Witness Name: Sharon Peacock
Statement No: 1
Exhibits: SP1/01 – SP1/11
Dated: 10 April 2025

UK COVID-19 INQUIRY

WITNESS STATEMENT OF PROFESSOR SHARON PEACOCK

I, **PROFESSOR SHARON PEACOCK**, will say as follows:

SECTION 1. INTRODUCTION

1. I make this statement in response to the request sent to me by the UK COVID-19 Inquiry ("the Inquiry") dated 27 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 roles as Chair of the C-19 Genomics UK (“COG-UK”) consortium and joint chair of the Hospital-Onset C-19 (“HOCI”) Working Group, and my knowledge of the Relevant Period is limited to my time in these posts. As I set out further below, I held a number of additional roles during this period which are relevant to the considerations raised in Module 7.

2. I was not a member of the National Testing Programme Leadership Team, namely the NHS Test and Trace initiative led by Baroness Dido Harding, which arose out of plans described in the document and plan published by the DHSC (Coronavirus COVID-19 Scaling up our testing programmes) on 4th April 2020.

3. I have also indicated where appropriate in this witness statement some restrictions to my roles during the Relevant Period that limit accordingly the contributions I can make on the considerations raised in Module 7.

4. As this is my first statement to the Inquiry, I would like to express my deep gratitude to staff at the Cambridge University Hospitals NHS Foundation Trust (where I am based) for their exceptional commitment to patient care during the height of the pandemic; and to everyone in the NHS across the country who cared for patients during this time. I am indebted to the members of COG-UK, the majority of whom were volunteers, and who made it possible to generate SARS-CoV-2 genomes during the pandemic response. I feel immense sorrow about the loss of life from COVID-19 in the UK and globally, and what this loss continues to mean for their family and friends.

SECTION 2. QUALIFICATIONS AND BACKGROUND

5. By way of summary as to my qualifications, I trained as a State Registered Nurse, qualifying from the Royal Sussex Country Hospital in Brighton in 1977. I trained as a medical doctor at the University of Southampton, qualifying in 1988. I undertook postgraduate medical training in Southampton, London, Brighton and Oxford, obtaining Membership of the Royal College of Physicians in 1992. I undertook specialist training in Clinical Microbiology at the John Radcliffe Hospital in Oxford and obtained Membership of the Royal College of Pathologists and my Certificate of Completion of Training in Clinical Microbiology & Virology in 1997. I completed a PhD in 2003. I am currently Professor of Microbiology and Public Health in the Department of Medicine, University of Cambridge, and Master of Churchill College, Cambridge. In 2015 I was appointed a Commander of the British Empire for my services to medical microbiology.

6. In my most recent employment history and prior to taking up my roles during the Relevant Period, between 2009 and 2015 I was Professor of Clinical Microbiology, Department of Medicine at the University of Cambridge. Thereafter between 2015 and 2019 I was Professor of Clinical Microbiology and Director of the Bloomsbury Research Institute at the London School of Hygiene & Tropical Medicine and University College London.

7. From April 2019 to June 2020, I was seconded as Director of the National Infection Service, Public Health England. From June 2020 to September 2021 I was seconded as Director, Science (Pathogen Genomics), Public Health England. From April 2020 to March 2023, I was Executive Director and Chair of the COVID-19 Genomics UK Consortium (COG-UK), and from September 2015 until March 2025 I was Non-Executive Director (and Senior Independent Director from August 2023) of the Cambridge University Hospitals NHS Foundation Trust.

SECTION 3. ROLES AND RESPONSIBILITIES

8. Between January and March 2020, I led the liaison function between Public Health England ("PHE") and the Department of Health and Social Care ("DHSC"). In the same period, I was an advisor on testing in my role as the Director of the National Infection Service. I co-chaired the Hospital-Onset COVID-19 ("HOCI") working group between April and May 2020. In support of Pillar 4 (serological testing) I established and chaired the PHE Serology

Programme Board between April and Sept 2020. I co-chaired the COVID-19 Serology Working Group between April and June 2020. From March 2020, I led the development of the COVID-19 Genomics UK Consortium ("COG-UK"), which rapidly grew into a full-time commitment. Sequencing was not used as a diagnostic test and was not a component of the plans described in the document published by the DHSC (namely, Coronavirus COVID-19 Scaling up our testing programmes) in April 2020.

