Witness Name: Dr Christopher David Johnson
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF Dr Christopher David Johnson BSc(Hons) MPH MFPH

I, Christopher Johnson, will say as follows: -

Professional Qualifications and Experience Prior to January 2020

1. I am a non-medical Consultant registered as a Public Health Specialist with the United Kingdom Public Health Register (Registration number FR0837). I was admitted to the register in 2016, and my most recent revalidation was in 2021. I am also a member of the Faculty of Public Health (MFPH) and up to date with all requirements for continuing professional development.

2. My public health training included knowledge of disease causation and the diagnostic process in relation to public health, including the epidemiology of disease of public health significance and the response to cases and outbreaks of these diseases.

3. I qualified in August 2016, and was admitted to the UK public health register. In January 2017 I was appointed to the substantive position of Consultant in Health Protection within the Health Protection Division of Public Health Wales.

Role of the Health Protection Division in Public Health Wales

4. The Health Protection Division (Health Protection Team) within Public Health Wales was part of the Public Health Services Directorate (later Health Protection and Screening Services Directorate). The team reported to the professional lead

Consultant in Communicable Disease Control (CCDC), and were responsible for delivery of an acute health protection services for Wales including:

a. Public health response to cases, clusters and outbreaks of communicable disease
b. Provision of specialist health protection advice
c. Participation in regional emergency planning and response structures

My role as Consultant in Health Protection in the Health Protection Division Public Health Wales

5. My general roles and responsibilities were:
    a. To lead the response to cases and outbreaks of communicable disease
    b. Provide specialist advice to key stakeholders, in areas such as emergency planning, infection prevention and control, and management of infectious diseases.
    c. Contributing to the delivery of a 24hr a day 7 day per week Health Protection service

6. As part of my role I was appointed as Proper Officer for the 22 local authorities in Wales and the Swansea Bay Port Health Authority for the discharge of local authority or port health authority statutory functions in respect to the control on infectious diseases pursuant to:

    a. The Public Health (Control of Disease) Act 1984 (as amended):
    b. The Health Protection (Notification)(Wales) Regulations 2010
    c. The Health Protection (Local Authority Powers)(Wales) Regulations 2010
    d. The Health Protection (Part 2A Orders)(Wales) Regulations 2010
    e. The Public Health (Ships) Regulations 1979 (as amended):
    f. The Public Health (Aircraft) Regulations 1979 (as amended):
    g. The International Health Regulations 2005; and,
    h. Any other legislation related to the control of communicable disease

7. My specific responsibilities included:
    a. Named Lead Consultant for Powys Teaching Health Board Area.

b. Attending Dyfed Powys Local Resilience Forum.
c. Health Protection Lead for Zoonotic Infections
d. Health Protection Team lead for Tarian and co-chair of the Tarian Change Advisory Board (Tarian is the Public Health Wales Health Protection Case and Incident Management System)
e. Additional capacity for Betsi Cadwaladr University Health Board area

8. Prior to January 2020 I had no specific experience with specific coronavirus outbreaks, but had some experience in control measures around MERS. I was responsible for chairing the outbreak control teams (OCT) and leading the investigation into cases and outbreaks of other communicable disease in line with the Communicable Disease Outbreak Plan for Wales **[EXHIBIT CJ/1 – INQ000089575]** and making recommendations for prevention of future outbreaks. At the time the pandemic started I had experience leading the multiagency response to several significant outbreaks.

Membership of messaging groups

9. During this period of interest from 21 January to 31 May 2022 I was not part of any WhatsApp or messaging group with Welsh Ministers, senior advisors or civil servants

Pandemic Response as Consultant in Health Protection - 21 January 2020 to 1 August 2021

10. Between 21 January and 1 August 2021 I continued in my pre-pandemic role as Consultant in Health Protection (CHP), and took on additional responsibilities including providing technical health protection advice on the development and delivery of the NHS Wales Test Trace Protect service.

