Witness Name: Ashley Gould
Statement No.: First
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**UK COVID-19 INQUIRY**

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**WITNESS STATEMENT OF ASHLEY GOULD**

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I, Ashley Gould, will say as follows: -

**Introduction**

1. In January 2020 I was the Consultant lead for tobacco control, working for Public Health Wales, and leading activity with a range of partners to reduce smoking prevalence in Wales. I had been in that post for just over four years with my work including leading the application of behavioural science to optimise the numbers of smokers in Wales quitting with NHS support. At that time I was also participating in the Public Health Wales Health Protection out of hour's rota, and had done so continuously since 2013 (continuing to date). This role is part of the organisational response to communicable disease notifications, as well as fulfilling requirements of a category 1 response organisation, for emergency response for non-communicable disease incidents. Before these roles I had been in Public Health Specialty Registrar training, mainly with Public Health Wales, between 2010 and 2015. This provided professional experience of all areas of public health, including Health Protection and specifically with providing communicable disease response. The work included periods of being first responder for out of hour's response but I had not specifically dealt with response to coronavirus infection prior to the pandemic. I have a B.Sc. (Honours) degree in Environmental Health, a Master's Degree in Public Health and am a member (MFPH, by examination) of the Faculty of Public Health of the Royal Colleges of Physicians of the United Kingdom.

2. My role in the pandemic response was that of a Consultant in Public Health, with changes in focus between January 2020 and May 2022. Initial activity included early contact tracing; supporting enclosed settings in their response; and supporting local response teams in Powys and Betsi Cadwaladr health board areas. I later focused on activity to integrate the application of behavioural science into the pandemic response, including providing technical advice, mainly around maximising adherence to personal protective behaviours.

3. In May 2020, I became involved with the Behavioural Science Support Cell that Public Health Wales established with the aim of optimising adherence to personal protective behaviours in line with their Public Health Protection Response Plan. At the time a small number of colleagues, mainly from the Public Health Wales, Behaviour Change and Public Information Team, and each with additional pandemic response roles, met regularly to develop the use of behavioural science in the pandemic response. Whilst not the Behavioural Science Unit (BSU) at that point the expertise and advice contributed to: Test, Trace and Protect through work on scripts and training call handlers; optimising vaccine uptake – segment specific and population-wide; work around barriers to distancing in healthcare staff; issuing a mis- and dis-information guide and training; and carrying out empirical research as mass test events were operated, with direct observation of adherence to COVID-safe behaviours at two events, in collaboration with Bangor University. I also contributed to PHW Advice Notes that formed advice provided directly to key advisors to the Welsh Government, such as the Chief Medical Officer, and to the work of the Technical Advisory Group (TAG) and the Risk Communication and Behavioural Insights Subgroup of TAG (RCBI), aligning outputs, for example the COVID-Code Advice Note and 21-day Review Advice note. **[EXHIBIT AG/1 INQ000232361; EXHIBIT AG/2 INQ000056331; and EXHIBIT AG/3 INQ000232375]**

4. From July 2021 I was seconded to the role of Programme Director of a newly established Behavioural Science Unit (BSU) in Public Health Wales (PHW). At that time the Unit had no staff and membership evolved over time with two Behavioural Science Specialists joining in February 2022 and a formal launch on the 19 May 2022. The role of the BSU, positioned in the Policy and International

Health/WHO Collaborating Centre Directorate in PHW, is to develop specialist expertise in, and increase the routine use of, behavioural science to improve and protect health and wellbeing in Wales. The Unit continued to develop after the public inquiry 'specified period' ended (May 2022), and now has professional expertise in health psychology, sociology, and public health, with a range of experience in the application of behavioural science across the domains of public health.

5. I was not a member of the Technical Advisory Cell ("TAC") as it existed in March 2020. I first attended a Technical Advisory Group ("TAG") meeting in December 2020 and I became a member of the Risk Communication and Behavioural Insights Subgroup (RCBI) in July 2020.