Chair of COG-UK

9. I assumed the role of Director and Chair of the COVID-19 Genomics UK Consortium on 1 April 2020, which was contingent on funding becoming available to begin this initiative. COG-UK's governance structure is available at **[SP1/01 INQ000575869].** The management team is available at **[SP1/02 INQ000575868].**

10. This role was created because efforts to develop a national capability for SARS-CoV-2 sequencing arose from a request from the then Government Chief Scientific Advisor. Following discussions with him in late February 2020 and early March 2020, I formed an expert science group in March 2020 that worked together to describe how the Consortium could be formed and operate. A written proposal was developed from these discussions, which was submitted for consideration to the Government Chief Scientific Advisor and Chief Medical Officer in mid-March. This was funded by 1 April 2020.

11. I took the lead on this initiative because I was listed as the principal investigator on the funding award. Funds were held at the University of Cambridge where I was based, and I was the responsible officer for the delivery of the proposed research. Dispersal of funds for sequencing that took place across our network was made to other parties from Cambridge through a Consortium agreement. Data sharing agreements and ethical approval documents were also developed in Cambridge (noting that we held no patient identifiable information), and a small management team was appointed in Cambridge in support of the wider Consortium of 600 people.

12. My remit was to provide effective leadership to the Consortium and to deliver on the objectives of the research proposal, which focused on delivery of SARS-CoV-2 genomes to the four public health agencies and to researchers worldwide. This included the technical innovations to store and analyse the genome data, and the logistics and operations required to move samples to sequencing hubs. Sequence data were released into public databases for others to use and was available to the four public health agencies.

13. COG-UK provided definable contributions to the pandemic response. Specifically, it:

    a. Helped to advance scientific knowledge about SARS-CoV-2 and improve genome sequencing and analysis methodologies;
    b. Informed key policy and public health decisions made in response to the COVID-19 pandemic in the UK;
    c. Informed medical innovation efforts, including evaluation of vaccine efficacy against SARS-CoV-2 variants and their susceptibility to therapeutics;
    d. Influenced how decision makers value pathogen genomics in building effective public health systems;
    e. Strengthened the UK pathogen genomics capacity and ability to respond to future infectious disease threats;
    f. Influenced international SARS-CoV-2 sequencing initiatives.

14. Key stakeholders, with whom I collaborated in making decisions on how COG-UK was delivered, were the twenty-one partners in the Consortium (16 universities, four public health agencies, and the Wellcome Sanger Institute ("Sanger")), with at least weekly operations meetings that included a representative from each partner. A Steering Committee met every fortnight, which had representatives of partner Universities, the Sanger, the four public health agencies of the UK, and representation from the fund administering body (the Medical Research Council).

15. Operational decisions were made at weekly meetings; at the Steering Committee; and where a responsibility was devolved to a regional group, by them. For example, we had several sub-groups that were formed to improve the efficiency of sequencing; to develop software for analysis of the genome data; and for management of the data in our cloud infrastructure. Sub-groups were able to innovate and operate independently, but each group reported their progress to the main weekly meeting.

16. There were additional weekly meetings between COG-UK and the Sanger, as well as additional logistics meetings to develop and grow the logistics required to identify and transport patient samples from NHS labs and testing centres to the relevant sequencing hub. We met with an external advisory group of scientific experts at least every three months. COG-UK also worked with SAGE, the FCDO, and additional universities from the UK and numerous countries.

Joint chair of the HOCI

17. I was a member of SAGE and in April 2020 I was asked by the then Government Chief Scientific Advisor to establish and co-chair a working group on HOCI, which I did together with the Chief Nursing Officer for England (Dame Ruth May) between 9 April and 21 May 2020. Thereafter, I was replaced by Professor Mark Wilcox.

18. The purpose of this group was to gain a better understanding of the transmission of coronavirus within the hospital setting. The first meeting was held on 9 April 2020. The group collated and evaluated information on infection prevention and control; cleaning; surveillance; and environmental transmission; all in hospitals. The group was also able to commission surveys and undertake rapid reviews. An example of this is the survey undertaken on nosocomial transmission rates and Infection Prevention and Control (IPC) practice in acute NHS Trusts **[SP1/03 INQ000575866]** dated 16 April 2020 and submitted to SAGE.

19. Key stakeholders during my tenure on this working group were NHSE/I, the wider NHS, PHE and NIHR. Information was exchanged with NERVTAG and reported into SAGE.