11. Although most work as a consultant in Health protection for supporting North Wales and Powys was focused on specific outbreaks, I also provided advice on one occasion directly to ministers. On Saturday 10 October 2020, I was asked to provide advice directly to the First Minister and Minister for Health and Social

Services who were considering the imposition of local health protection measures for the county of Gwynedd. On this occasion, Welsh Government did not issue local health protection measures on a county wide basis but did so for the City of Bangor only. **[EXHIBIT CJ/2 INQ000226071 , EXHIBIT CJ/3 INQ000226090, EXHIBIT CJ/4 INQ000226098, EXHIBIT CJ/5 INQ000226099, EXHIBIT CJ/5a INQ000226100, EXHIBIT CJ/6 INQ000226101, EXHIBIT CJ/7 INQ000226103, EXHIBIT CJ/8 INQ000226104]**

Role of incident management teams / Outbreak control teams for specific outbreaks, my role in them and their interaction with TAG and TAC

12. Incident management teams (IMTs) and Outbreak Control Teams (OCTs) are multiagency strategic groups established for the purpose of investigating and controlling outbreaks of communicable disease.

13. As the Consultant in Health Protection supporting the response in North Wales and Powys I was responsible for supporting IMTs and OCTs for clusters and outbreaks of COVID-19, other communicable diseases in the North Wales and Powys. These included, but were not limited to,
    a. Two Sisters Factory cluster, Anglesey (June/July 2020)
    b. Rowan Foods, Wrexham (June/July 2020)
    c. Wrexham Maelor Hospital, Wrexham (July / August 2020)
    d. Sidolis, Welshpool (September 2020)
    e. Operation Eagle, Holyhead (March / April 2021)
    f. St Davids College, Llandudno (March 2021)

14. These responses required significant partnership working with Local Health Boards and Local Authorities to achieve the outcomes required. Early in the pandemic response I chaired IMT/OCTs, however, as the number of outbreaks increased it was often necessary to ask others to chair meetings, and to provide advice only. These IMTS/OCTS were collectively responsible for leading the management of the response to the individual clusters including provision of testing, and recommendations such as site closure. I do not recall high level scientific advice from TAC or TAG directly playing a significant part in the local

decision about clusters. General evidence on transmission and incubation, and the impact on control measures, etc., which was generated by SAGE, TAG and TAC will have informed the response recommendations, but through case definitions rather than directly. I also do not recall the OCTs providing advice directly to TAG or TAC however, as OCT chair I did contribute to briefings for Chief Medical Officer for Wales and lessons learned exercises which will have fed into general situational awareness and intelligence. **[EXHIBIT CJ/9 INQ000226105, EXHIBIT CJ/10 INQ000226055]**

Role of Welsh Government COVID-19 Intelligence Group and my role in it

15. COVID-19 Intelligence Group was led by Welsh Government's CMO's office and allowed all Public Health Wales Consultants in Communicable Disease Control and the Consultants in Health Protection to discuss the situation in their local area and feedback on common themes from cases or outbreaks of infection. This group met twice weekly.

16. As a Consultant in Health Protection, I fed back on incidents and other intelligence from the North Wales and Powys region.

17. As this group fed intelligence into the Welsh Government I do not believe that it received advice from TAC, TAG or its subgroups. I am not aware of how intelligence shared at this meeting would have fed into TAC or TAG advice or the commissioning of such advice.

Role of Welsh Government Test Trace Protect Programme Board, its interaction with TAG/TAC and my role within it

18. Welsh Government Test Trace Protect Programme Board was a group established by Welsh Government to provide strategic leadership and governance to the Test Trace Protect service. It was led by Welsh Government

19. As a result of the technical advice I had provided to the design of the NHS Wales Test Trace Protect service, and the Customer Relationship Manager (CRM) software which underpinned contact tracing at scale, I was a member of the board.

I was one of a number of members from Public Health Wales, including the professional lead consultant in communicable disease control and professional lead microbiologist. My role was to provide specialist technical advice on health protection.

20. I am not aware of the extent to which discussion at Test Trace Protect Programme Board directly informed discussion at TAG/TAC or visa versa. Several members of Programme Board were also members of TAG/TAC, but I was not.

21. To illustrate the nature of my advisory role on the board, on 12 April 2021 I presented a paper to the Programme Board on testing of contacts in the context of ongoing asymptomatic testing programmes. The paper was discussed by the board and the board agreed to the recommendations. **[EXHIBIT CJ/11 INQ000226056, EXHIBIT CJ/12 INQ000226057, EXHIBIT CJ/13 INQ000226058]**