**TAG and its sub groups**

6. I first attended a TAG meeting some months after its establishment and, probably as a consequence of the pace of activity at the time, cannot recall a specific conversation covering its roles. The TAG chairs noted, on several occasions, that the central role of TAG was to provide technical advice, and how and if that was implemented was a matter for policymakers and Ministers. I felt TAG discussions were always pragmatic, with discussion around how to optimally respond to circumstances – this arrangement appeared strong. The TAG co-chairs and TAC provided the bridge to Welsh Government for advice, as far as I was able to perceive, including from subgroup activity. Given my experience I do not feel in a position to offer meaningful comment on the strengths and/or weaknesses of this approach, beyond that it probably provided consistency at times of high stress in the system, and probably minimised time delays in getting advice to Ministers. I think the publication of TAG advice was a strength, in terms of transparency and to underline the separation of scientific advice and policy making.

7. In the TAG meetings I attended there was a frequently expressed diversity of views and opinions. I did not feel there was 'groupthink' in these meetings, but consensus was reached through discussion. I think there was challenge within TAG and RCBI, to ensure evidence-based advice was provided, in as timely a manner as possible, so as to impact the spread of the virus, and that challenge felt sufficient.

8. Equity of impact of the pandemic, and in response activity, was a recurring theme of TAG discussion, illustrated, for example in TAG advice around the five harms arising from COVID-19 **[EXHIBIT AG/4 INQ000232376].** Regard for at-risk and vulnerable groups was also core to the Vaccine Equity Strategy development as an example, that behavioural science was also integral to (Figure 4). **[EXHIBIT AG/5 INQ000232377]** I am not aware of impact assessments or research articles published in this regard.

9. I think recognition of the value of applying behavioural science in response to the pandemic (and consequently sufficient account of it) grew. This was in some part, a reflection of developments elsewhere, for example with the WHO convening an expert group on behaviour change. **[EXHIBIT AG/6 INQ000232378]** There was recognition of the importance of behaviours to reduce spread of the virus but perhaps early-on less of an appreciation of the systematic approaches to understanding the determinants of those behaviours, and how to develop interventions to account for them. Behavioural science certainly featured overtly in multiple TAG outputs, as evidence of sufficient account being taken of it.

10. Others have noted an unequal access to information or ability to influence the timing of actions which had impacts across the four nations, and I would recognize and agree with that, particularly in relation to developments such as vaccine roll-out, for example. Without being fully sighted on plans, or able to share possibly peculiar challenges to vaccine take-up, activity risked being inequitable. In the RCBI arena specifically we were aware of observational study around 'mass events', commissioned by Department of Health and Social Care, and I believe there was unequal access to information (and involvement) around this.

11. TAG might be better equipped with the integration of RCBI into activation procedures, with consideration of behavioural science from very early on in emergency response, if human behaviours may feature. The webinars that RCBI arranged for TAG members and others (referenced below in paragraph 28) were well attended, building on this increasing knowledge and awareness of behavioural science, could contribute to the increasingly effective translation of scientific advice into evidence-based policy.

12. Based on my experience and level of involvement I do not have a firm opinion on whether or not science-policy advisory mechanisms should be re-evaluated. I believe that the mechanisms do need to centre on developing and maintaining a shared understanding of the priority (research/technical) questions, and ultimately desired impact. Space to systematically consider needs, evidence and implementation approaches supports this, and policymakers being party to scientific discussions can support the absorption and use of scientific advice in development of evidence based policy.

13. Given the dynamic nature of the pandemic and the volume and complexity of response activity, the structures of TAG and its subgroups were probably as effective as they could have been in informing decision-making, and overall I believe they worked well in this regard. I have no other observations that I believe would be of substantial interest to the Inquiry.

14. Some connections were made between TAG sub-groups but there was scope for more of this (for example the 'sharing' of member(s)) to further inform scientific advice from a behavioural perspective, and vice versa. I cannot recall RCBI members being aware of behavioural science expertise or work of members of other sub-groups, but members of RCBI were usefully connected to other networks (academic and informal, national and international, established before and during the pandemic). The inter subgroup connection could also be extended to colleagues in a similar position elsewhere in the UK and beyond, being mindful of burden on individuals, group size and group dynamics. The link with the Independent Scientific Pandemic Insights Group on Behaviours (SPI-B) (i.e. two RCBI members attended SPI-B, one co-chairing for a period, the other as an observer) and other groups (e.g. Cabinet Office comparators group) and access to discussions/evidence was useful, as was the ability to discuss work with UK governmental/public health agency colleagues involved in the pandemic response. To help systematic gain from serendipitous connections, there may be value in inviting colleagues from similar groups in other (devolved) administrations to attend subgroups, and reciprocate, but timing would need to be proportionate.

