Witness Name: Robin HOWE
Statement No.: First
Exhibits: 1-34
Dated: 20th October 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF Robin HOWE

I, Robin HOWE, will say as follows: -

Background

1. I have been a Consultant Microbiologist since 2001 and worked within Public Health Wales and its predecessor organisation since January 2005. In the latter role I have been involved in the public health response to many communicable diseases both within hospitals and in the community.
2. I had only peripheral involvement with SARS-CoV-1.
3. I was involved in the development of the arrangements to deal with the potential importation of MERS- CoV. My involvement was mainly to ensure that there were appropriate safe procedures in place for safe transport of samples for testing and appropriate testing algorithms in place across the Public Health Wales network.
4. As a Clinical Microbiologist, I have advised on individual cases of infection with seasonal coronaviruses.

Policy Advisory Groups

5. I was a number of a number of groups supporting the policy and operational elements of the Test, Trace & Protect (TTP) programme including:

- TTP Programme Board
    - My involvement in this group commenced in May 2020.

- TTP Oversight Group
    - My involvement in this group commenced in May 2020.
- TTP Testing Group
    - This was established on 21st March 2020 and stood down on 9th July 2020
    - This group was established to oversee work to establish an All Wales Covid-19 Testing Network to coordinate and deliver the strategic and operational activities required for the successful implementation of the Test, Trace and Protect strategy.
- TTP Testing Strategy sub-Group
    - This was established on 27th August 2020 and stood down on 17th December 2020
    - This group was established to set the direction to ensure the Testing Strategy was met across workstreams and task and finish groups.
- Testing Clinical Advisory & Prioritisation Group (TCAP)
    - This was established on 21st October 2020 and continues currently.
    - This group was established to provide clinical expertise into the national Covid-19 Testing Programme.
    - The purpose of TCAP was to, "… advise on new and existing policies for clinical scrutiny and any new testing being proposed. This group will review new and existing policies and, in keeping up to date with developments, the group will look to explore different testing programmes, utilising management information and trends in developing these. The group will also help in assessing responses to testing capacity and management."

Additional groups included:

- Social care testing and infection control strategy and policy development group.
    - This was established in November 2020.
    - The purpose of this group was to provide a forum to co-ordinate clinical, social care sector and operational intelligence to inform the effective

design and implementation of testing and infection control strategy and policy for social care.

- Nosocomial Transmission Group Wales, chaired by Deputy Chief Medical Officer for Wales
    - I was not a member of this group but was invited to meetings to advise on testing matters such as asymptomatic patient testing, asymptomatic staff testing, symptomatic staff testing, or the role of testing in enabling release of patients or staff from isolation.

Incident Director

6. I became an Incident Director alongside my colleague Dr Giri Shankar (Director of Health Protection Services) in February 2020. Our initial selection as Incident Directors was largely based on the leadership roles that we were carrying at the time of the start of the pandemic. As it became clear that the pandemic was going to be protracted, we drafted in additional colleagues, Dr Chris Williams (Head of Public Health Wales Communicable Disease Surveillance Centre), and later Dr Eleri Davies (Deputy Medical Director, Public Health Wales, and Head of the Healthcare associated Infections, Antimicrobial Resistance & Prescribing Programme (HARP), Public Health Wales).

7. The initial role was as described in the Public Health Wales Emergency Response plan (Tactical Incident Director). **[EXHIBIT RH/1 INQ000089558]**

Director of Infection Services

8. I was appointed to the new role of Director of Infection Services in April 2022 follow a restructure of the management arrangements in the Health Protection and Screening Services Directorate within Public Health Wales. Prior to this I was in a very similar role as National Clinical Lead for Microbiology Services from 2014.

9. The role was/is to provide overall clinical leadership for Public Health Wales Microbiology Service. The title changed in 2021 to recognise the fact that Division included Clinical Microbiology services and Infectious Diseases, as well as Diagnostic services.

TAG and its Subgroups

10. I was a member of the Children and Education and Testing subgroups of TAG, although my involvement in the Children & Education sub-group was limited to discussions involving testing for SARS-CoV-2.