22. Additional papers I contributed technical advice to for this group included
    a. PHW SBAR – Enhanced contact tracing (Sept 2020) **[EXHIBIT CJ/14 INQ000226059]**
    b. PHW Operationalising Test and Release Policy within Contact Tracing CRM (Oct 2020) **[EXHIBIT CJ/15 INQ000226060]**
    c. PHW Contact Tracing in a Population Screening Environment (Nov 2020) **[EXHIBIT CJ/16 INQ000226061]**
    d. PHW Contact tracing implication of test and isolate policy (Nov 2020) **[EXHIBIT CJ/17 INQ000226062]**
    e. PHW Professional Advice on public health action based on negative results from Lateral Flow Devices (December 2020) **[EXHIBIT CJ/18 INQ000226063, EXHIBIT CJ/18a INQ000226064]**
    f. COVID-19 Phase 3 Case Finding and Contact Tracing: Operating framework **[EXHIBIT CJ/19 INQ000226066, EXHIBIT CJ/19a INQ000226069, EXHIBIT CJ/19b INQ000226070]**

Issues, obstacles or missed opportunities in relation to information sharing, access and communication and coordination with TAC, TAG and SAGE

23. I think that information sharing, access to intelligence and information and communication between the groups in Wales was effective given the pace of the response.

24. In earlier evidence I stated that I believe "*it sometimes felt like the ability of groups to maximise effective operation was sometimes handicapped by unequal access to information or to influence the timing of actions which had an impact on all four nations*" [INQ000183826]. Where this was most evident was in areas that where we wanted to influence at a four nations level.

25. To illustrate this, I highlight two areas where barriers existed to influencing decisions in England and mitigating the impact of them in Wales.

26. In March 2020 I was asked to provide a technical health protection perspective in my role as a Consultant in Health Protection to the Public Health Wales digital cell. This cell was led by a Consultant Epidemiologist and was providing advice to Public Health Wales and Welsh Government on digital issues including data sharing. The cell was requested to contribute a technical view to a Ministerial Advice Note on the use of the NHSX COVID App as part of a population contact tracing solution in Wales. **[EXHIBIT CJ/20 INQ000226074, EXHIBIT CJ/21 INQ000226078, EXHIBIT CJ/22 INQ000226079, EXHIBIT CJ/23 INQ000226080, EXHIBIT CJ/24 INQ000226081, EXHIBIT CJ/24a INQ000226082]** Concerns about this approach were very difficult to address as specific queries regarding the App had not been answered fully or clearly by Public Health England and that plans for the NHSX App continued at pace without sufficient engagement with Wales despite efforts by Public Health Wales, Welsh Government and NHS Wales Informatics Service (NWIS).

27. This problem persisted as evidenced in conversations on 22 May 2020 which state "*However the technical detail is missing and comms with PHE is slow. They are I think completely overstretched. We need to understand properly where they are on the different tracing options and feed requirements above, and we need to know how the information flows in and out of CTAS as soon as possible. Then we can advise Ministers on whether this is achievable. And then we need to develop and test feeds from and to Wales.*". **[EXHIBIT CJ/25 INQ000226083, EXHIBIT CJ/26 INQ000226084, EXHIBIT CJ/27 INQ000226085]**

28. The ability to influence the technical solutions in England made efforts to create effective or seamless solutions for the population of Wales more difficult.

29. The second example related to the decisions around the basis for contact tracing. From a public health perspective for maximum effectiveness in preventing spread, contacts needed to be isolated quickly, so initial designs for a contact tracing system in Wales were based on tracing on symptoms **[EXHIBIT CJ/28 INQ000226088]**. However, decisions made by UK government changed this position. **[EXHIBIT CJ/29 INQ000226089].** Responding to changes in this way was a challenge to the design and delivery of a contact tracing service and to the potential effectiveness of the service in preventing disease spread.

30. I believe that challenges such as these made it significantly harder to establish effective systems in Wales for the contact tracing response.

Pandemic Response as Consultant Epidemiologist and interim Head of Vaccine Preventable Diseases Programme - 2 August 2021 – 30 May 2022

My role as Consultant Epidemiologist and interim Head of the Vaccine Preventable Diseases Programme

31. On the 2nd of August I was appointed to the role of Interim Head of the Vaccine Preventable Disease Programme (VPDP) within the Public Health Services Directorate in Public Health Wales. This post reported to the Deputy Director of Health Protection Service.

32. VPDP was primarily responsible for

    a. providing specialist clinical, epidemiological and scientific advice to Welsh Government, NHS Wales and other stakeholders on vaccines and vaccine preventable diseases.
    b. producing public information relating to vaccines
    c. producing or contributing to surveillance data on vaccine uptake, safety and effectiveness
    d. managing public communications campaigns relating to vaccination in Wales.

