Witness Name: Thomas Evans
Statement No.: 3
Exhibits: TE 01 - TE 10
Dated: 29 May 2025

UK COVID-19 INQUIRY

WITNESS EVIDENCE FOR MODULE 7

THIRD WITNESS STATEMENT OF THOMAS EVANS

I, Thomas Evans, will say as follows—

SECTION 1. INTRODUCTION

1.1. I make this third witness statement to the UK Covid-19 Inquiry ("the Inquiry") in response to a Rule 9 Request for Evidence dated 1 April 2025 for Module 7, which I understand concerns the Government's approach to test, trace and isolate from 1 January 2020 to 28 June 2022 ("the Relevant Period") in England, Wales, Scotland and Northern Ireland. This includes Test and Protect (Scotland), Test and Trace (England), Test, Trace, Protect (Wales) and Test, Trace and Protect (Northern Ireland).

1.2. I am chair of the Advisory Committee on Dangerous Pathogens ("ACDP") (2016 — current), a scientific advisory group to the Department of Health and Social Care, and co-chair the High Consequence Infectious Diseases ("HCID") subgroup of the Scottish Health Prevention Network ("SHPN"), a part of Public Health Scotland (2018 — current). I also was a member of the precautionary Scientific Advisory Group for Emergencies ("SAGE") advising on Zika from February 2016 to August 2016.

1.3 The background to my appointment as chair of ACDP was outlined in my Module 1 statement **[INQ000183413]** as follows:

> *"3.* I applied to be Chair of ACDP in response to advertisement and was appointed initially as a member following interview according to regulations

regarding government scientific advisory groups. In my first meeting in 2015 1 was a member and thereafter I was appointed as Chair, following Chris Whitty relinquishing the post as he moved to be Chief Scientific Advisor to the Department of Health. Over the time period covered, I attended all 12 meetings of the ACDP, 4 of the 5 pre-SAGE Zika meetings, and all of the 4 meetings of the HCID subgroup of the SHPN. My role in all of these meetings was to ensure important matters of concern for the different committees were brought forward for discussion, to provide expert insight into the areas reviewed by these bodies, and to help shape explicit advice to government on these matters".

1.4. The ACDP is an independent scientific advisory committee of the Department of Health and Social Care ("DHSC"). Its role is to provide scientific advice on the risks of exposure to various pathogens (the risks from pathogens includes potential exposure during testing for pathogens such as SARS-CoV-2). ACDP's work cuts across a number of organisations, including the Health and Safety Executive ("HSE"), UK Health Security Agency ("UKHSA"), and the Department for Environment, Food and Rural Affairs ("Defra"). Its terms of reference are to provide, as requested, independent scientific advice to HSE, and to ministers through DHSC, Defra, and their counterparts under devolution in Scotland, Wales and Northern Ireland, on all aspects of hazards and risks to workers and others from exposure to pathogens. In addition, the committee provides, as requested, independent scientific risk assessment advice on transmissible spongiform encephalopathies ("TSEs") and related prion threats to ministers through DHSC, Defra, and their counterparts under devolution in Scotland, Wales and Northern Ireland, and to the Food Standards Agency. The ACDP is not involved in the implementation of the advice it has issued to all UK Government departments.

SECTION 2. ADVICE REGARDING THE CLASSIFICATION OF SARS-COV-2 INFECTION AS A HIGH CONSEQUENCE INFECTIOUS DISEASE

2.1. The ACDP was asked for advice on some aspects around the testing for SARS-CoV-2, the causative virus of COVID-19, in February 2020. The committee's view was sought on aspects of testing that related to safety of healthcare and other personnel. This included safe laboratory practices, and transport of material potentially containing the SARS-CoV-2 virus. These requests came to the committee from those organising testing within Public Health England ("PHE") and the Office of the Chief Medical Officer

("CMO") [see **Exhibit: TE/01 INQ000606865; Exhibit: TE/02 INQ000223406; and Exhibit: TE/03 INQ000606866].**

2.2. Patients presenting in the UK with non-endemic infectious diseases which pose a significant risk to healthcare workers and the public have been managed within the NHS for many years. They present specific problems in infection control, and require that a sustainable response is in place. Following the Ebola outbreak in West Africa in 2014-2015, a programme for managing such infections was established under the auspices of NHS England. As part of this work, a list of infections that required such specialist management was drawn up and defined as HCIDs. These are defined by the following criteria:

- acute infectious disease
- typically has a high case-fatality rate
- may not have effective prophylaxis or treatment
- often difficult to recognise and detect rapidly
- ability to spread in the community and within healthcare settings
- requires an enhanced individual, population and system response to ensure it is managed effectively, efficiently and safely