11. I was Chair from the establishment of the Testing subgroup of TAG (subsequently Virology & Testing TAG (VT-TAG)) on 18th June 2020 until it was stood down in May 2022.

12. I was invited to undertake the role of Chair by Dr Rob Orford, Chief Scientific Adviser for Health in Welsh Government.

13. My expertise in respect of chairing this group was from considerable experience of leadership and delivery within Microbiology, experience of designing pathways for testing, diagnosis and management of infections, and experience in chairing multidisciplinary groups.

14. VT-TAG had some variation in scientific membership during the course of the pandemic, but essentially had 10 members from outside Welsh Government. There was a core of 6 non-governmental members who attended and input consistently. At some meetings there were as many of 10 representatives from Welsh Government; a mixture of policy and scientific colleagues. This occurred because colleagues in Welsh Government could invite colleagues into the meetings which were held remotely.

15. I think there is/was benefit in policy and governmental colleagues being present at the VT-TAG discussions, in order to understand the strength of scientific evidence or consensus on difficult areas of uncertainty. However, I think they should generally be present as observers, except for individuals who might be bringing a specific commission.

16. My role as chair of the group was to ensure where possible that the group had appropriate scientific membership for the subjects under consideration, set the agenda, clarify, and agree commissions to the group,

17. The challenge was to frame commissions into scientific questions, and advice into scientific advice rather than policy advice.

18. The questions coming to VT-TAG tended to be posed by policy or advisory colleagues working within Welsh Government.

19. Questions could be raised in a number of contexts, including informal discussions, policy or operational advisory meetings or through the wider TAG.
20. I found that the main challenge in chairing VT-TAG was to ensure that the discussions and outputs from VT-TAG were focused on science rather than policy. This was often difficult since I, along with other scientific colleagues were spending significant time in policy or operational meetings with the same policy colleagues from Welsh Government who would attend VT-TAG. It was therefore a challenge to differentiate the discussion in VT-TAG from similar discussions in other fora, and to ensure that there was an appropriate scientific focus.
21. The questions would often initially be expressed as policy questions rather than scientific questions. For example, the initial question might be, "What policy should we have regarding discharge of patients from hospitals to care homes?" This would be refined through discussions within VT-TAG and with Welsh Government colleagues to establish the scientific questions that could be addressed by the VT-TAG. These included determination of the infective period of individuals following SARS-CoV-2 infection, their infectivity throughout that period, and the performance of different available diagnostic tests. Elements that were outside the expertise of the VT-TAG membership, such as the non-covid health benefits or otherwise of remaining in hospital or being discharged, were left to other groups.
22. In describing the science of SARS-CoV-2 infections and testing, VT-TAG endeavoured to describe risk (e.g., of individual infectivity or false negative results) so that policy makers could then balance that risk against others.
23. VT-TAG then produced guidance on the infectivity of COVID-19, testing criteria for discharge of asymptomatic patients to care homes.
24. VT-TAG was able to frame the questions to some extent, but the group was primarily answering queries from policy makers.
25. VT-TAG was able to develop advice that had not been specifically sought, although this was limited by time resources.
26. An example of advice that was internally commissioned and produced by VT-TAG was the "Guidance for assessing the Potential for New Technologies to improve SARS-CoV-2 diagnostic testing" that was published by TAG on 19th October 2020.
27. The TAG included intelligent experts from many diverse areas. This diversity could sometimes be a challenge as experts in other fields might comment on issues beyond their professional expertise. I think it was/is part of their role to provide

scientific challenge to information/papers delivered by subject matter experts. The subject may be outside their expertise, but this should not preclude challenge and discussion. However, it is not appropriate that colleagues should promote advice outside their areas of expertise. This can be a fine line, and perhaps should be explicit within the group Terms of Reference or Rules of Engagement.