33. As interim Head of VPDP I led a team of over 30 individuals supporting these functions.

My membership of TAG

34. On appointment to the role of interim of Head of VPDP role I was invited to join Welsh Government's TAG main group. At the time of my appointment, I did not consider it to be a disadvantage to not be a member of any subgroups, as the information required to undertake my functions was presented at UK Joint Committee on Vaccination and Immunisation (JCVI) and at the Commission on Human Medicines COVID-19 Vaccine Benefit Risk Group, both of which I was an observer at. In addition, I contributed to internal meetings within Public Health Wales where other members of TAG and its subgroups were present and we were able to discuss advice.

35. At the time of my appointment to TAG, I do not recall receiving a copy of the terms of reference, and therefore I did not have a full understanding of the roles within TAG, or its relationship to its subgroups and other structures.

36. During the period between 2nd August 2021 and 30th May 2022 I only attended TAG on 6 occasions, and can recall only contributing to one piece of advice that was developed by TAG. **[EXHIBIT CJ/30 INQ000226091, EXHIBIT CJ/31 INQ000226093, EXHIBIT CJ/32 INQ000226094]**

37. Although TAG provided advice to Welsh Ministers through the Chief Scientific Adviser for Health ("CSA(H)") and Chief Medical Officer (Wales) ("CMO(W)") it was not responsible for providing advice to Welsh Ministers on vaccination. At the time I joined in August 2021, advice on vaccination was provided directly to Welsh Ministers by JCVI, with detailed advice and interpretation also being made through the Vaccine Programme governance via the Wales Vaccine Clinical and Prioritisation Group (VCAP). I am not in a position to express an opinion on the strengths and weaknesses of this approach for topics that I had no involvement in or prior to my membership of TAG.

38. As a member of the group for a relatively short period I was not aware of the relationship between TAG and its subgroups and senior politicians, and can therefore not express an opinion on its strengths or weaknesses.

39. I was one of a number of members of Public Health Wales staff from the Public Health Services directorate who attended TAG. One of the strengths of this was that there was resilience in terms of always having health protection specialists present when discussion of these areas was required, and also to feedback into Public Health Wales internal meetings where issues could be discussed fully. However, I believe it could be considered a disadvantage as I felt that a significant number of senior specialists were tied up in attending TAG meetings, and that this drew on the very same pool who were also required to attend many other critical meetings. It is for this reason that I did not attend TAG frequently.

40. I joined TAG in August 2021, and therefore do not have an opinion on TAG prior to my becoming a member, especially relating to the early part of the pandemic. As I was not a member of any subgroups, I am also not able to form or express an opinion on how sub-group reports were shared, discussed or accepted or feedback was provided to subgroups.

41. The limited nature of my role also means that I am not able to express an opinion of the relationship between TAG and SAGE or the involvement of other TAG members in SAGE.

42. The limited involvement that I had in TAG makes it impossible to form an opinion on whether the advice was subject to sufficient challenge, or whether a broader range of expertise would have changed this. I do not recall any instance where I felt that the contribution of other members to advice on vaccination went beyond their area of expertise. I am also unable to comment on the experience of others in pandemic planning and response, or the diversity of other professional specialties such as behavior science, and the impact this had in the critical stages of the pandemic response.

43. Throughout my contribution to TAG, I do not believe that I required any additional resources to fulfil my role, however, I am unable to express an opinion on whether others would have felt as adequately resourced.

My role in developing the commissions of advice from TAG and the response to commissions

44. During my membership of TAG, I was not aware of the process for commissioning advice, and therefore am unable to express an opinion of the appropriateness of the process, or whether there was sufficient feedback to improve processes and procedures. I am also not able to provide any insight into whether sufficient feedback was available on the advice provided, including its implementation, impact or alignment with strategic aims.