Director of the National Infection Service

20. I was appointed to the role of Director of the National Infection Service on 1st April 2019. The position was advertised nationally and appointed through a competitive process. Contractually, I was employed through a secondment agreement with the University of Cambridge. The stated remit of the role was to lead and direct Public Health England's National Infection Service in the provision of an infection service including epidemiology and specialist and reference and diagnostic microbiology health protection services.

21. By September 2019, I had led the development and publication of the first PHE Infectious Diseases Strategy. This was launched on 10th September 2019, and explicitly described an increase in the chances that we would witness a global pandemic in the coming years, including pandemic influenza and novel viruses. The Strategy set out plans to work on ten strategic priorities, including one that aimed to strengthen the PHE emergency response to major incidents and emergencies including pandemic influenza. The pandemic virus had emerged within two months of its completion, and we had not had sufficient time to develop and implement plans.

22. My role in PHE changed once the PHE National Incident and Emergency Response ("NIERP") was triggered in January 2020 in response to the

pandemic. The NIERP is the plan that provided operational details of how PHE prepared for, responded to and recovered from any public health related significant incident. It described a mechanism to operate leadership and decision making which it referred to as 'command, control and coordination'. 'Delivery cells' were set up to undertake specific pandemic response-related functions, which reported directly into the PHE National Incident Coordination Centre ("NICC") and the Incident Directors, who reported to the Senior Responsible Officer for the PHE response and the PHE CEO.

23. NICC developed a virology and testing cell, which reported into the National Incident Coordination Centre and Incident Director. This superseded the 'peacetime' governance and leadership arrangements for laboratory functions.

24. In response to the NIERP being triggered, I clarified my role in January 2020 through written and verbal communications with PHE senior leadership (PHE CEO and PHE SRO for the response). I was assigned to a liaison role between PHE and DHSC, which required me to develop a small team who became embedded within the DHSC. This fulfilled the NIERP requirement that, 'at the request of the Department of Health, PHE will send liaison staff to ensure the effective flow of information and tasking between the Department of Health and PHE's NICC'.

25. By joining meetings of both PHE and the Department of Health, the liaison team worked to identify key issues each day that required prioritisation and co-ordinated action. These issues were collated and conveyed in daily emails as a 'hot topics' list to the NICC. I continued in this role until my time became fully consumed by leading COG-UK in April 2020. At this point I returned to Cambridge to manage COG-UK, although the liaison team and function continued. I stepped down as Director of the National Infection Service at the end of June 2020, to focus on the delivery of genome data through COG-UK.

Other advisory roles

26. I also worked in an advisory capacity in relation to testing in the first quarter of 2020, as well as taking active roles that fell into two main areas.

Serological testing

27. PHE provided laboratory support to pillar 4 of the DHSC (COVID 19) plan for scale up on their testing programme based on a five-pillar testing strategy published on 4 April 2020. This pillar, led by Sir Jeremy Farrar, aimed to determine the population seroprevalence to SARS-CoV-2 in England over time.

Serology Programme Board

28. In support of pillar 4 and Sir Jeremy, I instigated the creation of a new oversight group within PHE (named the Serology Programme Board) to bring operational coordination to the delivery of pillar 4. The stated purpose of this Board was to 'ensure the Director of the National Infection Service has oversight of prioritisation and coordination of COVID-19 serology activities within PHE and receives assurance of effective delivery of the agreed outputs'.

29. The Board provided essential oversight and coordination to the operational support of pillar 4 in the first half of 2020. It met every week from 29th April 2020 and 24th June 2020, when it reduced frequency of meetings to every fortnight until 2nd September 2020. At this point, co-ordination of activities had become embedded as 'business-as-usual' and the Board was disbanded.

30. In addition to operational oversight functions, Board members were responsible for review and approval of a report **[SP1/04 INQ000223810].** This is one example of weekly reports that began on 21 April 2020, produced by the PHE Surveillance Cell on seroprevalence (rates of infection) in England; I am not aware for how long these reports continued. This was the key source of information on seroprevalence in the early months of the pandemic, prior to an expansion in data generation by other groups who were funded to develop national or population-based studies (for example, research studies referred to as VIVALDI and REACT, and the COVID-19 Infection Survey). The PHE report was signed off by me before it was shared with numerous groups, including the NICC, SPI-M, SAGE and the CMO. The report also contained information on human blood samples stored and collected by PHE, data management, and commercial assay evaluation conducted by PHE. Copies of these surveillance reports are available on request, together with agendas, minutes and papers from the Board.