**The Risk Communication and Behavioural Insights Sub Group of TAG – membership and activity**

15. The role of the Risk Communication and Behavioural Insights Subgroup (RCBI) was to give detailed and strategic consideration to the behavioural and technical evidence on COVID-19 as it related to risk communication and behaviour. At the following strategic points in the pandemic, RCBI issued advice: post firebreak, transition to alert level 0; and in developing the Coronavirus Control Plan. **[EXHIBIT AG/7 INQ000232379**; **EXHIBIT AG/8 INQ000232380, EXHIBIT AG/9 INQ000232381]** The subgroup also contributed regularly to 21 day reviews; and provided behavioural considerations to various TAG papers, including vaccine certification, contact tracing, the safe conduct of elections, and the use of face masks. **[EXHIBIT AG/10 INQ000232362, EXHIBIT AG/11 INQ000232363, EXHIBIT AG/12 INQ000232364 AND EXHIBIT AG/13 INQ000232365]**

16. The RCBI comprised external academics (a Professor of Behavioural Psychology; a Professor of Environmental Psychology/Director of an Understanding Risk Research Group; and an Applied Research Lead), Public Health professionals; a Police Liaison Unit representative and to provide a direct interface with key users of the advice being produced on a real-time basis, Welsh Government colleagues in, for example, communications and vaccine policy. The group was chaired by a Professor of Public Health and Psychiatry, Health Data Science who was also a member of the Independent Scientific Pandemic Insights Group on Behaviours (SPI-B). I understand that Welsh Government officers invited members, but have no further understanding of the initial recruitment process. Membership remained relatively stable, with two members standing down due to other work commitments and ill health in January 2021 and November 2021. The group was joined by a Professor of General Practice and Director of the Wales COVID-19 Evidence Centre in May 2021; and an Emeritus Professor of Health Psychology and a Lecturer from a College of Human and Health Sciences in September 2021. As I recall these latter members were invited following discussions between the co-chairs and Welsh Governments' TAC Support officer (detailed in paragraph 21 below) around bolstering relevant expertise as the pandemic evolved. From summer 2021, I shared chairing duties, generally alternating the chairing of

meetings. Several external academics were also invited to attend RCBI meetings on an ad hoc basis to present and discuss emerging findings from their research.

17. I believe RCBI membership recognised the multidisciplinary nature of behavioural science, while retaining a group size that was productive in terms of discussion, formulating advice and speed of output. TAG was, out of clear necessity, a much larger group, and from what I feel is my limited position to comment, offered a useful diversity of expertise. I believe the gender balance of RCBI, and TAG, was appropriate. I do not feel in a position to offer definitive opinion on the ethnicity balance of the TAG or RCBI without having information on the ethnic diversity in the cohorts of experts required/who volunteered their input.

18. The RCBI sub-group first met on 22nd July 2020, agreeing initial Terms of Reference at the 5th August 2020 meeting. Meetings took place on a weekly basis until September 2021 when they moved to a fortnightly frequency. In total, the sub-group met 53 times up to the end of May 2022. The group relied on email and MS Teams for communications, no WhatsApp or similar groups were established, and I was not involved in groups of this nature with Ministers, advisors or civil servants, through TAG nor RCBI.

19. RCBI members had multiple connections with external partners and harvested evidence and considerations made by others, for example an emerging debate on 'pandemic fatigue' was picked up via academic networks and brought into RCBI, with constructive output. This was framed more appropriately, RCBI believed, as 'alert fatigue' (as opposed to a perceived fatigue in complying with personal protective behaviours) – a useful distinction and some offsetting of a narrative that might have falsely normalised 'non-compliance'. Having key Welsh Government stakeholders in the group meant advice could be quickly fed in, in real-time, and also proved to be a useful, if informal, feedback loop. Group members also referred to reciprocity in their involvement suggesting, for example, they had gained valuable insights into the evidence-policy interface, as well as making new contacts.