The designation of a HCID is based on the combination of the above criteria. The current list of infections classified as HCIDs is exhibited here **[Exhibit: TE/04 INQ000606867].**

2.3. I would like to emphasise that this programme of managing HCIDs was not part of pandemic preparedness planning. Its main purpose was to provide a safe system of working for healthcare personnel and preventing wider community spread for limited numbers of imported HCIDs. The name HCID was not meant to imply that other infections were not of high consequence – for example tuberculosis (TB) and malaria are diseases whose global health burden is enormous. However, neither infection is classified as an HCID – we have robust programmes for managing patients with TB and effective treatment is readily available; the arthropod vectors of malaria are not found within the UK; and hence person-to person transmission does not occur.

2.4. The classification of SARS-CoV-2 as an HCID was made in January 2020 by the 4 nations public health HCID group. The view of ACDP were not sought for this classification.

2.5. In March 2020, the DHSC asked the ACDP to consider if SARS-CoV-2 should continue to be a HCID. This was considered by ACDP at a teleconference held on 13 March 2020. The unanimous view of the committee was that SARS-CoV-2 should no longer be classified as a HCID **[Exhibit: TE/05 INQ000223384].** The reason ACDP gave for this consensus view was because the overall case fatality rate was about 1%, and the majority of those infected did not require specialist care or hospital admission. At that time community transmission was already well established in many countries, and it was becoming clear that asymptomatic cases accounted for a significant number of infections that could mediate transmission before contact with a healthcare facility. Thus, continuing designation of COVID-19 as an HCID would not prevent such transmission within the community. In addition, a specific and sensitive test was available using nucleic acid amplification by the polymerase chain reaction (PCR). The decision was communicated to DHSC by a letter addressed to the then Deputy Chief Medical Officer **[Exhibit: TE/06 INQ000115534].** Following this advice, DHSC changed the designation of SARS-CoV-2 from HCID.

SECTION 3. ADVICE REGARDING THE CLASSIFICATION OF SARS-COV-2 AS A HAZARD GROUP 3 PATHOGEN

3.1. All pathogenic organisms are given a hazard group classification by the HSE in consultation with ACDP. There are four hazard groups, with group 4 being the highest. Classification is based on the level of risk of infection to humans. Classifications are published as the Approved List of Biological Agents which covers biological agents that can be harmful to human health, usually due to infection although some are toxic or can cause an allergy. The descriptors for this classification are as set out below and contained in **[Exhibit: TE/07 INQ000606907]:**

Information box: Hazard group definitions When classifying a biological agent it should be assigned to one of the following groups according to its level of risk of infection to humans.	
Group 1	Unlikely to cause human disease.
Group 2	Can cause human disease and may be a hazard to employees; it is unlikely to spread to the community and there is usually effective prophylaxis or treatment available.
Group 3	Can cause severe human disease and may be a serious hazard to employees; it may spread to the community, but there is usually effective prophylaxis or treatment available.

Group 4	Causes severe human disease and is a serious hazard to employees; it is likely to spread to the community and there is usually no effective prophylaxis or treatment available.

3.2. Under the Control of Substances Harmful to Health Regulations 2002 **[Exhibit: TE/08 INQ000269676],** employees and any other person working with biological agents in Hazard Groups (HG) 2, 3 and 4 are to assess the risk of exposure to those biological agents and handle them under appropriate containment. There are 4 levels of laboratory containment.

3.3. **Containment Level 1 ("CL1") -** these laboratories typically handle low-risk pathogens, such as genetically modified organisms, animals and plants, and so don't need as many special biosecurity measures in place as the higher CL categories. However, there should be a risk assessment protocol in place, access needs to be strictly controlled (particularly for guests and visitors, who should be supervised at all times) and the lab should be locked if it isn't being used. All the laboratory surfaces should be impervious to water, acid and solvent-resistant and easy to clean. All the ventilation systems and safety cabinets should be inspected and tested at least once a year.

3.4. **Containment Level 2 ("CL2") -** CL2 rooms and labs represent a step up in protection levels because they handle what are classified as 'medium-risk' biological agents. These can include pathogens which are linked to human disease, such as staphylococcus aureas (also known as staph infections) and the HIV virus. All the protections in place for CL1 rooms and labs also apply here, along with some additional safety measures. More emphasis is placed on user cleanliness with hand sanitisers and eyewash stations provided, as well as the use of personal protective equipment. Risk assessments should also be carried out, with reference to the COSHH (Control of Substances Hazardous to Health) regulations of 2002. In a CL2 lab, care should be taken to avoid any splashes as these can settle on surfaces and be transferred through the hands. Any procedures which could cause infection via an airborne route should be carried out in a biological safety cabinet. The use of sharps – any instruments which could puncture the skin – should be avoided where possible.