28. In my opinion there was an appropriate amount of challenge in TAG and VT-TAG.
29. There were occasions when subjects presented at TAG would have benefitted from prior discussion in VT-TAG. One example was when modelling colleagues presented modelling for a number of non-SARS-CoV-2 respiratory viruses to the main TAG. It was not clear that all elements of known viral behaviours had been taken into account, and experts on viral dynamics and seasonal molecular epidemiology felt that a discussion outside the wider TAG would have been helpful.
30. There was no regular or substantive formal feedback downwards from the work of TAG. However, I was aware through other channels that the advice was taken into account by policy makers. In my opinion, there was sufficient feedback on the advice provided from VT-TAG.
31. All of the papers that were prepared in VT-TAG were ultimately published by TAG. My impression was that the work directly influenced policy.
32. It felt there was unequal access to information (compared to colleagues in England) or to emerging policy. There was sometimes very short notice that England was planning to change a policy and then there was a need to establish the potential scientific basis for any potential changes and to prepare to react rather than influence the decision.
33. There was limited membership of SAGE available for TAG and I did not have access to SAGE meetings. I did have access to some SAGE papers.
34. I do not know what involvement colleagues from TAG had in SAGE meetings, or the degree of challenge they gave.
35. Personally, I found it disadvantageous that I was not a member of SAGE, as described below. I particularly experienced a challenge due to lack of access to SAGE meetings when there were discussions regarding the shortening of self-isolation periods in December 2021/January 2022.
36. At this time UKHSA modelling was presented to SAGE to show the impact of different durations of isolation and different testing strategies. I and VT-TAG colleagues were asked for similar work to support potential shortening of self-

isolation. Unfortunately, the papers that could be accessed from SAGE did not give sufficient detail to reproduce the models and analysis. A de novo model had to be constructed which gave qualitatively similar outputs but was different in detail. Attendance at SAGE would have enabled clarification and challenge of the UKHSA model and potentially saved resource and time in the construction of a de novo model.

37. Two members of VT-TAG were observers at NERVTAG; Dr Rachel Jones, Clinical Lead for Virology, Public Health Wales, and Dr Catherine Moore, Consultant Clinical Scientist, Wales Specialist Virology Centre.
38. Dr Jones joined as an observer in April/May 2020, and Dr Moore took over in June/July 2020.
39. I think it was helpful to have observers on NERVTAG to have exposure to wider discussions in that group regarding potential developments in the pandemic and diagnostics.
40. I understand from my colleagues, that as observers, they did not get access to all papers and were not able/encouraged to speak in meetings.
41. At different stages of the pandemic, I experienced a multiplicity of requests for information, although this was not in the context of VT-TAG.
42. I faced a multiplicity of requests to explain VT-TAG advice and diagnostic test performance by policy colleagues leading on many different areas. I suspect this was unavoidable as Diagnostic testing and test performance were new concepts for many colleagues in Welsh Government at the start of the pandemic.
43. I think the potential strength in CSA(H) and CMO(W) being the direct interlocutors with policymakers is/was that ministers would have digested and summarised advice. The potential weakness would be the challenge for colleagues to accurately express levels of uncertainty or consensus. I was not aware of delays caused by this procedure
44. .I am not clear what levels of experience of pandemic planning and response would be expected or required from the membership of TAG. I would have expected that the pandemic planning and response would sit outside the TAG and that the purpose of the TAG was to provide scientific knowledge, analysis and expertise to support those groups coordinating the response.
45. I think the roles within TAG and its subgroups were clear.
46. The Testing TAG role was described in its Terms of Reference as, "The testing sub-

group of the Technical Advisory Group (TTAG) exists to give detailed and strategic consideration to the scientific and technical evidence on COVID-19 as it relates directly to testing. It provides a steer to the wider Technical Advisory Group (TAG) on this area, and specific advice to policy makers as appropriate. It also ensures that key research questions are fed into the TAG and SAGE."

47. The VT-TAG roles were refined to:

- "Give detailed and strategic consideration to the scientific and technical evidence relating directly to virology and testing, with the focus on the SARS-CoV-2 virus.
- To provide a steer to the wider Technical Advisory Group (TAG) on this area.
- To provide specific advice to policy makers as appropriate.
- To provide mutual support to its members when they are asked to provide advice on subjects within the scope of the group.
- To contribute to the identification of key research questions to be fed into the TAG and SAGE."