20. The work of the RCBI subgroup featured in TAG consensus statements and upward advice, for example this 21 day Review Advice note **[EXHIBIT AG/3 INQ000232375 as above].** Some have expressed a view that they did not receive feedback on the advice provided, and that there was a lack of clarity on how their outputs were used. I would agree with this to an extent but recognise the pace of activity at the time meant that feedback came in an informal way, mainly via our secretariat connection to TAC. Although there may not have been overt causal links, there were examples of communications output, for example, aligning with RCBI advice. I do not believe that the informal approach to feedback impacted on our work. I believe RCBI worked well, in great part down to the collegiate, collaborative and enthusiastic engagement of all group members, each of whom was undertaking this work on a voluntary basis. I think we came together at particularly stressful times both on an individual level, and in relation to trying to apply our expertise and experience, and made a valuable contribution to the pandemic response.

21. I believe RCBI (and TAG) were adequately resourced, the coordination of the group and other TAC support was critical and ensured effective communication with no burden of administration on technical/scientific members – a key link person (the Deputy Chief Social Research Officer, Social Research and Information Division, Welsh Government and also a TAC member) as well as professional administrative support were in place for almost every meeting of RCBI, reflecting what I deem to be sufficient resources for RCBI, and reflected in TAG, as far as I could tell. Occasional significant short-term demands were made but members never felt overburdened. The effective organisation/recording of meetings and maybe more so the 'translation' of rich discussions in the meetings into succinct and actionable 'products', both by TAC support and co-chairs was critical to maximising the group's wider input/impact. Meeting frequency was regularly reviewed taking into account the phase of the pandemic and members' competing demands. While the group was established in summer 2020, it could be stood up immediately in the future should an emergency situation arise. Improving the ability for multiple group members to edit shared documents in real-time would be helpful to enable more efficient drafting, particularly when working to tight deadlines.

22. Discussions during meetings featured a diversity of perspectives and experience, including inputs from members who had attended SPI-B meetings. SPI-B conclusions were regularly discussed by RCBI with consideration given as to how findings might be best applied in Wales, as circumstances required. The RCBI chair was a member of SPI-B, and our secretariat support attended as an observer, and whilst I believe that this provided sufficient communication between RCBI and SPI-B, I do not feel I have the knowledge to comment on the level of sufficiency of challenge that this offered. My involvement solely as a consumer of outputs from SPI-B does not allow me to comment on the ability of TAG members to seek clarifications from SAGE.

23. Our focus in RCBI throughout was the translation of evidence from multiple sources, at pace, into actionable advice (with reasoning). I believe RCBI felt capable and confident to offer advice on our areas of interest and expertise whether asked or not, based on our thoughts about prevailing circumstances. For example, RCBI was not asked to provide advice on 'COVID Can I Do It?' – a web resource identified through international networking, but advocated for this or similar alternative to be developed for Wales. The behavioural science contribution to RCBI (and TAG) from Public Health Wales (not necessarily defined as from BSU, due simply to the timing of developments) was regular and frequent, and mainly through my involvement.

24. The subgroup had no formal approach for receiving commissions as such, but requests would be added to the agenda for each meeting or if quicker turnaround was required, direct via email to the group, from the TAC secretariat. Requests were received via this channel, but I am not able to comment on the input ministers or their representatives had in that process. In those areas that were worked upon I do not recall incorrect, naive nor unscientific questions being posed. RCBI provided behavioural considerations to various TAG papers, including vaccine certification, contact tracing, the safe conduct of Senedd and Policy and Crime Commissioner Elections, and the use of face masks. **[EXHIBIT AG/10 INQ000232362 as above EXHIBIT AG/11 INQ000232363 as above, EXHIBIT AG/12 INQ000232364 as above, EXHIBIT AG/13 INQ000232365 as above]**

25. Relationships developed with colleagues across the group, particularly in Welsh Government communications, leading to ad-hoc requests for advice. Similarly real-time discussions took place on a wide range of topics at the frequent meetings. Whilst these did not necessarily always result in written advice it appeared a valuable method contributing to behaviourally informed policy and communications.

