Witness Name: Michael Coupe
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF MICHAEL COUPE

I, **MICHAEL COUPE**, will say as follows:

SECTION 1. INTRODUCTION

1.1 I make this statement in response to the request sent to me by the UK COVID-19 Inquiry ("the Inquiry") dated 29 January 2025 (“Rule 9 request”) for Module 7 which concerns the approach to testing, tracing and isolation adopted during the pandemic in England, Wales, Scotland and Northern Ireland from 1 January 2020 until 28 June 2022. The focus of the questions in the Rule 9 request relate to my role as Testing Divisional Director of NHS Test and Trace ("NHSTT") between September and December 2020, and my knowledge of the Relevant Period is limited to my time in post at NHSTT.

1.2 I have set out to answer the questions posed in the Rule 9 where I can, but many were outside my direct knowledge and remit.

1.3 As this is my first statement to the Inquiry, I would like to offer my personal condolences to anyone who lost a loved one as a result of the COVID-19 pandemic. I would also like to thank those who worked with me during my time in Test and Trace for their hard work and dedication in what were extremely challenging circumstances.

SECTION 2. QUALIFICATIONS AND BACKGROUND

2.1 When I took up the unpaid role of Testing Divisional Director of NHSTT, I had over twenty years' experience as an executive board member of major UK public limited companies. Prior to my appointment as Testing Divisional Director, I was Chief Executive Officer of J. Sainsbury Plc from 2014 to 2020 and was a member of its board from 2007 to 2020 in Group Commercial Director and Trading Director roles. Previously I had been an executive board member of Asda Plc from 1999 to 2002 and the Big Food Group Plc (as Managing Director of Iceland Foodstores) from 2002 to 2004, and a Non-Executive Director at Greene King Plc from 2001 to 2019.

2.2 In these roles, which included running the UK's second largest retailer and a FTSE 100 company, I was an experienced multisite retail leader with a detailed understanding of grocery, clothing and general merchandise retailing. J Sainsbury plc was/is a complex logistics business with around 160,000 employees serving around 30 million customers every week. I was a representative on many industry bodies including the Confederation of British Industry Executive, British Retail Consortium Executive, Institute of Grocery Distributors' Policy Council and the Consumer Goods Forum. I also have a BSc in Physics.

SECTION 3. ROLE AS TESTING DIVISIONAL DIRECTOR

3.3 I took over this role after retiring as CEO of Sainsbury's on 4 July 2020, where I had accrued significant experience in running large multi-site operations for the second biggest retailer in the UK, moving goods around the country at pace and leading large groups of people.

3.4 I received a call from a recruitment agency and was recruited following an interview with Baroness Harding, the Executive Chair of NHSTT. Although I did not have a formal job description or appointment letter, my appointment coincided with the strategy to significantly increase testing capacity. The high sensitivity Polymerase Chain Reaction ("PCR") testing capacity was around

450,000 per day when I joined, with a plan to increase to around 800,000 per day.

3.5 My role encompassed all aspects of testing, including the operational day to day management of the testing centres, capacity, bottlenecks and reporting, as well as exploring alternative methodologies beyond PCR testing for testing the general population, particularly focused on Lateral Flow Device antigen tests ("LFDs"). As well as evaluating and establishing capacity to import LFDs (mainly from China), I was tasked with creating a capability to produce LFDs in the UK that were sufficiently accurate to provide meaningful results to minimise our dependence on purchasing them from China. As part of the programme of work on capacity, I also spent time considering whether we could create a more industrialised process for PCR testing using technologies that were used in the agricultural industry.

3.6 This was a role I held from the beginning of September 2020 until Christmas 2020. I took over from Sarah Jane Marsh with a handover period of approximately two weeks. As set out in the organogram **[Exhibit: MC01/01 INQ000593164],** reported to Baroness Harding and had a team reporting to me.

3.7 I was part of Baroness Harding's senior team, which involved a high level of interaction with the other team members, regular interaction with Government ministers and the Prime Minister at meetings, and other third parties such as representatives of universities and schools, and the Confederation of British Industry.

3.8 The team reporting to me was fairly fluid. As of mid-September 2020, for example, Kerry Edwards (Testing Strategy & Policy Director), Alex Cooper (Mass Testing Development Director), Mark Hewlett (Testing Operations Director), Anna Dominiczak (Lab Operations Director), Frank Hayden (MD Lateral Flow Testing Manufacturing) and Bryan Clark (Megalabs Programme Director) all reported to me.

3.9 Our remit changed as political and medical views changed and we reacted to those pressures: this was a fast-moving and dynamic environment that was changing daily. There were several occasions when new variants resulted in a surge in demand for testing and there was an ongoing call to increase testing capacity against a backdrop where 'isolation' policies were changing on a regular basis.