48. My requirement for support was primarily for chairing VT-TAG. Welsh Government supported with secretarial support and a scientific adviser who played a key role in coordinating activities of the group.
49. I think that where there was divergent opinion, there was discussion to explore the different opinions. My impression was that after discussion, the divergence was expressed through the strength and confidence of recommendations using a similar scale to SAGE.
50. I was not a member of any WhatsApp or similar messaging groups with Welsh Ministers, senior advisors, or civil servants.

<u>The early stages of the pandemic</u>

51. I first became aware of undiagnosed pneumonia in Wuhan professionally on 7th January 2020. A colleague had joined a Public Health England situational awareness update and circulated a synopsis of the discussion.
52. I did not provide guidance to core decision-makers in the Welsh Government in January and February 2020 concerning the threat posed by Covid-19.
53. From 29th January 2020, I joined the Public Health England Wuhan Incident Management Team meeting with colleagues from Public Health Wales. This meeting was renamed as "IMT meeting-2019-nCoV" from 26th February 2020.

54. When I attended these meetings, I gave updates on elements of the situation in Wales and could raise issues for clarification.
55. I did not have any direct liaison with WHO or other international organisations during January/February 2020.
56. Asymptomatic transmission received significant attention throughout the pandemic, but I do not think that it was clearly defined or described.
57. In January 2020, as SARS-CoV-2 started to spread outside China, I did not have specific knowledge about asymptomatic transmission but assumed that SARS-CoV-2 would act similarly to other respiratory viruses. I expected that infected patients may be infectious for a period of 1-2 days prior to the recognition of symptoms, and then be at peak infectivity for the first few days of symptoms before infectivity waned.
58. On 29th January 2020, a paper was published by the Public Health England Virology Cell. This concluded that, "…*The currently available data is not adequate to provide evidence for major asymptomatic/subclinical transmission of 2019nCoV. Detailed epidemiological information from more cases and contacts is needed to determine whether transmission can occur from asymptomatic individuals or during the incubation period on a significant scale."* **[EXHIBIT RH/2 INQ000276044]**
59. During February and March 2020, there were a number of case reports, published, or otherwise that described transmission from asymptomatic individuals. As individual case reports, these did not immediately register as a particular concern, since pre-symptomatic transmission was to be expected. There was also some uncertainty as to the definition of 'asymptomatic' in different reports. During this time, we had a case definition in the UK which defined COVID infection through the triad of new continuous cough or fever or loss of/ change in smell or taste. However, many people with COVID had a range of other symptoms and might not have fulfilled this definition. During February/March 2020, it was initially unclear whether reports of asymptomatic infection/transmission were truly asymptomatic or just not fulfilling the case definition.
60. By the end of March 2020, it was becoming clear that asymptomatic infection did occur and transmission from these individuals could be a significant factor in spread of SARS-CoV-2.
61. During the period January to March 2020, I was primarily leading on the development of laboratory testing infrastructure and advising on sampling.

62. I was not involved in any discussions around the Stereophonics concerts.
63. Regarding the Scotand vs Wales rugby match, my recollection is that Vaughan Gething, as Health & Social Services Minister, visited Public Health Wales on 12th March 2020 (2 days before the Wales/Scotland match). There was an informal chat that morning including the Minister, Tracey Cooper (Public Health Wales Chief Executive) and myself that included discussion about the coming game. Again, from my recollection, it was acknowledged that there was uncertainty that the event itself would pose a significant risk, but concern about the risk related to the significant numbers of people travelling to Cardiff and the impact of crowding in pubs etc. Overall, it was recommended to postpone/cancel the match, but the Minister suggested that the Welsh Government position remained for the game to proceed.
64. At the time, there were more than 300 cases identified in England and 6 cases identified in Wales. However, there was significant concern that the true case numbers were higher due to testing and reporting delays. My view at the time was that the major risk from an event such as the Wales Scotland rugby match would be caused by spread during the many hours of travel on crowded public transport or hours in crowded pubs rather than necessarily the limited time that the crowd would have been within the stadium. It was therefore my view that the match should have been cancelled prior to the public travelling to the event.
65. I have not altered my view, and still think that the match should have been cancelled prior to public travel.