26. A number of sources of data were used to assess adherence to protective behaviours, movements and to shape RCBI advice on non-pharmaceutical interventions, including but not restricted to: Wales Ipsos MORI surveying; Public Health Wales surveying; ONS (infection survey, vaccine uptake data, COVID Test and Trace Contacts Insights Survey, COVID-19 module of the Opinions and Lifestyle Survey); YouGov/Imperial College London surveying; Google Community Mobility Reporting; Determinants of COVID-19 health related behaviours work from Queens University Belfast; and via the Public Health England/UK Health Security Agency Behavioural Science and Insights Unit database. SPI-B data was also frequently relied upon. The data used to form a picture of public adherence, were limited in many topic areas, particularly at small-area geography, in relation to their timely availability, and were often subjective self-report in nature. This led to the need for pragmatic and dynamic syntheses of data and evidence.

27. Data sufficiency changed during the course of the pandemic, for example in relation to data around self-isolation (with increased precision and ability to assess barriers and facilitators to adherence) and in relation to vaccine uptake - as measurement of the desirable behaviour (receipt of vaccination) was clear and measurable. This allowed more effective application of behavioural science, with work to explore barriers to vaccination in those yet to get their vaccination, and tailored communications, based on evidence-based frameworks. This approach was also used in relation to vaccine equity. Whilst polling-type data collected on, for example, face covering use, may have provided repeatable/comparable measures, (and were relatively easy to collect in a timely manner) they probably were not reliably accurate (precise) because they were wholly self-reported. Comparisons in samples between self-reported and observational data to validate

the former, and similar, would be a helpful improvement. Some observation of face covering adherence was carried out as part of a study around mass-event restarts. **[EXHIBIT AG/14 INQ000232366]** The early and routine consideration of human behaviours in intervention design and in epidemiological modelling, to the extent of making more realistic assessment than relying on presumed levels of adherence, would strengthen models.

28. The subgroup arranged five well attended webinars in 2021, each involving sub-group members alongside invited speakers. The themes covered by the webinars were: using behavioural science to inform policy and practice; public disorder; risk communication; behavioural science frameworks; and community development and mutual aid. While each webinar had a specific theme, the overall aim was to promote the principles of behavioural science to a broader audience in TAG and beyond.

29. Throughout the period there was regular liaison with behavioural science colleagues working in the UN (International Covid-19 Behavioural Science and Policy Group), WHO (Risk Communication and Community Engagement ad-hoc group) and weekly conversations with those engaged in similar activity in the UK home nations (and for a period of time, the Republic of Ireland).

**Behavioural science and its role in the pandemic response**

30. Behavioural Science is the systematic study of observable measurable actions (behaviours). This tends to be in groups that are well-defined and have several shared characteristics, to understand what elicits the behaviour, what prevents it, and how it might be better enabled/restricted through the ethical application of behavioural models and frameworks, ideally co-produced with people in that well-defined group. This is essentially the scientific method that RCBI applied, at pace during the response, to inform public health interventions. Our systematic consideration of the factors that influence behaviours, mainly used the capability opportunity motivation model (COM-B) and the Behaviour Change Wheel (BCW) because they provide an established evidence-based summation of many of the theories and frameworks in the behaviour change literature, which was/is

particularly useful with limited time. Other theories were brought into consideration in the RCBI, for example dual-process theory, a particular research interest of one the RCBI group members, and we had conversations around the use of 'anticipated regret' as an approach, due to published research from another group member, that was ultimately not recommended. Use of APEASE was advocated in RCBI advice, and published as TAG guidance, and overtly notes the impact of equity. Public trust in organisations is an important determinant of success of actions designed to shape behaviour – hence the above overt approach to understanding the barriers and enablers of action in defined groups and engagement and co-production of 'next steps'. **[EXHIBIT AG/15 INQ000232368]**

31. I agree with advice Professor Susan Michie gave around integrating behavioural science in the [UK's] public health response, in her BMJ Blog in February 2020. I think recognition of the utility/necessity of behavioural science grew, and as noted above believe that consideration of behavioural science from very early on in emergency response, if human behaviours might feature, is crucial. The establishment of the RCBI sub group later than other sub groups is an indication that behavioural science was not integral to the Welsh Government's response early-on, but I believe it became integrated, with TAG advice notes frequently drawing on behavioural science.