SECTION 4. DEVELOPING KEY TEST POLICIES AND STRATEGIES

4.1 Through my role as Testing Divisional Director, I was involved in testing technologies, timing of tests, prioritisation of testing, access to testing, considering the use of consultants to assist with testing, and considering utilising and expanding existing infrastructure to contact trace. My role was focused on testing. A number of colleagues were separately focused on tracing as a separate operation. I was not involved in policy making on trace and isolate, but was present in some meetings with those colleagues in case incorrect assumptions were being made about the testing capacity which would have an impact on tracing and isolation.

4.2 There were many key and fluid decisions in which I was involved, and we were balancing many interests against trying to ensure we were doing the right thing. There was an 'established' prioritisation of need (e.g., health workers, vulnerable groups, care workers were afforded greater priority) when I joined the programme. This was reviewed regularly in light of the perceived need and the available capacity. For example, there was a period of time between October and Christmas 2020 when a mass volume of LFDs began to arrive in the UK and decisions needed to be made on their use by priority groups (for instance, NHS staff and care workers). Ultimately, the decision on who received LFDs first was made through COVID-O chaired by Michael Gove. I was present in COVID-O meetings where this was discussed.

4.3 For my part, I focused on the advice of the scientists and to use their expertise to guide decision making. I am a scientist by background and had a good understanding of the importance of sensitivity and specificity, particularly with regard to the use of LFDs for testing. There were many LFD tests on the market but very few met the required accuracy benchmarks.

4.4 When I arrived, available data was extremely well managed and there was high level visibility as to how many tests were available, turn around times, and the ability to move volume between sites.

4.5 There was a huge amount of data created and used on a day-to-day basis in order to manage a complex supply chain in real time. I reviewed day to day operational data in order to analyse fast turnaround times and whether we could get lead times down on testing. We were relying on the models created by data scientists. There was a very large amount of data in the testing business unit plus backward and forward-thinking modelling.

4.6 It was very difficult to deal speedily with short term changes, such as a new variant that would make the demand curve rise very quickly. If you have a fixed capacity supply chain with limited number of available tests, if demand went above a certain level, then that immediately put capacity under pressure and lead times increased. For understandable reasons there was an intense media focus on testing turnaround times. In absence of additional capacity, the only thing that can alter are the lead times. Alternatively, tests could be 'rationed' but this was both unattractive and difficult to execute.

4.7 Another challenge was rationing by omission: if one testing centre has problems, its testing area sees turnaround times fall. There was an apparent initial lack of understanding before my arrival that if you have fixed capacity and demand rises significantly, you need to address this problem by creating more capacity than demand is imagined to be. LFDs created headroom above PCR tests to expand that capacity but only in sufficient numbers from late 2020/early 2021. During my time, not enough LFDs were available coming into the UK and they were given first to public servants such as NHS workers; they were not as widely available to the general public. We sought to enable industrial-scale production and importation of LFDs to create enough capacity for the general population to test themselves and follow up with a PCR test if the result was positive. We could move capacity between PCR test laboratories but there was a finite capacity, and we were working as fast as we possibly could to increase the availability of LFD tests.

4.8 Prior to my arrival there was significant ramping up of capacity, when PCR tests were the only tests available, from circa 450,000 to a target of 800,000 tests a day. There was huge pressure to optimise and increase the existing large scale UK PCR testing laboratories by pushing the boundaries of what was possible in order to further increase capacity. There were physical and equipment limits on what was possible. As an example, PCR testing relied on sophisticated fume cupboards to decant samples and unsurprisingly this equipment was in huge demand globally.

4.9 In reality, the only scalable technology beyond PCR testing were LFDs but there was an issue with accuracy. We were analysing the specificity and sensitivity of various producers, but the accuracy rates varied hugely. It was not until we had accurate prototype samples that we could actually start purchasing them at scale. Significant volumes started arriving in October and early November 2020. During my time we were trying to ramp up testing capacity from 450,000 to two million tests per day, a gap largely closed by LFDs.

4.10 Our targets for capacity increased continually. PCR tests were hugely in demand, and we had to tell Government ministers that it was not easily possible to scale up LFDs given the need for a certain level of accuracy. As noted earlier, the constraint on the volumes of PCR tests were largely equipment based, although I recall occasions when the availability of the reagents used was also an issue. We had line of sight to be able to grow to a total of 800,000 PCR tests a day.

4.11 Over time, capacity and volume significantly increased and by Christmas 2020 we had increased capacity so that millions of LFDs were available to the general public. This was the most significant capacity building during my time in the role.

