Witness Name: John-Arne Røttingen,
Chief Executive Officer,
for and on behalf of
the Wellcome Trust Limited,
as trustee of the Wellcome Trust
Statement No.: M7/Wellcome/01
Exhibits: JAR/01, JAR/02, JAR/03
Dated: 14/05/2025

UK COVID-19 INQUIRY

WITNESS STATEMENT OF THE WELLCOME TRUST LIMITED AS TRUSTEE OF THE WELLCOME TRUST

The Wellcome Trust Limited, a company limited by guarantee registered in England (company number 2711000) as Trustee of Wellcome Trust a charity registered in England and Wales (charity number 210183) (Wellcome), will say as follows: -

A. INTRODUCTION

1. Various teams across Wellcome have contributed to our response, and as such this represents an organisational opinion rather than the expertise of any one individual. Where appropriate we have used section headings provided by the Inquiry to structure our response and answered the specific questions asked by the Inquiry in our response. By doing this, we hope to support the Inquiry in achieving its aims.

2. It is important to note that during and since the proposed date range Wellcome has grown and changed significantly as an organisation, and staff turnover means that various key Wellcome personnel who were employed before and during the Covid- 19 pandemic are no longer at Wellcome.

3. This includes Sir Jeremy Farrar who was Wellcome's Director (the role is now known as Chief Executive Officer) during the period and whose term has come to an end. Sir Jeremy left Wellcome in 2023 and took up a new role at the World

Health Organization. During the period under consideration, Sir Jeremy was also a member of the Government's Scientific Advisory Group for Emergencies (SAGE), but was acting in an independent and personal capacity, and as such he may well have material and direct experience and evidence that is pertinent to the Inquiry, which Wellcome does not have. We understand that members of SAGE during the proposed date range have been contacted by the Inquiry separately.

4. It is also important to note that at the request of the Inquiry, Paul Schreier, in his capacity at the time as Chief Executive Officer (Interim) of Wellcome, submitted a witness statement dated 25/05/2023 in relation to Module 1 of the Inquiry. Paul Schreier has also since left Wellcome.

5. John-Arne Røttingen became Chief Executive Officer of Wellcome in January 2024, taking up post following the end of term of Paul Schreier, who was Chief Executive Officer (Interim) between February 2023 and February 2024.

6. In summary, Wellcome did engage to a limited extent on issues relating to test, trace and isolate (TTI) during the period in question. Where relevant, we will highlight key examples of this in our answers below. Our activities in relation to TTI were primarily in our role as a research funder, and with a much greater emphasis on activities to strengthen the response internationally – particularly in low- and middle-income countries (LMICs) – rather than in the UK domestically. As such, we had limited engagement with policy decisions in the UK.

B. BACKGROUND

History and overview

7. Wellcome is a UK-based charitable foundation which supports science to advance solutions to urgent global health challenges. Wellcome was founded in 1936, upon the death of Sir Henry Wellcome.

8. To achieve its mission, Wellcome:

- enables and invests in research,
- influences change in policy and practices, and
- engages and works with people.

9. Wellcome's mission is funded through our endowment and investment portfolio (which currently stands at £38 billion). Our charitable expenditure last year was £1.6 billion.

Legal and Governance

10. Wellcome is a charity registered in England and Wales (charity registration number: 210183,). The sole trustee of the Wellcome Trust is The Wellcome Trust Limited, a company limited by guarantee registered in England (company number 2711000) (Wellcome).

11. Wellcome's Board of Governors guides and oversees Wellcome in achieving our mission. Wellcome's day-to-day activities are managed by an executive committee made up of senior managers from across the organisation, which is chaired by the Chief Executive Officer, who is accountable to the Board of Governors.

Issues and/or groups of people which Wellcome supports and/or represents and the work Wellcome conducts in relation to this.

12. Our charitable investments/funding are focused across four global programmes to support science-based solutions for health and well-being: discovery research into life, health and wellbeing; the catastrophic health impacts of the climate crisis; escalating threats from infectious diseases; and mental health problems holding millions of people back. Wellcome also has a free museum and library, the Wellcome Collection, which explores the past, present and future of health. Wellcome has an international focus across our programmes. Wellcome works with partners across research, industry, civil society and governments globally to achieve our goals.