32. Whilst RCBI did not develop or build models and theories or implement behavioural interventions itself, it offered advice on maximising adherence to interventions (to maximise personal protective behaviours and vaccination for example) mainly through facilitative approaches. The group frequently considered, recommended systematic consideration of, and/or presented the physical, social, cognitive and psychological barriers and enablers for the population (and sub groups therein) to undertake personal protective behaviours. Whilst directive approaches were necessary at a time of national emergency, RCBI was clear that sustaining adherence required a facilitative approach, for example in the advice 'Behavioural insights to *support* a post-firebreak Wales'. **[EXHIBIT AG/7 INQ000232379 as above]**

33. The type of policy options and intervention types covered the full range of options as technically defined in the Behaviour Change Wheel model. The policy option

almost consistently used was that of communication and marketing, focused on increasing understanding and awareness, for example on virus spread mechanisms, and the headline personal protective behaviours; training, for example on judging 2m social distance, or correct mask wearing; aspects of persuasion (as technically defined – inducing positive feelings to stimulate action); modelling (showing social distancing and (correct) face covering use) were also prevalent in application. Environmental restructuring became an important intervention type, with one-way flows, floor markings, screens, and blocking-off of seats/tables etc. Restrictions (as technically defined – rules to reduce opportunity to engage in behaviour) were clearly used and felt with, for example, the stay-home instructions. Services, such as testing and vaccination; fiscal measures such as the self-isolation payments, and guidelines (for example, for workplaces) were also technically defined policy categories deployed.

34. The key determinants of effective behavioural response changed across the course of the pandemic, but included perception of the risk of contracting the virus, becoming ill and succumbing to it; perception of the benefits of personal protective behaviours outweighing the 'costs'; social norms, and collectivism in response; and a range of individual factors, such as age, gender, and personality, alongside access to accurate and timely information. I think factors such as trust in public authorities, perceived control, stress and overall mental health and wellbeing also influenced behaviours, in the public, and in those 'responding'.

35. Nudge theory is a concept that proposes that changing the design of the decision environment can influence the behaviour and decision-making of groups or individuals. Ethical problems can arise in nudging behaviour because of the perceived reduction in agency (individual ability to choose). The concept relies on an understanding that people have two distinct systems for processing information - system 1 is fast, automatic, and highly susceptible to environmental influences; system 2 processing is slow, reflective, and takes into account explicit goals and intentions. With time constraints or other pressures people tend toward system 1-type automatic responses/actions. During the pandemic response one-way systems in shops and floor spacing markers were examples of changes to environments used to encourage (more automatic) adherence to personal

protective behaviours, and I believe these contributed, alongside many other factors, to reducing risk. RCBI advocated a focus on understanding behavioural determinants (cognitive, psychological, social and environmental) and co-producing the 'solution', and situational behavioural support as summarized in its output. **[EXHIBIT AG/9 INQ000232381 as above]**

36. Contrary to this approach, actions designed to deceive and hide the true objective or to covertly control people, would be unethical and could be classed as manipulation. During the pandemic response environmental changes to encourage or enable behaviours, such as the well signposted supply of free masks at shop entrances (to encourage face covering wearing in indoor public spaces) was a frequent, transparent, and overt population wide activity to support the reduction in the spread of a deadly virus, but could not be classed as manipulation nor coercion.

**Government strategies and communication**

37. RCBI was clear about including the rationale for advocated personal protective behaviours, and I agree completely with the view that explaining reasons behind changes is more likely to lead to positive responses, as noted in the article "Staying 'Covid-safe': Proposals for embedding behaviours that protect against Covid-19 transmission in the UK" **[EXHIBIT AG/15a INQ000283302 ]**. A member of RCBI contributed to this article. The inclusion of reason helps to build understanding of the purpose of the action and why it is important. It can also give a sense of ownership over the decision, which makes follow through more likely. Whilst not always easy when trying to craft clear, short calls-to-action or when advice was necessarily instructive in nature, Welsh Government *did* adopt the inclusion of 'the reasons behind' actions, but perhaps not as a matter of routine, such as around Test, Trace, Protect **[EXHIBIT AG/15b INQ000283303]**. Use of this principle featured in public health guidance which overtly included the reasons for the advocated personal protective behaviours. **[EXHIBIT AG/16 INQ000232369]** The words "*We've all got a reason* [to keep Wales safe]" were also used (August 2021 campaigning) to tap into in the motivational drivers of behaviour.