Wellcome-PHE Covid-19 Serology Working Group

31. I worked with Sir Jeremy Farrar to form and co-chair the Wellcome-PHE Covid-19 Serology Working Group. This group was created following a request from the Government Chief Scientific Advisor and in support of Pillar 4. It was scientific in purpose and nature. It shared scientific information on studies, fostered collaboration and co-ordination, and informed and updated SAGE. The membership consisted of scientists (virologists and immunologists), most of whom were actively undertaking research on COVID-19 that was being used to inform discussions at SPI-M, SAGE and elsewhere.

32. This Working Group had access to the reports generated by the Serology Programme Board, which formed an agenda item and was discussed in detail.

The group shared their knowledge on sero-prevalence and immunological studies being undertaken in Oxford, London and elsewhere. It undertook a situational analysis of sero-epidemiology studies internationally; and undertook evidence reviews. The group reviewed and provided feedback on the technical performance of the antibody assays (ELISA) being developed or used by PHE. This was a forum where more detailed scientific discussions could be held on immunology/serology and we summarised discussions for SAGE; a member of Go-Science was in attendance.

33. The first meeting took place on 8th April 2020. The last meeting took place (to my knowledge) on 29th July 2020. In my view, this working group built cohesion and collaboration in the early scientific response during the first half of 2020, was important for data sharing, and provided the opportunity for more detailed discussions of data during the early stages of the pandemic.

COVID-19 Serology diagnostics taskforce

34. I became a member of this DHSC taskforce in April 2020 (by invitation) and attended my last meeting in August 2020. The aim of the taskforce was to mobilise the full breadth of UK research and development to develop the best serological technology, support its manufacture, and scale it up for roll-out to NHS and for population testing in order to understand immunity and seroprevalence. I brought knowledge of the two other committees to this meeting, providing communication across these activities.

Diagnostic testing

35. The testing and diagnostic cell reported into the NICC during February 2020. Additional oversight was added in March 2020 with the creation of a PHE Incident Management Team on testing chaired by the PHE CEO, of which I was a member. I attended meetings held at least twice weekly between March and May 2020. The purpose of this meeting was to provide oversight to the coordination of PHE efforts to increase diagnostic testing provision.

SECTION 4. DEVELOPING KEY TEST, TRACE AND ISOLATE POLICIES AND STRATEGIES

36. I was involved in developing Test, Trace and Isolate policies and strategies but only to the limited extent set out below. I did not have a role evaluating the effectiveness of these, nor in shaping how guidance on them was communicated to the public, or managing adherence or pilots. In my roles, I

did not work, observe, collaborate or consult with healthcare providers/governments in other jurisdictions.

37. I was aware of the PCR test for COVID-19 developed by an international team of scientists, including senior virologists at PHE but I was not involved in this development.

38. I was aware of laboratory studies performed by the PHE cell for testing and diagnostics to evaluate commercial diagnostic tests for COVID-19 **[SP1/05 INQ000575871]**. I attended a roundtable held at No 10 on 17th March 2020 (call to arms for COVID-19 testing), which confirmed the pillars described in the DHSC strategy for diagnostic COVID-19 testing but I was not involved in the further development of key test, trace and isolate policies and strategies relating to sensitivity and specificity of tests.

39. I was aware of the prioritisation of testing during periods of significant demand, as defined by the National Incident Coordination Centre on 11th March 2020. This grouped people into one of 6 groups based on clinical need. Beyond this, I was not involved in the development of key test, trace and isolate policies and strategies relating to prioritisation of testing.

40. COG-UK was the main generator of sequence data during the pandemic. These data were made available to the four public health agencies who were able to link this genome data with the public health and patient level data that they held, and to scientists but anonymised of any patient or public health data. COG-UK wrote a blog **[SP1/06 INQ000575867]** that reflected on the first variant identified (Alpha).

41. I was aware of a communication **[SP1/07 INQ000223410]** relating to containment level 3 and dispensing with the conditions required in Control of Substances Hazardous to Health ("COSHH"). The rationale to work at less than the minimum containment conditions for CL3 by dispensing with certain conditions required in COSHH was submitted by the virology lead for PHE to the National Incident Coordination Centre, with a request to provide this to the Chair of the ACDP on 28 February 2020. I responded on the same day to this email from Professor Maria Zambon requesting that I receive updates on pace and decisions, because I was of the view that testing needed to be expanded to NHS laboratories and elsewhere, and that the containment level required (CSL3) would be a barrier to doing so.