13. In Infectious Disease our work currently, and over the past decade, has included working with partners to support strengthening of global epidemic and pandemic preparedness, for example our programmes on Ebola and Zika. This work has placed a particular focus on activities to support research and development (R&D) for known diseases with epidemic potential (such as Ebola), as well as building capabilities to rapidly deliver new tools (particularly vaccines) for novel epidemics

and pandemics. This has included work to develop and fund international collaborations such as the Coalition for Epidemic Preparedness Innovations (CEPI), launched in 2017.

C. SYSTEM READINESS

14. **At the onset of the Covid-19 pandemic in 2020, the UK was notable for having – by global standards – generally strong capacity and capability for the diagnosis, analysis and surveillance of infectious disease outbreaks.** This included high-quality laboratory capacity across the NHS and public health system, and within the research sector (i.e. universities.) This underlying capacity, well-dispersed nationally, was complemented by nationally and globally significant institutions, such as the Wellcome Trust Sanger and Francis Crick Institutes. These are home to world-leading expertise and capabilities on issues such as pathogen genomics.

15. Although this capacity was not by itself adequate to respond to a public health emergency of the scale of the Covid-19 pandemic, it meant that the UK had a strong foundation on which to build TTI response.

16. **In our role as a major UK research funder, Wellcome was, and remains, widely involved in providing support to elements of this national capacity, particularly in the academic sector and through long-term funding commitments to both the Francis Crick and Sanger institutes.** These funding commitments reflect our longstanding organisational prioritisation of discovery science and infectious disease research, including activities to build an understanding of diseases with epidemic and pandemic potential. However, our pre-2020 engagement and funding support was not specifically with a view to building capacity for emergency preparedness or response, nor did we explicitly consider the scalability of this capacity in response to a major public health emergency.

Lessons learned from earlier outbreaks

17. **As highlighted in our earlier evidence to the Inquiry, experiences of outbreaks in the years preceding the Covid-19 pandemic – including the**

2009 H1N1 swine flu pandemic, the West African Ebola outbreak of 2014, and Middle East Respiratory Syndrome (MERS) in 2012 – all provided opportunities for the UK to learn lessons about the effective response to disease outbreaks. This included key lessons in relation to TTI capacity and capability. Specifically:

a. All three outbreaks showed the importance of being able to effectively monitor the progression of an outbreak, including where cases from an outbreak overseas were imported to the UK.

b. The experience of MERS, where one of the first diagnosed human cases globally was identified in a traveller to the UK, showed the importance of being able to leverage specialist diagnostic capabilities (including genomic sequencing) to rapidly build understanding of a previously unknown disease. This experience also underscored the importance of timely international sharing of such insights.

c. The rapid progression of the H1N1 pandemic and Ebola epidemic demonstrated the need to quickly scale up testing capacity (including the role of point-of-care diagnostics) as a core part of the response to a rapidly moving outbreak.

18. **The UK demonstrated that some of these lessons had been understood and acted upon, including through its participation in research collaborations such as the Global Research Collaboration for Infectious Disease Preparedness (GloPID-R) and International Severe Acute Respiratory and emerging Infections Consortium (ISARIC.)** These research collaborations, of which Wellcome is also a member, provided a mechanism for global research funders to align on lessons learned from earlier outbreaks and prioritise and share their research investments accordingly.

19. However, in our view, investments by the UK (and others) in responding to lessons learned from earlier outbreaks were often piecemeal, and not well aligned with the level of the risk that the outbreaks highlighted. We also observed that while there was significant momentum and good intention immediately after the West Africa Ebola outbreak of 2014 to respond to the challenges for outbreak response that it identified, this declined during the period from 2016 to the beginning of the Covid-19 pandemic.

Scientific advice to government

20. The Inquiry has requested further clarity on evidence previously provided by Wellcome, that we are of the view that a lack of transparency regarding the use of scientific advice provided to government led to “a damaging politicisation of science during the pandemic.” We would note that this statement was not related to the use of scientific advice specifically in respect of TTI, or any other single dimension of the Covid-19 response. Rather, it is a view based on how the UK Government generally presented the role of scientific advice in guiding policy decisions.