38. RCBI guidance in January 2021 (Pandemic and beyond - using behavioural science to inform policy and practice) referenced the SAGE/SPI-B advice in December 2020 advocating for "…providing a clear rationale for actions thought necessary." **[EXHIBIT AG/15 INQ000232368 as above].** This principle was expanded in RCBI guidance on sustaining COVID-safe behaviours in Wales in August 2021 with the recommendation to "Explain the WHY (to build intrinsic motivation); focus on rationale (transmission prevention, keeping life going); employ the 'question-behaviour' effect – ask pertinent questions, rather than issuing instructions or mandates." **[EXHIBIT AG/8 INQ000232380 as above]** RCBI advice in March 2022 (Living safely with COVID-19 in Wales: risk communication and behavioural science perspectives) confirmed "Messaging should emphasise […] the rationale behind these behaviours and what benefits will result." **[EXHIBIT AG/9 INQ000232381 as above]**

39. Government and others appropriately used multiple channels and methods of communication, and these altered, as a necessity, through the response. For example, the high levels of interest initially meant that headline media (news) outlets provided a channel with high reach. This was supplemented by other channels, and related activity to reinforce messages in the public realm as the response progressed – e.g. signage at public building entrances, and targeted communication for those 'yet to get' vaccinated. The periodic (21 day) review process was a useful mechanism to provide updates as scientific understanding evolved. Adapting communication frequency, channels and methods was important to share an actionable (not overwhelming) flow of advice, and I believe Welsh Government adequately communicated changes in approach as scientific understanding evolved.

40. I believe that successful risk and crisis communication strategies are underpinned with treating people with respect, capable of taking decisions themselves and managing personal risk, and this was reflected in the Welsh Government response. The foundations for this belief featured in the RCBI advice "Technical Advisory Group: Behavioural insights to support a post fire break Wales" and carried through into a Ministerial announcement after the firebreak measures in

November 2020. **[EXHIBIT AG/7 INQ000232379 as above, EXHIBIT AG/17 INQ000232370]**

41. I understand, from public surveying **[EXHIBIT AG/17a INQ000283304 ]**, that trust in Welsh Government was relatively high and remained so throughout the pandemic. This supported the public response to Welsh Government issued advice, and offers an indication that public engagement was adequate. Public engagement, and a dynamic understanding of factors of importance to the public that are likely to influence public health, are critical to effective action. Routine and frequent surveying and observation to gather data on the above, and the testing of messages, for example, are particularly useful. Barriers can be understood, from the communities' perspective, through targeted and commissioned social research. Systematic application of behavioural models to understand individual and group behaviour were advocated in RCBI advice, and would add to the above if systematically applied. **[EXHIBIT AG/7 INQ000232379 as above]** The work of the Vaccine Equity Committee, and the subsequent Vaccine Equity Strategy to better understand and plan to overcome barriers (and enablers) to action in under-served groups, illustrates how this approach can be undertaken, and how barriers within certain groups of society can be overcome. **[EXHIBIT AG/5 INQ000232377 as above**] These are examples of engagement with communities on the ground, and could help maintain/improve public trust. I believe this engagement needs to integrate with scientific evidence around effectiveness, balancing professional recommendations (that the public should rightly expect) with barriers and enablers of implementation including public knowledge levels, (perception of) social norms and held beliefs.

42. I think breaches (alleged or otherwise) of social restrictions by Ministers, officials and advisors probably damaged public confidence, but I have no empirical evidence around the subsequent impact of observance by the public of those restrictions. To some extent the actions, and more so the subsequent news coverage and public debate, probably provided some with a justification for their breaches of restrictions.

43. I do not believe that the public were/are 'panic prone' and base this on research during life-threatening emergencies indicating that spontaneous helping behaviour is far more common than selfish/irrational 'panic' behaviour (Drury, Reicher, Stott, 2020). **[EXHIBIT AG/18 INQ000232371]**. Fear and uncertainty can drive behaviour, and particularly early on in the pandemic probably contributed to adherence to personal protective behaviours by some. The mechanisms that shape decisions in this respect include protection motivation theory (people protecting themselves based on a threat appraisal followed by a coping appraisal) and the availability heuristic (making judgments based on information that's easily recalled due to recent exposure – like the daily updated numbers of COVID related deaths). This driver of behaviour probably faded over time, based on more proximal personal experiences, such as people contracting the virus and recovering. Media-reported public disorder narratives and the sustained coverage of empty shelves probably caused concern in an uncertain context and, at worst, may have reinforced the non-constructive behaviours in question through a cascade effect. I do not consider that the Welsh Government approach to the pandemic relied-on nor used fear as a tactic – transparent communication about an uncertain and highly dynamic situation was offered. Public surveying confirms this and indicated a perception that Welsh Government (and the NHS) were generally seen to be doing a good job at containing the spread of the virus. **[EXHIBIT AG/19 INQ000232372]**