42. I was not involved in the decision to abandon finger prick testing, nor in decisions relating to timing of tests, the availability of tests, and isolation.

43. My evidence in paragraphs 3.1.26-27 above sets out the limits of my involvement in serological testing and diagnostic testing and the key factors affecting my decision-making in them.

44. In relation to consideration of utilising existing infrastructure to test, trace and isolate including its expansion, I was aware that the testing cell worked to roll out the COVID-19 PCR test that they had developed at Colindale into PHE laboratories in England (Bristol, Birmingham, Manchester, Cambridge) and to collaborating laboratories in Leeds, Southampton and Newcastle during February and March 2020. This utilised existing PHE infrastructure (or affiliated laboratories) to undertake diagnostic testing. I understand that four laboratories in the Devolved Administrations also adopted the PCR testing protocol. I was aware that the virology cell was in communication with the NHS in February 2020 to support NHS laboratories to adopt the testing protocol, although I was not present at these meetings.

45. Regarding the email chain between colleagues and myself between 10 and 11 March 2020 **[SP1/08 INQ000129041]**, where reference is made by me to the focus of testing that can "support the NHS response", I was referring to a prioritisation for testing that was agreed by PHE, NHS England and the DHSC and reflected in a letter sent from the National Incident Director to SARS-CoV-2 testing labs on the 11th March 2020 **[SP1/09 INQ000087299]** that provided an order of testing for periods when demand for diagnostic test may exceed local laboratory capacities and triaging of requests was required, namely:

a. **Group 1:** (test first) was patients requiring critical care for the management of pneumonia, ARDS or influenza-like illness, or an alternative indication of severe illness has been provided.
b. **Group 2:** all other patients requiring admission to hospital for management of pneumonia, ARDS influenza-like illness
c. **Group 3**: clusters of disease in residential or care settings
d. **Group 4:** community patient meeting the case definition and not requiring admission to hospital – over 60 years or risk factors for severe disease; over
e. **Group 5:** community patient meeting the case definition and not requiring admission to hospital - under 60 years and no risk factors for complications
f. **Group 6** (test last) contacts of cases.

46. Ideally, we would provide a diagnostic test to everyone who required one, including people in the community, but this was not possible at this point in time. In my email response written at 23.42 hours on 11th March 2020, I wrote that "Whilst mass community testing is appealing, we are focusing on the most

unwell until we are confident that this is robustly supported". This was written to convey the prioritisation of testing towards the NHS and sick individuals. Testing of people in the community became deployed once capacity was greater and supported individual diagnosis and medical care, and the use of relevant infection prevention and control measures to prevent onward viral transmission. If I had written this email during normal office hours rather than just before midnight, I believe that I would have chosen my words more carefully, using an alternative word to replace "appealing". In retrospect, the word "appealing" is subjective rather than objective and I regret using it.

47. Both types of test are important: virus detection for clinical case finding, diagnosis and patient care; and serology to detect recent/past infection. Both were the focus of the testing strategy published by DHSC in April 2020, and I have set out from paragraph 3.1.19 my involvement in serological testing. As more tests became available, a greater proportion of people with symptoms would have had access to testing, but I was not involved in NHS Test and Trace.

48. In my supporting roles to Pillar 4 and serological testing, the Serology Programme Board and Serology Working Group reviewed data as it emerged on the performance of commercial assays for serological tests. This influenced the choice of assay adopted at Porton Down for serological tests performed there.

49. Data were also gathered and documented in the report produced by the PHE Surveillance Cell on seroprevalence (rates of infection) in England (referred to in paragraph 3.1.22 above) on serological testing results from numerous concurrent studies, which aimed to capture data on different age groups and populations in the UK, highlighting areas of need for further sampling (for example, children and young adolescents in the early months of testing).

50. In relation to the most significant challenges I encountered in relation to testing, there was a perception in the first 2-3 months of the pandemic, as it became clear that testing needed to ramp up, that PHE labs could provide all of the necessary diagnostic testing for England. I would reflect on the fact that there was not enough capacity within PHE as an organisation to provide national testing. Most of the test capacity and capability in the early months of the pandemic resided in the NHS.