The timing of the first national lockdown

66. I think that a national lockdown was necessary. At the start of the pandemic, the immune naivety of the population and the characteristics of the SARS-CoV-2 virus meant that there was rapid transmission of infection and associated significant morbidity and mortality.
67. In order to slow transmission and thereby reduce morbidity and mortality there was a need to reduce the mixing of infectious individuals with the rest of the population. In the absence of significant asymptomatic transmission, there would have been alternative options based on the isolation of symptomatic individuals. However, there was concern regarding the implementation and compliance to such a plan,

and concern of a lack of efficacy if there was significant asymptomatic transmission. Thus, I think there was no viable alternative to a national lockdown to reduce transmission.

68. From the sole perspective of controlling the speed of spread of the virus, an earlier national lockdown would have been more effective. It would have been difficult, particularly in border areas, to implement without a similar approach in the other UK countries.
69. My impression was that the advice recommending a national lockdown came primarily from UK groups rather than from those advising the Welsh Government.
70. I was not involved in discussions with policymakers at that time regarding the timing of introductions of NPIs and cannot comment on potential 'groupthink'.
71. My view at the time was that NPIs would be less effective if introduced gradually. My impression was that the public make individual assessments of the various NPIs and some would pick holes in perceived inconsistencies and comply according to individual assessment. I do not think that there was sufficient discussion about public health risk as opposed to personal risk.
72. There were a number of factors influencing the timing of the first national lockdown, including social, behavioural, and financial issues. These were/are outside my expertise.
73. As noted above, my view at the time and now is that an earlier lockdown would have been more effective with respect to the control of COVID.
74. In my opinion, if the lockdown had been implemented sooner, there would have been less mixing of individuals and thereby a slowing of the spread of SARS-CoV-2. It is uncertain whether the slower spread of SARS-CoV-2 would have resulted in fewer cases of COVID in the first wave of infections, but I think it most likely that the peak in numbers of infections would have been later and lower. I think it most likely that a delayed and lower peak in infections would have enabled service, including the NHS, to cope better. I think the later and lower peak would have been associated with lower mortality.

April 2020 onwards

75. I think the high-level aims of Welsh Government were probably clear to members of TAG following the implementation of the first lockdown.
76. Welsh Government published 'Leading Wales out of the coronavirus pandemic' on

24th April 2020 which gave high level principles for the COVID response. This document described the '4 harms' from COVID (firstly, through direct harm to individuals from SARS-CoV2 infection and complications including for those who develop severe disease and in some cases sadly die as a result; secondly, the harm caused if services including the NHS became overwhelmed due to any sudden large spike in demand from patients with COVID-19 on hospitals, critical care facilities and other key services; thirdly, harms from non-COVID illness, for example if individuals do not seek medical attention for their illness early and their condition worsens, or more broadly from the necessary changes in NHS service delivery made during the pandemic in Wales to pause non-essential activity; fourthly, socioeconomic and other societal harms such as the economic impact on certain socioeconomic groups of not being able to work, impacts on businesses of being closed or facing falling customer demand, psychological harms to the public of social distancing and many others). A fifth harm was subsequently added regarding harms arising from the way COVID-19 has exacerbated existing, or introduced new, inequalities in our society.

77. The harms from COVID, and the aim to reduce them were frequently referenced in TAG.
78. I was aware, as a member of the public, of varying compliance with NPIs determined by individual or group interpretation of evidence or media-messaging.
79. I was aware that compliance and 'behaviour fatigue' were factors considered by policy-makers.
80. Advice that I gave regarding testing strategies in various settings did not deal with behaviour fatigue.
81. I am not aware that the issue of discharge of asymptomatic patients without testing was discussed in TAG during March or April 2020.
82. I was asked, as chair of VT-TAG to provide advice on this in August 2020. The group developed advice that was published by TAG on 11th August 2020. **[EXHIBIT RH/3 INQ000276045]**
83. I became aware of the fact that patients were being discharged from hospitals in to care homes without testing for COVID-19 on 22nd March 2020 through a forwarded email from a colleague in Public Health England that referenced the fact and that this was Public Health England policy. **[EXHIBIT RH/4 INQ000276043]**
84. Subsequently, on 26th March 2020, I had a draft of "Guidance for discharging

