UK Covid-19 Inquiry

Module 2B of the UK Covid-19 Public Inquiry
Request for Evidence under Rule 9 of the Inquiry Rules 2006
Reference for Request - **M2B/JS/01**

Questionnaire reply from Professor Julian Sampson, member of TAG, Wales.

Q1. I am an academic medical geneticist, now retired from clinical practice. My qualifications include medical and postgraduate degrees (BM, BS, BMedSci, MSc, DM) and I am a Fellow of the Royal College of Physicians, the Academy of Medical Sciences and the Learned Society of Wales. In January 2020 I took flexible retirement and since then have been working 0.2 WTE for Cardiff University on a research and teaching contract and a part time (0.6WTE) locum consultant post in clinical genetics with Cardiff and Vale University NHS Trust that ended in June 2021. Prior to January 2020 I was a full time Professor and Honorary Consultant in Clinical Genetics at Cardiff University, Head of the Institute of Medial Genetics, Director of the Division of Cancer and Genetics at Cardiff University Medical School and Chairman of Wales Gene Park. I served previously on the Welsh Scientific Advisory Committee, including as Chair (2015-2018). My expertise is in human genetics and genomics and my work has focused on the clinical and molecular genetics of inherited diseases. I have published approximately 200 research articles in these areas. I have not undertaken or published research in relation to COVID-19.

Q2. I was a member of TAG from March 27th 2020 through July 2021. I also participated in discussions of the Welsh National COVID-19 Test Plan Task & Finish Group between March 27th 2020 and 29th May 2020. I was not a participant in SAGE or other relevant groups.

Q3.

a) I was approached in March 2020 by Dr Rob Orford (Chief Scientific Advisor for Health with Welsh Government) to join discussions regarding potential involvement in Wales in research into the human genetics of Covid-19 infection, early plans for which were being developed elsewhere in the UK, including via the involvement of Genomics England and an emerging UK partnership led from Scotland. I was subsequently asked to join TAG's meetings.
b) I attended over 100 meetings, all online (details can be provided by the TAG Secretariat at Welsh Government). My contributions included reviewing and providing feedback on draft documentation that was circulated prior to each meeting and discussing data (from monitoring) and forecasts (from modellers) presented at TAG to reach consensus on data interpretation and recommendations made by TAG to Welsh Government.
c) My roles included working with Dr Orford and his team to reach a decision on Welsh involvement in research into the human genetics of COVID-19 infection via discussions with Genomics England and other partners (the outcome was recruitment across Wales of patients hospitalised with COVID-19 to the GenOMICC consortium study led from Edinburgh. Whole genome sequencing of patient DNA was performed by Genomics England). I reported back to TAG on UK and international research findings in this specific area. I also participated in wider discussions in TAG, including the response to the pandemic based on review and interpretation of data provided by others. I did not undertake data gathering or research for TAG.

Q4. I did not author/contribute to any documents to advise TAG or its subgroups. At TAG, I reviewed and discussed draft documents authored by others. Final drafts of the documents are publicly

available at:
Gov.wales/technical-advisory-group-modelling-updates-and-subject-specific-reports

Q5. I did not write any articles or give interviews and/or evidence regarding the work of TAG or its subgroups or Welsh Government's response to the pandemic.

Q6.

a. TAG brought together a wide diversity of expertise from the NHS and academic communities. In addition to public health and infectious disease expertise (clinical and laboratory), representation from psychology and psychiatry, immunology, genomics, statistics and business and economics was included. TAG members from the NHS and academic communities worked seamlessly with Welsh Government staff.

b. Generally, Dr Rob Orford and his team identified and prioritised issues for TAG and its subgroups to address. In addition, members of TAG raised issues relevant to their areas of expertise that were then addressed by TAG or its subgroups. Dr Orford sought assistance from specific members of TAG with specific issues, according to relevant expertise but was always open to assistance from all TAG members. The groups worked at pace, with deadlines set by Dr Orford's team.

c. Welsh Government provided a high level of support for TAG, including secretariat and IT support. The Secretariat was effective in the timely circulation of draft documentation and information in advance of TAG meetings, and minutes following meetings. Communication was very effective, with the Secretariat being readily available and responding quickly to enquiries and requests. Timely information on the wider UK situation was provided to TAG by the ONS.

d. Advice and recommendations from TAG were extremely wide ranging. They included: interpretation of data from monitoring in the community and in hospitals and of modelling to predict demands on health and care services - particularly the NHS; impacts on provision of education; proposed and implemented restrictions to freedoms and their potential to reduce harms in terms of morbidity and mortality but also to result in other harms including those for wellbeing and the economy.

e. TAG and its subgroups appeared to work effectively together. Subgroups were tasked with addressing specific issues by gathering data and preparing reports and recommendations that were brought promptly to TAG and Welsh Government.

f. Welsh Government appeared to use structures available to it (e.g. the army, the NHS, HEIs) and the policies that it could utilise (e.g. emergency restrictions to freedoms) to mitigate the impact of successive waves of the pandemic on morbidity and mortality. Data on public compliance with Welsh Government policies (e.g. stay at home, work from home, social distancing, restrictions to travel, facemask wearing and social contact bubbles) were presented at TAG. Compliance appeared to be generally high, with only modest waning over time. Data on immunisation was presented to TAG once vaccines became available. Specific efforts (e.g. through community networks and media) were employed to reach sections of the community where compliance or vaccine uptake were low. Monitoring of infection rates, hospitalisations and deaths was presented at TAG and appeared to demonstrate effectiveness of policies in reducing transmission of COVID-19 and preventing or delaying infections, hospitalisations and deaths. The effectiveness of policies aiming to delay infections until immunisation became available, achieved largely through restrictions to freedoms, appeared to be reduced by the rapid relaxation of restrictions following the October-November 2020 "firebreak" lockdown in Wales.

Q7. Welsh Government achieved its aim of avoiding the NHS becoming overwhelmed by the demands of the pandemic, although COVID-19-associated mortality was high relative to many northern European countries. The advice provided to Welsh Government through TAG was generally reflected in the policies that it implemented. The diversity of expertise in TAG was broadened over the initial months of the pandemic and TAG might have benefited from inclusion of more experts in psychology, psychiatry, social science and communication (with the public) from the outset. As I left TAG in summer 2021, I am not aware of the changes made to TAG and its working since that time.

Q8. I have electronic copies of some draft documentation from TAG's work (for example as email attachments received from TAG's Secretariat) and some additional email communication from and to members of TAG, but the Secretariat will have the definitive and comprehensive archive of TAG documents. As requested, I will retain all documentation that I hold.