44. I think there was sufficient discussion regarding measures to minimize spread via all viral transmission routes, including aerosol. I believe the 'Eat out to help out' scheme incentivised social contact, which was no doubt good for some people's mental health and wellbeing. It provided an economic stimulus, but it is also highly plausible (given the increased socially-close mixing indoors that it enabled) that it led to increased case numbers. I do not recall RCBI being consulted on the initiative.

45. I agree with views indicating that face covering use and social distancing were vital prior to and during the vaccination programme – RCBI advice published in January 2021 stated "Of particular immediate importance is the need for communications to impress upon the population the need for continued adherence to key personal

protective behaviours", and communication materials at the time confirmed this advice (with a clear rationale). **[EXHIBIT AG/15 INQ000232368 as above, [EXHIBIT AG/20 INQ000232373]** I am of this opinion because of the 'multiple levels of protection' principle from organisational safety - characterized by the 'Swiss cheese' metaphor, that recognises that with multiple layers, each with its own strengths and weaknesses, a more resilient approach that minimizes the risk of failure can be adopted.

46. I first attended a TAG meeting in December 2020, and so was not party to communications or able to offer comment of the clarity of aims of the Welsh Government, to TAG and TAC, around the first lockdown in March 2020.

47. I do think that uncertainties in evidence were communicated clearly in advice to Welsh Government, including through the frequently used Professional Head of Intelligence Assessment probability yardstick, and onward to the Welsh public. I think having both Ministers and, for example, the Chief Medical Officer presenting at press conferences, helped illustrate the difference between the politicians and scientific professionals. The phrase 'following the science' may have blurred the line between scientific advice and policy decisions, but I do not believe it changed how scientific advisers set out their expert views – TAG chairs were always clear that our role was the provision of scientific advice, and RCBI provided that advice, for example, around 'vaccine passports'. **[EXHIBIT AG/21 INQ000232374]**

48. The concept of 'behavioural fatigue' as portrayed in the media was one challenged by RCBI in its advice to Welsh Government, insofar as the narrative could have been interpreted as 'a public lacking the motivation to adhere to personal protective behaviours'. **[EXHIBIT AG/7 INQ000232379 as above]** We felt this interpretation was incorrect, with indications that the majority of people wanted to do what was being asked of them but lack of support, non-enabling environments or misunderstanding of increasingly complex restrictions, with variation across nations, was undermining this. This consideration of determinants/influences of behaviour shaped interventions, for example introducing (and increasing) the self-

isolation payment, but I do not believe interventions were imposed because of the concept per se.

**Lessons Learned**

49. In addition to the areas covered above, I believe that work in Wales and elsewhere has promoted awareness and understanding of what risk communication and behavioural insights can offer in responding to emergency situations and public policy more broadly. Ideally a move far beyond shaping public communications and the provision of specialist advice, toward considering how best to create behaviourally informed organisations is now needed. Widespread knowledge, skills, systems and processes that support the routine (and early, in the case of outbreaks/incidents) consideration of the determinants of behaviours, across differing population groups, would help shape development of effective responsive activity.

50. There is a need to ensure risk communication and behavioural insights are integrated into future emergency preparation and response activity (from the start) – particularly in an increasingly volatile, uncertain, complex and ambiguous world.

51. There is value in exploring how to best develop risk literacy in the population – building wider understanding in-general of consequences (outcomes) and chance (probabilities) associated with actions (or in-actions). This broader understanding could support people further in making risk-informed decisions in their daily lives, including at times of public health emergency.

52. Retaining and enhancing the collaborative working relationships developed during the pandemic, including through/around TAG and RCBI, for routine decision making and future emergencies has clear utility.

**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**: 31.10.23