51. A historical narrative is informative in this regard. As described by Claas Kirchhelle in a review published in 2022 (Giants on Clay Feet – COVID-19 infection control and public health laboratory networks in England, the USA and (West-) Germany (1945-2020) **[SP1/10 INQ000207449]** the laboratory network developed by the Public Health Laboratory Service (PHLS, the first iteration of

a public health laboratory function) reached its height in 1969 when there were 63 labs. This dwindled over time. By the time that this transitioned into the Health Protection Agency in 2010, the public health agency was responsible for just 8 laboratories, with the majority of PHLS labs being taken over by the NHS. The number of public health laboratories further declined when the HPA transitioned into Public Health England, and by the time the pandemic began. Specifically, by January 2020, the PHE laboratory network was responsible for routine diagnostic microbiology laboratories on behalf of (and in collaboration with) NHS Trusts in 4 cities (Manchester, Birmingham, Bristol and Cambridge) and had laboratory capability in Colindale and Porton Down. The PHE laboratory in London had closed some years before the pandemic began.

52. A further challenge was leveraging capacity in research laboratories in the early months of the pandemic at a time when other testing capacity was insufficient for the growing need. There was considerable frustration that this could not be rapidly unlocked, but the reality was that such laboratories needed to be networked with the source of positive samples (hospitals) and PHE did not have direct control over the NHS or their laboratory network. In addition, research labs were not able to handle patient-level information without relevant steps to anonymise samples.

SECTION 5. LESSONS LEARNED

53. My reflections on lessons learned are based on my experiences in my roles in the first half of 2020.

NIERP

54. With the benefit of hindsight, it is my personal view that the NIERP structure used by PHE was not designed to deal with a global pandemic. It aimed to purposefully funnel all information and decisions into a single place to achieve command and control. For a small incident I can see the benefit of this plan, but the amount of information being fed into the NICC grew exponentially, the risk of overwhelm was real, and the early response did not appear to be able to transition beyond the reactive.

55. I am also of the view that the NIERP structure used by PHE was not designed to deal with a global pandemic caused by a novel coronavirus. The NIERP was based on tackling an influenza pandemic. The UK Influenza Preparedness Strategy published in 2011 makes scant mention of diagnostic testing; the report refers to the use of testing to detect and diagnose early cases in the initial phase when there is a need to develop a diagnostic test specific to the

new virus. There is also reference to the laboratory analysis of a sample of cases to identify the genetic features of the virus and any changes to it such as development of antiviral resistance. Exercise Cygnus conducted by PHE in 2016 based on an influenza pandemic did not address the requirement for testing. I was not aware of the existence of Exercise Alice, conducted as a tabletop exercise by PHE in 2016 and based on planning and resilience to a large-scale outbreak of MERS-CoV in England, but this did not recommend planning for large scale diagnostic testing beyond the development of a serological assay that could confirm (recent or past) infection, and there was no national testing plan to be used during a pandemic that I was aware of. Collectively, this meant that the early focus of diagnostic testing was for PHE to develop a test for a novel virus and to test early cases.

Diagnostic testing capacity

56. In my view, a national review of the roles and responsibilities of the UKHSA in both routine, reference and emergency response diagnostic testing is now warranted, since its laboratory network has gone into a terminal decline in the last 20 years, with the important exception of its highly specialist reference functions.

57. In the event that this has not been undertaken, I consider it to be of vital importance to develop a plan that describes how to mobilise testing capability in NHS laboratories and research laboratories in the event of a future emergency, together with systems to connect data flows and manage issues such as the handling of patient data.

58. The No 10 round table on testing and the document published by the DHSC (Coronavirus COVID-19 Scaling up our testing programmes) in April 2020 was essential to provide that strategic direction, which led to the creation of Test and Trace.

The work of COG-UK

59. As to the legacy for responding to another pandemic, COG-UK is now closed but has left a public record of how it was rapidly developed, how it identified and enlisted national capabilities in sequencing, how it analysed and stored the genome data, and made the sequence data available to public health organisations and researchers **[SP1/11 INQ000575870].**

60. I suggest that COG-UK could be recapitulated with appropriate leadership in the event of another pandemic. It is also my hope that a national plan has been developed that describes scaling of genomic capabilities across the UK in the event of a 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:

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Dated: 10th April 2025