21. **Overall, we believe there was a lack of clarity regarding how and where scientific advice was being used, and the point at which political decision-making rightly took over.** The UK Government clearly placed a strong emphasis on ensuring that it had high-quality scientific advice available to it throughout the period 2020 to 2022, as evidenced by the prominent roles of the SAGE, and of the Chief Medical Officer and Chief Scientific Adviser. However, we think that the UK Government could have been clearer with the public that in a rapidly evolving situation like Covid-19, even high-quality scientific advice has limitations, and will not provide simple or clear-cut answers. This means that scientific advice alone could not provide a singular guide to policy decision-making. In turn, there was a lack of transparency about whether policy decisions were the result of legitimate and necessary political judgements, either because the scientific evidence was unclear, or to allow trade-offs with competing policy priorities. This lack of transparency ran counter to the established ‘Principles of scientific advice to government’ published by the UK Government on 24 March 2010 (**Exhibit JAR/01 [INQ000587309]**).

22. **We would also note, though, that there was sometimes a similar lack of clarity within the scientific community about the role that scientific advice and evidence could and should be playing.** Leaders and experts from within the scientific community rightly provided public commentary in mainstream media or on social media about the progress of the Covid-19 pandemic and measures to mitigate its impact. In large part, this commentary provided a valuable means to connect the public with the science and improve

understanding of it. However, there were instances where such commentary did not adequately acknowledge the uncertainties associated with the evolving evidence base and the complex trade-offs required in making policy decisions – for instance, by portraying that there was an obvious or single 'correct' policy response.

23. **In our view, together, these factors created confusion about the role of scientific advice, and its proper role within policymakers' decision-making.** There are key lessons here both for government and for the scientific community about how to better explain to the public how the evidence base will evolve rapidly during an emergency like Covid-19, how this can inform decision-making, but also its limitations. This should emphasise a clear distinction between advice provided by scientific experts, and the decisions taken by political leaders.

D. POLICIES AND STRATEGIES FOR TTI

24. During the early response phase of the pandemic between 2020 and 2022, Wellcome focused its efforts on supporting the global development of, and equitable access to, vaccines and therapeutics. We did not actively or systematically seek to influence domestic policy decisions, or routinely take detailed public positions, on TTI in the UK in the period in question. However, we were clear in broader public statements about the criticality of having high-quality, real-time data on the progression of the pandemic, and the importance of governments in the UK and elsewhere adopting robust, evidence-based interventions to suppress transmission. A full record of public statements made by Wellcome during the period in question can be found on Wellcome's website (**Exhibit JAR/02 [INQ000183290]**).

25. In line with this belief about the criticality of data and evidence-based interventions there were specific interventions – addressed in answers below – where Wellcome leveraged its position and resources as a research funder to support activities related to Covid testing and surveillance.

Global Monitor on Covid

26. The Inquiry has asked for specific insight on Wellcome's work in relation to the Global Monitor on Covid, its role in relation to pandemic surveillance, data production and management, and its use by decision-makers in relation to TTI.

27. Wellcome Global Monitor is a periodic global survey, the world's largest study into public attitudes towards science and health. It was first launched in the UK in 2009, and extended globally in 2018.

28. The 2020 iteration of the Wellcome Global Monitor gathered data in 113 countries during the pandemic. It sought to better understand how this crisis affected people around the world and how their experiences may have influenced perceptions and trust of science, healthcare, systems and government. Its full report and findings were published on Wellcome's website (**Exhibit JAR/03 [INQ000249525]**).

29. These findings and conclusions were freely available for public use, but while the report undoubtedly contained insights which would have been of value for policymakers in the UK and globally, it was not intended to directly support decision-making in respect of TTI.

E. TESTING

Testing technologies and capacity

30. **Wellcome did not directly or significantly engage on influencing UK policy decisions on testing strategies during the period in question.** Where we engaged on issues relating to testing capacity in the UK, it was in our position as a funder of, or partner to, research facilities (either universities or specialist centres such as the Crick and Sanger Institutes) that possessed laboratory capacity and capability that could be deployed as part of the national response to Covid.