COVID-19 patients from hospital to home or residential settings (COVID-19)" shared by Public Health England. This draft guidance did not recommend testing prior to discharge**. [EXHIBIT RH/34 INQ000308696]**

85. At the time, I was content with the advice for discharge of patients to care homes without prior testing for SARS-CoV-2. The guidance recommended that service users should be asymptomatic and should be isolated for 14 days following transfer to a care home. Given the dynamics of infection and infectivity as understood at the time and subsequently, I think this was a reasonable approach and did not challenge it. If service users were asymptomatic, they had either not contacted SARS-COV-2 or had had infection or were incubating infection. For those who had had infection, the duration of infectivity was generally up to 14 days and so they should have been non-infectious by the end of their quarantine period. For those who may potentially have been incubating infection, the incubation period of 4-6 days would have meant that they would develop infectivity by Day 6 following admission to a care home, while they would by in isolation and then be infectious for approximately 8 days (during isolation). Fewer than 10% of patients were infectious 8 days after onset of symptoms.
86. A policy of testing prior to discharge was introduced on 22nd April 2020.
87. From the perspective of controlling the spread of SARS-CoV-2, I think the Eat Out to Help Out Scheme was ill-conceived. The scheme seemed to actively encourage intermixing of individuals and added the context of food and alcohol that might compromise healthy behaviours. I am not aware that TAC was consulted on this scheme, and I did not advise on this scheme.
88. I did not give personal specific advice on NPIs but was involved in the production of Advice Notes from Public Health Wales to the Chief Medical Officer to Wales. These are listed in the table below. I was particularly involved in terms of drafting or significant input in Advice Notes 16, 21, 24, 26, 29.

Exhibit No.	INQ No	Advice Note	Date
RH/5	INQ000056301	Possible next steps in COVID-19 response	12/10/2020

Exhibit No.	INQ No	Advice Note	Date
RH/6	INQ000056300	Possible next steps in COVID-19 response	24/10/2020
RH/7	INQ000068154	Record of advice from Public Health Wales	05/11/2020
RH/8	INQ000068155	Possible next steps in COVID-19 response	07/12/2020
RH/9	INQ000056302	Post-Christmas next steps in COVID-19 response	11/12/2020
RH/10	INQ000056304	Christmas period 2020 and response to the Coronavirus Control Plan for Wales	15/12/2020
RH/11	INQ000056306	COVID-19 epidemiological update and restrictions	14/01/2021
RH/12	INQ000056311	COVID-19 epidemiological update and return to school & education	22/01/2021
RH/13	INQ000056331	Risk communication	08/02/2021
RH/14	INQ000056312	Covid-19 epidemiological update and easing of restrictions	10/02/2021
RH/15	INQ000056327	International Travel	09/03/2021
RH/16	INQ000056328	International Travel	16/04/2021
RH/17	INQ000191773	Additional Targeted vaccination	09/06/2021
RH/18	INQ000056313	Variation of NPI for vaccinated individuals	06/07/2021
RH/19	INQ000056314	Control Measures for Alert Levels 0 and 1	07/07/2021
RH/20	INQ000056329	Moving towards recovery for COVID response	16/07/2021
RH/21	INQ000056324	Management of COVID outbreaks and incidents in care homes	19/07/2021
RH/22	INQ000056317	Exceptions to self-isolation guidance for vaccinated individuals	22/07/2021
RH/23	INQ000056335	Management of COVID clusters in educational settings	25/08/2021
RH/24	INQ000056330	Ongoing control of COVID during recovery	08/09/2021

