that time. This document was provided originally by the Cabinet Office and relevant officials from that Office are likely to best placed to address Counsel to the Inquiry's question about how the figures PHE supplied to DHSC were used to inform the figures in that document.

6. The inquiry has noted that the version of the PHE Response Plan for Possible, Presumptive and Confirmed Middle East Respiratory Syndrome (MERS-CoV Cases) **[Exhibit: JH/M1 004 - INQ000001332]** supplied to them is marked as "Interim Draft for Internal Use only" and has asked UKHSA to confirm if this plan was ever finalized.

7. To address this question, firstly I will note that, as described on page 4 of the document, this was a threat specific plan, which was intended for use within the PHE national incident and emergency response plan (NIERP) framework. It was developed as an internal plan to inform planning for potential MERS-CoV cases, and the management of the public health response within PHE. It did not aim to supersede existing guidance around the laboratory diagnosis of cases, infection control and public health follow-up which were already published on the PHE website, examples of which have been provided to the inquiry as part of our general disclosure for Module 1. Nor did it provide advice on clinical treatment or the NHS pathway, which would be led by NHS England. The plan described and highlighted the key specific guidance documents; described the composition of both local and national incident management teams and those arrangements; summarized the public health management of cases and contacts; and detailed the steps for closing an incident.

8. The final draft of this plan was tabled at the EPRR Oversight Group Meeting on 6 October 2017 **[Exhibit: JH/M1 005 - INQ000179643]** for approval and sign-off. I was present at that meeting, and as Senior Responsible Officer for the concurrently developing High Consequence Infectious Disease Programme, I requested that the plan be checked against those emerging arrangements to ensure full functional alignment. It was documented that the plan would be

published internally whilst those checks took place and was therefore operationally ready for response use. Subsequent to that meeting, the plan was updated with the "interim draft" wording, and a reference included on page 4 noting that discussions with NHSE were pending. The plan was then shared with PHE Health Protection Teams and placed on the Duty Doctors pack (an internal repository of guidance that Health Protection Teams can refer to when on call and managing public health incidents). Therefore, the plan was effectively fully operational from October 2017.

9. Any final version of the PHE internal plan needed to be fully aligned with the output from the overarching cross system High Consequence Infectious Disease programme and was therefore dependent on external timeframes. I can confirm that the version of the document provided to the inquiry remains the extant version of the plan, and it includes the "interim draft" marking. However, the interim plan was operationalised successfully during the response to the UK case of MERS-CoV in August 2018, and PHE worked closely with NHS England to manage the case via the HCID pathway.

10. The inquiry has asked whether this plan was ever exercised. As noted above the plan was utilized during the response to a confirmed case of MERS-CoV in the UK in 2018 which was successfully contained, with no onward transmission from the index case. Therefore, the plan was *de facto* exercised in an active public health response before any specific exercise to test the plan could be designed and delivered.

11. The inquiry has asked whether the Health Protection Agency's (HPA) Interim Contingency Plan for SARS (2003) **[Exhibit: JH/M1 006 - INQ000179082]** was ever exercised. This plan was exercised in June 2003 via Exercise Shipshape. Exercise Shipshape was a tabletop exercise commissioned by the Department of Health and designed to develop the response of the health community in the event of a SARS outbreak, and to identify and recommend potential improvements. The exercise included the following participants:

a. Local and national participants from the HPA, the NHS (including Directors of Public Health that were situated in NHS Primary Care Trusts at the time), Government offices for the Regions and local authorities.
b. Government departments and agencies including the Cabinet Office, the Home Office, the Health and Safety Executive, the Defence Science and Technology Laboratory.
c. Representatives from the Devolved administrations and the EU.

12. The inquiry has asked UKHSA to supply the report of exercise Shipshape, and any other key documents related to this exercise. I have exhibited the handbook **[Exhibit: JH/M1 008 - INQ000235216]** by exercise participants, and the report of the exercise which contains the findings and recommendations from the exercise **[Exhibit: JH/M1 009 - INQ000235217]** This exercise was delivered in 2003, shortly after the formation of UKHSA's predecessor organization the Health Protection Agency (HPA) was very recently formed.

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 August 2023