31. **Where Wellcome did deploy emergency funding towards testing and surveillance efforts for Covid-19, this was largely outside of the UK, and**

focused on building pathogen sequencing capacity internationally. For instance, through our Global SARS-CoV-2 Genomic Surveillance Initiative, we sought to build an international network of researchers in LMICs to conduct genomic sequencing of Covid-19 infections locally, and rapidly share this data via international platforms to inform research and both global and country-level public health responses. Similarly, we provided support to our Major International Programmes (Wellcome-funded research centres in Thailand, Vietnam, Malawi, South Africa, and Kenya) to work as a consortium to increase sequencing capacity for Covid-19 within their host countries.

32. **While our efforts in this space were primarily oriented towards surveillance and sequencing capacity internationally, we did provide some limited support towards the development of testing technologies.** For instance, the then Department for International Development (DfID) and Wellcome ran a joint emergency funding call, which made investments including a £1m grant to a UK-based company, Mologic (now Global Access Diagnostics), to explore early development of lateral flow tests for Covid-19.

33. **The mobilisation of the Covid Genomics UK (COG-UK) consortium was led by the Wellcome Sanger Institute, of which Wellcome is the major funder.** This consortium was intended to leverage the UK's significant expertise and capacity in pathogen sequencing to support the response to Covid-19 both domestically in the UK, and internationally. Where Wellcome provided additional funding to support the mobilisation of COG-UK, this was specifically to ensure that the consortium supported the development of sequencing capacity in LMICs as outlined above, rather than supporting the sequencing of UK samples.

34. **Wellcome took some initial steps to support the escalation of testing capacity in the UK in early 2020, but otherwise did not engage directly or significantly in the UK government's efforts to expand TTI capacity during the period in question.** For instance, in late March 2020 we joined a collaborative project with UK universities, the NHS, Public Health England, and private sector partners (including diagnostics companies, Boots, Royal Mail, and Amazon) to support the development of testing capacity and capabilities. The project was intended to increase the UK's diagnostic capacity, starting with

testing for frontline NHS staff, with the aim of widespread roll out of tests for the coronavirus itself, and for antibodies against the virus (i.e. to identify who had had had the virus in the past.) Beyond these early efforts, though, as outlined in our answers above our efforts were primarily focused on supporting strengthened capacity internationally, in LMICs. Specifically, we did not and do not have a view on the commitments made by the Secretary of State for Health in April 2020 to rapidly increase testing capacity to 100,000 tests per day, or other headline TTI policy commitments made by the UK Government during the period in question.

F. TRACING

35. Wellcome did not have material involvement with policy decisions or delivery of tracing capabilities in scope of the requests from the Inquiry. This includes the use of digital technologies for tracing, and we did not and do not have an organisational view on the role and functionality of NHS tracing apps.

G. ISOLATION

36. Wellcome did not have material involvement with policy decisions on the development of isolation measures in scope of the requests from the Inquiry.

H. DATA & MODELLING

37. **The pace with which the Covid-19 pandemic emerged in 2020, and the way subsequent waves progressed over the next two years, meant it was extremely challenging for governments to maintain an accurate information picture.** As described in earlier answers, throughout the period in question it was Wellcome's firm organisational view that having the most complete information possible about the progress of the pandemic was essential to inform effective decision-making at a national and sub-national level. The UK faced challenges with this but was by no means unique internationally in this respect. Even though the UK had strong foundational capacity in place for disease surveillance prior to the pandemic, this was not adequate to a public health emergency on the scale of Covid-19. This resulted in the UK government facing issues of fragmented and incomplete data,

particularly during the early stages of the pandemic, and in common with many other countries.

38. **Wellcome made some investments as a research funder to fill data gaps through stronger disease modelling, although as with other aspects of TTI this was usually with a focus on supporting capacity internationally and particularly in LMICs.** Although modelling data is by definition imperfect, we regarded it as an important tool to improve understanding of the progress of the pandemic, and a means to support decision-making by governments. There would be particular benefits to modelling data being available in LMICs where testing and surveillance capacity was much more limited. As such, we provided funding support (including to Imperial College in the UK) to improve Covid-19 modelling in LMIC settings.