4.12 I was also involved in the sign off a project to build an industrial-scale laboratory using veterinary technology to significantly increase the availability of PCR tests. As far as I am aware, this project was never implemented as the roll out of the vaccine reduced the need for the additional testing capacity, and the general public became adept during late 2020 and 2021 at using LFDs for self testing.

4.13 The mantra was to grow capacity for testing as fast as we possibly could, and because of the limited capacity to grow PCR testing there was a focus on LFDs. Once LFDs were available in the UK in significant quantities, their availability meant that anyone could self test in a short period of time. This coincided with the roll out of the vaccine programme in early to mid 2021.

4.14 The initial orders for LFDs were huge (hundreds of millions at a time). However, the demand was also potentially huge. For instance, the requirement to test NHS staff regularly required an allocation of up to 20 million per week in the run up to Christmas 2020.

4.15 In order to address the challenges, I met with the leadership of the laboratories virtually and regularly. The day-to-day operational role involved looking at the data, getting feedback on issues arising and feeding those issues upwards within Baroness Harding's team, moving capacity around, and working with various and many interested parties to increase the capacity of laboratories and bring LFDs on stream. We were looking carefully at whether or not we could build on the capacity of LFD testing and scale it up using different technology, especially through the Milton Keynes laboratory.

4.16 The testing team met regularly in large team meetings, going through various strategic challenges and I had frequent meetings with the teams and individuals on addressing the challenges at any particular moment. This operation was very slick by the time I became involved and was good at highlighting day to day and week to week issues.

4.17 There was a weekly meeting on a Friday morning with Dominic Cummings and then with the Prime Minister and various ministers of state, the Chief Scientific and Medical Officers and Baroness Harding (amongst others), in which we were challenged on what we were doing to increase capacity for testing, particularly with regard to LFDs. Conceptually, we were challenged to be able to increase the availability of LFDs such that people could self test before socialising.

4.18 I was not involved in shaping isolation policy and guidance, nor in evaluating it. However, it was not foreseeable how strategy would need to be developed because no-one could have foreseen various variants, nor predict what those variants would be, when they would occur and what they would do to change the nature of disease. For example, as Christmas 2020 approached and in the context of a political desire to enable the population to spend Christmas together, the rules and guidance needed to be changed as new variants occurred and the prevalence and risk of the disease rose.

4.19 In any fixed capacity system, once demand for tests goes up you reach the point where something has to give way by either rationing tests or the lead times will get worse. This happened, for example, with at the end of the summer holidays and at Christmas: people wanted to be able to test themselves before leaving for their holidays and on their return. With hindsight this was predictable, but it is easy to look back with hindsight and we were working at great pace to try to meet demand.

4.20 We tried to mitigate capacity issues, for example, by using mobile testing operations and vans to collect samples from them for testing, but the majority were tests undertaken at static sites. In addition, we were asked (by health professionals) to concentrate efforts in certain geographies when a new variant had been detected, pushing a lot of mobile capacity into a particular geographic location to get on top of the variant to stop it spreading.

4.21 In relation to testing pilots, their genesis was the Prime Minister's desire to try to test the entire UK population over a weekend in order to determine who was testing positive and who was testing negative for COVID-19, so that those testing negative could go about their daily lives (and therefore the isolation policies could be relaxed). The scientific challenge of the exercise was that the accuracy of the LFD tests was not good enough. The probability of false negatives could enable a person to become a superspreader unwittingly. There were several debates around the need for a follow up PCR test if a LFD test was positive, which of course undermined the premise of the quick turnaround LFD test.

4.22 It was decided that instead of the Prime Minister's proposal, a relatively small geographic area would be piloted in an intensive testing programme to analyse the extent to which people with COVID-19 could be identified, then traced and isolated, with those testing negative being able to move about freely. By definition, if you choose to test one part of the population intensively, you are choosing to prioritise testing capacity into one geographic location over others. Ultimately, this was a decision for the politicians, but I was present at the meeting when the decision was made to use Liverpool as the testing pilot.

4.23 Liverpool was identified as a centre which could also potentially address inequalities. There were known groups such as individuals in Black, Asian and Minority Ethnic ("BAME") groups, or those from lower socio-economic groups who had limited engagement in the testing program, or for whom a positive test might affect their income. A number of techniques were trialled such as engaging with local faith groups or knocking on doors and offering tests. The army was also deployed to scale the number of tests available.