Exhibit No.	INQ No	Advice Note	Date
RH/25	INQ000056336	Respiratory virus testing for winter	16/09/2021
RH26	INQ000056325	Recommendations for Care Homes Autumn - Winter 21/22	23/09/2021
RH27	INQ000056305	NPIs during COVID Urgent	01/11/2021
RH28	INQ000056315	Reduction in isolation period supported by LFD testing for cases of COVID-19	24/12/2021
RH29	INQ000068176	Impact of vaccination on infection and transmission of SARS-CoV-2	18/01/2022
RH30	INQ000056316	Reduction in isolation period supported by LFD testing for cases of COVID-19	20/01/2022
RH31	INQ000068178	Wider impacts of COVID on 5-11-year olds in Wales	19/01/2022
RH32	INQ000068179	Management of COVID in Care Homes - Alert level 0	19/01/2022
RH33	INQ000068180	Hospital Testing for SARS-CoV-2	16/02/2022

89. I do not have the details of what other factors (e.g. economic) were taken into account by Welsh Government when reviewing the advice from TAG in September/October 2020 to re-introduce NPIs, and so I don't know what weight was put on these as opposed to the TAG advice.

90. From the perspective of controlling the spread of SARS-CoV-2 , I think the advice from TAG was appropriate.

91. In my opinion, if the firebreak and third national lockdowns had been implemented sooner and for a longer period they would have had a greater effect in terms of slowing the spread of SARS-CoV-2 and would have reduced morbidity and mortality.

Children and Education subgroup

92. I believe the Children and Education subgroup of TAG was established on 5th May 2020.

93. I presume it was established to advise on interventions involving Children and

Education, and their impact.

94. I was only involved in advising around testing options for this group.
95. I think I had appropriate access to the data/information required for my role in this group.

Communication of Scientific Advice

96. I do not know why TAG did not publish its advice prior to May 2020.
97. All of the papers developed by the VT-TAG were presented at TAG and subsequently published on the TAC website.
98. I think that 'following the science' blurred the boundaries between scientific advice and decision-making. This was compounded by selective reporting of science to support policy decisions. There was extensive reporting of the numbers and modelling of COVID infections, but little about the modelling of compliance with NPIs, or economic, or wider health impacts of COVID and the COVID control measures.
99. I think there was a, perhaps understandable, wish to manage the messaging of scientific advice, both reassure the public and also to promote acceptance and compliance with the various interventions.

Lessons Learned

100. My impression was that TAG and its sub-groups were effective in informing decision-making, particularly as it became more established from around May 2020.
101. I think that TAG could have established sub-groups, such as VT-TAG earlier in the pandemic.
102. I think more time in the main TAG could have been spent on agenda-setting, both for the main TAG and the sub-groups.
103. I think that there could be benefit from a central scientific evidence collation/cataloguing resource. During 2020-22 there was an enormous amount of scientific and other literature published or shared. It was then almost impossible for individuals to keep up with new evidence. In the VT-TAG, the key membership had other responsibilities such as managing the Public Health Wales response, rolling-

out SARS-CoV-2 testing across Wales, delivering a clinical service, developing and delivering a comprehensive genomic service. Someone to collate and catalogue scientific publications so that VT-TAG members could easily access and assess the evidence would have been very helpful.

104. As noted above, I think that improved agenda-setting and the establishment of sub-groups earlier would help. I think that this potentially would lead to additional areas for advice. For example, when considering key worker status for prioritised testing in March/April 2020, there could have been advice collated through a sub-group from potential key-worker groups as to the implications of restricting their working. Similarly, I assume that there was expert advice regarding the economic implications of different intervention, but this was not apparent through the TAG process.

105. I think the public should be more engaged with the development of pandemic policy and this should improve the public trust in the Government's response. The response to the COVID pandemic has required significant sacrifice for society and individuals. I think prior engagement with community representatives would be helpful to establish societal consensus about the difficult questions of how much different societal cohorts should sacrifice for other cohorts.

106. I think that there should be engagement with a wide range of sections of society (geographic, socioeconomic, age, ethnicity, faith) in the development of some key principles in a pandemic plan.

107. During a pandemic, there should be active consideration of equity and equality and engagement with different groups when potential issues are identified.

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: ___20th October 2023