The use of data in a future pandemic

39. **As our earlier answers reflect, the importance of good data to support decision-making during a disease outbreak was already well understood by the public health community and had been underscored by experiences of previous outbreaks in the UK and globally. The Covid-19 pandemic provided important lessons about doing this at a global scale, and demonstrated more than ever the value for national governments (including the UK) in understanding the international situation rather than taking a simply domestic view.** Like any country, the UK Government needed to make domestic policy decisions that were informed by the progress of the pandemic globally. Covid-19 exposed the frailties that exist internationally – particularly in LMICs – in monitoring a large-scale and rapidly evolving pandemic. However, it also demonstrated where investments in global disease surveillance capacity in LMICs can deliver significant global benefits. The ability to rapidly identify and characterise the Omicron variant in South Africa in November 2021, for example, was the result of long-term pre-pandemic investments in laboratory capacity and sequencing capabilities in that country (primarily driven by the needs related to understanding and tackling HIV and TB pandemics).

40. **Wellcome sought to use emergency research funding commitments between 2020 and 2022 to improve such LMIC capacity and capability, and since then have supported some key initiatives to continue the adoption of these lessons.** This has included support for the mobilisation of the International Pathogen Surveillance Network (IPSN) based at the new World Health Organization (WHO) global surveillance hub in Berlin, which should strengthen the delivery of the WHO's vital role in future large-scale outbreaks. Lessons about the importance of effective data collection and use are also embodied in the 100-Day Mission for the delivery of vaccines, therapeutics and diagnostics during future epidemics and pandemics (outlined during the UK Government's G7 presidency in 2021), and we are supporting the delivery of this mission by hosting the International Pandemic Preparedness Secretariat (IPPS).

41. **In this vein, we believe that the Office of National Statistics (ONS) Covid Infection Survey (CIS) demonstrated significant value during the pandemic, as one tool to improve understanding of Covid-19 prevalence regionally and nationally.** We believe that the CIS approach can be applied internationally, so we are supporting the ONS, through a five-year award, to make available a toolkit of methods, products, and materials to enable National Statistical Offices in LMICs to maximise their existing resource to monitor and respond to epidemics and pandemics. The toolkit is being co-developed with three National Statistic Office partners who are geographically dispersed and represent a range of different levels of maturity in this space. The output will be an online toolkit of resources for National Statistics Institutes to leverage in response to emerging infectious disease threats.

I. PUBLIC MESSAGING

42. As described in earlier answers, TTI as a domestic issue was not a primary focus of Wellcome's activities or public communications during the period in question. However, some public comments and statements made during the period in question by Wellcome spokespeople (including our then Director, Sir Jeremy Farrar, also a member of SAGE) did refer to issues in the scope of TTI defined by the Inquiry, and the implications of these for control measures in the UK and internationally. As set out in paragraph 24, a full record of public

statements made by Wellcome during the period in question can be found on Wellcome's website.

J. INEQUALITIES

43. The Inquiry has requested further clarification on Wellcome's approach to inequalities in the UK. Our earlier evidence to the Inquiry stated that "Wellcome's work relevant to pandemic planning and preparedness has historically not specifically considered issues of inequalities and vulnerable groups within the UK."

44. **Addressing inequity is a core tenet of Wellcome's strategy, and we seek to drive equitable outcomes in all aspects of our work.** Given that a significant volume of our work in infectious disease (including in relation to Covid-19) is and was internationally focused, in practice our work on equity in this space is geared towards addressing global inequities. This reflects that the risk and burden of infectious disease is felt disproportionately in the global south, and that global biomedical research and product development continue to underserve the needs of communities there.

45. **We are very clear that significant and persistent inequities also exist within the UK, though, in relation to infectious disease as well as other issues on which Wellcome works.** Wellcome does now have active programmes that consider how we can support reduced inequities in the UK. For example, in 2024 we launched a £20m programme of Wellcome Accelerator Awards to provide targeted support to researchers of Black, Bangladeshi and Pakistani heritage in the UK . These UK-oriented activities are not specifically focused on issues of infectious disease or pandemic preparedness, but will help ensure that the UK research community more accurately reflects the diversity of the UK population, with greater involvement from currently under-represented groups.

K. LESSONS LEARNED AND LEGACY

46. We have no further reflections on TTI issues and lessons for future epidemics and pandemics, beyond those offered in our answers above.

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:
Name: John-Arne Røttingen

Signature: **Personal Data**

in my capacity as Chief Executive Officer, for and on behalf of the Wellcome Trust Limited, as trustee of Wellcome Trust

Dated: 14/04/2025