4.24 My role in and assessment of these pilots in Liverpool was through regular contact with the local team. The program was mobilised over a very short period of time (days) and required a daily review the local authority (including the Chief Executive Officer of Liverpool Council and representatives) during the early part of the trial. There were numerous challenges setting up a program of this scale at short notice. It was logistically demanding and required intense briefing of local representatives. The army was also drafted into help requiring training on testing protocols. There was also a separate communication plan put in place. The data was monitored on a daily and weekly basis, and academics were engaged in assessing the programme. Despite the speed of execution, I would view the logistical challenge as a success and a credit to all involved. I am unaware of any published assessments of the trial.

4.25 I was not involved in the pilot at Merthyr Tydfil, which I believe was run by the Welsh Government. Similarly, I have no memory of being directly involved in the Isle of Wight trial.

4.26 The testing pilots were reliant on cooperation from the local population, because even if there is an 80/90% testing rate, the behaviour of those who do not test drives the vector of the disease. From memory, the Liverpool test demonstrated the challenge of engaging certain populations in mass testing.

4.27 The Liverpool testing pilot would have been physically and financially impossible to replicate on a larger scale at the time. The deployment of the army would only be possible in a limited geographical area, as would the door knocking and use of mobile testing units. However, it is also fair to say that the use of LFDs to self test became more widely accepted and adopted over time as the volume of LFDs became widely available to the general public.

4.28 There was a time thereafter and before I left when Shona Dunn was brought in to deal with population testing. There was a degree of ambiguity as to her role relative to mine. My personal view is that whole population testing (i.e., testing a large proportion of the population at the same time) was logistically impossible in late 2020 and scientifically unsound.

4.29 In my view, it was scientifically unsound because of the accuracy of the LFDs: the likelihood of 'false negatives' would result in infected members of the public believing they did not need to isolate. The only way of being sure of infection was through PCR testing, which required a lot more infrastructure and the turn round times were days, and not minutes (as per LFDs). In addition, the evidence suggested a significant proportion of the population would also not engage in mass testing (as demonstrated through the Liverpool testing pilot). Again, this would lead to a significant proportion of the population not knowing whether or not they were infected. It would not have made sense to relax the isolation rules unless the uptake was closer to 100%.

4.30 In my view, whole population testing would have been logistically impossible because there was not enough resource available to ensure a high enough take up of LFD testing. It is true to say that the general public became used to LFD testing over time, but this was once the vaccine had been deployed and the impact of the disease started to reduce.

4.31 These views of the feasibility of whole population testing were communicated to all levels within Government and there were a number of intense debates around the feasibility and scientific validity of mass population testing using LFDs. As far as I am aware, mass population testing never gained traction despite a huge amount of political focus and was superseded by the vaccine rollout in 2021.

4.32 There was a marketing director (Ben Stimson), who was part of Baroness Harding's senior team, with whom I worked closely on the testing communication campaign on many levels, such as on advertising through to the app and persuading the population to download the app. I believe that there was a high level of awareness of testing, what people need to do to get tested, and what to do with results arising from a well-engineered and communicated campaign before I arrived. Our key message to people was that if they thought they had COVID-19, they should get tested. Clearly there was also a lot of communication as to what to do if you tested positive.

4.33 We reflected on learning from the communication campaign during my time. For example, certain population groups were difficult to communicate to, such as BAME groups. We tried a number of methods to address this issue, such as talking local faith groups and knocking on doors to discuss testing face to face.

4.34 In relation to adherence to testing rules and guidance, my role did not look at real time data but considered at a high level the granular testing data. My role was focussed on the delivery of tests.

SECTION 5. LESSONS LEARNED

5.1 It would appear to me that at the beginning of the pandemic the government did not take COVID-19 seriously enough early enough. At the time of the outbreak of the pandemic, I was the CEO of J Sainsbury, and it was clear in early 2020 that there was a serious issue brewing.

5.2 Having seen a number of businesses threatening crises (e.g., the global financial meltdown and COVID-19 itself), I would observe the nature of these risks is highly unpredictable and therefore it is difficult to pre-plan a response. Accordingly, I suggest that a priority should be having the levers and mechanisms in place to be able to adapt to whatever pandemic transpires in the future, with processes in place to be able to adapt quickly, manage and lead with delegated authority, speed of decision making and having the right expertise around the table. I suggest we need a national plan for how to deal with this, addressing what mechanisms that exist within Government to be better set up on day one to deal with any new emergency.

5.3 There should be a national register of those with the expertise and leadership qualities to be able to be 'drafted in' to support any such national emergency.

5.4 The UK's diagnostic capability was limited at the outset of the pandemic, and it was clear when I joined the team that there were many things outside our control, particularly our dependency on imported equipment, reagents and devices (such as LFDs). I would be of the view that the UK should invest in its diagnostics capability in anticipation of any future pandemic.

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: 9 April 2025