45. Throughout my membership of TAG I believe that I only made a contribution to the development of advice on the effectiveness of the COVID-19 pass **[EXHIBIT CJ/32 INQ000226094 as above]**. I provided some technical comment on vaccine effectiveness against transmission and infection and the impact on the COVID Pass. **[EXHIBIT CJ30 INQ000226091 and EXHIBIT CJ/31 INQ000226093 as above]** I did not have enough experience to express an opinion on whether the questions posed were the correct ones, and I am not clear how the questions were derived and as a consequence I cannot offer an opinion on whether those formulating the question understood the issues. My technical comments on the draft paper made it clear that in looking at the effectiveness of vaccination to prevent spread of infection, effectiveness against transmission was not the only vaccine endpoint of interest, and that protection against infection was more important. Therefore, it could be argued that the person drafting the questions and the initial areas of evidence did not fully understand the true effect of vaccination on infection dynamics. Furthermore, as I was only responding to a draft document, I did not play a significant part in refining the questions asked and was limited by the framing of the question. However, I do not believe that this was a significant drawback as I was able to contribute technical advice into Welsh Government through other routes, where necessary, for example drafting Advice notes to the CMO(W) (e.g., drafting PHW advice not 20 on impact of vaccination on transmission**). [EXHIBIT CJ/33 INQ000226095]**

46. As someone who was contributing to the development of expert advice directly into Welsh Government I did feel that there was on occasion a multiplicity of requests. As such, I do share the views of Dr Williams expressed in his questionnaire response [INQ000183834] that the "*multiplicity of requests sometimes led to duplication and was difficult to manage*." As my role in TAG was limited to the later phases, I do not have an opinion on whether processes with TAG improved over the course of the pandemic response. However, I do recall that in some instances requests were coming in from different departments in Welsh Government and that coordination of these requests prior to them being submitted to Public Health Wales would have made it easier to manage.

My role as an observer at JCVI and member of COVID-19 monitoring working group

47. As part of my role I was the Public Health Wales observer at JCVI meetings. In addition to myself, Wales was also represented by a co-opted member and a Welsh Government observer. We worked together to ensure that there was common understanding of the decisions that were arrived at by the JCVI and the scientific justification for them. As observer, I did not have a role contributing to discussions, but on occasion I was asked to present Wales' data to the group to help inform their discussion.

48. The JCVI COVID-19 monitoring working group allowed services from all 4 nations to provide an update to JCVI on vaccine uptake. This group was for information sharing and did not provide advice. I presented data on behalf of Wales at these meetings. As with main JCVI meetings Welsh Government had observers at working group meetings.

49. I believe that the relationship between Public Health Wales and Welsh Government worked very well, and we were able to shape service planning, response and policy in Wales based on the information presented. However, as an observer it was often clear from discussion in JCVI meetings that conversations and briefings occurred between JCVI, UKHSA and UK Government outside the meetings, which shaped some considerations and the timing of advice being provided to Welsh Government and made public. This relationship often felt

unequal, and that we had to react to decisions made outside Wales which we were not always an equal contributor to shaping.

Transparency of advice and links between policy and science

50. I have no concerns about the transparency of the scientific advice provided during the pandemic. However, I do have reflections about the impact of the phrase 'following the science' and the blurring of the lines between science and policy. Whilst I do not believe that I ever experienced difficulties setting out my advice without being accountable for policy, I do think that on a number of occasions policy did not follow the scientific evidence. I do not think this necessarily wrong, but implies a scientific foundation that is not necessarily present or available. I believe that policy needs to take into account many perspectives in coming to its conclusions and that the use of the phrase 'following the science' implied that all policy was derived from one perspective, the technical and scientific perspective, when in reality policy decisions were made, not unjustifiably, on a balance of considerations.

51. One instance which highlights this relates to the development of NHS Wales Test Trace Protect. Evidence from extensive experience in public health practice favoured contact tracing and isolation based on symptomatic cases. In infections with a short incubation period and an infectious prodrome, this approach provides the most robust chance of identifying the next generation of cases, and isolating them before they become infectious. This was never implemented as policy, and NHS Wales TTP worked on contact tracing on positive cases throughout. In my opinion this limited the effectiveness of the system, and was not 'following the science'. However, when viewed from the perspective of societal impact, where people are isolated unnecessarily because the index case had a different cause for their symptoms, it can be argued that it was a justified balance.

52. A further example related to the policy on vaccination of high school aged children. JCVI in their statement of 3rd September 2021 stated that *"The margin of benefit, based primarily on a health perspective, is considered too small to support advice on a universal programme of vaccination of otherwise healthy 12 to 15-year-old*

children at this time." **[EXHIBIT CJ/34 INQ000226096]** In advice provided to CMO(W), Public Health Wales set out the broader considerations that we, as public health advisors, felt needed to be considered prior to making a decision in the absence of high-quality scientific evidence. **[EXHIBIT CJ/35 INQ000226097]** Following consideration of broader factors the 4 CMOs agreed a policy of vaccination of children aged 12-15.

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: 21/09/23