3.5. **Containment Level 3 ("CL3")** deals with pathogens. These types of laboratories handle comparatively high-risk pathogens, such as the those which cause yellow fever, West Nile virus and the bacteria that causes tuberculosis. This means there is a much higher risk of passing on an infectious disease if the appropriate measures are not in place.

Safety protocols in a CL3 room or lab include decontamination of waste and clothing, a separate regular fumigation, and (sometimes) a separate lobby area to minimise the risk to staff and patients. The PPE and personal hygiene requirements which are found in CL2 rooms are also applicable here. There are also stricter rules around air circulation – any fresh air should be drawn into the lab from 'clean' areas and with no recirculation. This is partly down to the presence of pathogens which could transmit infection via an airborne route. It also places great importance on the room's critical ventilation systems. Most CL rooms in hospitals are classified as level 3. As a result of the stricter containment levels, it was necessary to determine whether the classification of HG3 could be modified to allow for greater freedom for diagnostic work.

3.6. **Containment Level Four ("CL4") - t**his is the highest biosecurity level in operation in the UK. It is not very common because they deal with highly hazardous – but also extremely rare – pathogens, such as those which are associated with Lassa Fever and the Ebola virus. Anything brought back from a space exploration programme would also have to be examined in a CL4 lab.

3.7. ACDP considered the hazard group classification of SARS-CoV-2 at a meeting on 13 February 2020. At that meeting, representatives of the HSE proposed that SARS-CoV-2 should have a provisional classification as a HG3 pathogen **[Exhibit: TE/09 INQ 000527983 and Exhibit: TE/10 INQ000527881]**. The committee evaluated the likelihood of laboratory acquisition of infection, severity, and containment required to limit infection. Based on the data at that time, and applying the criteria set out in paragraph 3.1 above, the committee endorsed a HG3 classification for SARS-CoV-2. The classification was initially made provisional as the scientific knowledge of the pathogen at this time was limited. That was consistent with the usual practice when dealing with a new pathogen.

3.8. Of relevance to the issues in this module, is how the HG3 classification was modified to allow greater freedom for diagnostic work. On the 28 February 2020 I received an email from Dr Maria Zambon, the Head of Influenza and Respiratory Virology and Polio Reference Service at PHE **[Exhibit: TE/01 INQ000606865].** The attachment from this email is submitted as **[Exhibit: TE/02 INQ000223406].** PHE's request was to allow certain diagnostic procedures to be carried out at facilities with a lower containment level than CL3 to allow for testing to be carried out at scale as rapidly as possible without jeopardising the safety of laboratory personnel. This request was sent on for email comment by ACDP committee members **[Exhibit: TE/3 INQ000606866].** The

factors the committee considered were the potential routes of exposure to laboratory personnel from diagnostic material. Importantly, potentially infectious material in diagnostic samples was either on swabs or in liquid samples and the risks therefore of airborne transmission in that context were negligible. The committee endorsed the proposal, and this was communicated to HSE. Subsequently, Professor Andrew Curran, Chief Scientific Advisor to HSE at that time, confirmed that HSE approved the proposed derogation for diagnostic testing of COVID-19 [**Exhibit: TE/10 INQ000527881]** on 1 March 2020. This derogation did not change the hazard grouping of SARS-CoV-2, which remained as HG3, but allowed work on testing to be carried out at a lower level of containment.

3.9. The practical implication of this derogation was important in facilitating the rapid testing of diagnostic samples at scale within laboratories. CL3 conditions require dedicated laboratory suites with controlled airflow systems. Diagnostic laboratories in general would only have one such suite; some would have no access to such a facility and samples would have to be sent elsewhere for testing. CL2 facilities are much more generally available, and this change allowed much greater access, speed and quantity of testing.

3.10. The ACDP as an advisory committee has not been asked to carry out any reviews of recommendations made in respect the Covid-19 response, or of lessons learned as this is not within the remit of the committee. The committee was not involved in issues surrounding the test, trace, and isolate programmes.

SECTION 4 – PERSONAL REFLECTIONS

4.1 I have a number of personal reflections on the work of the ACDP relating to this module. I believe the committee had the necessary range of expertise to provide useful advice to its sponsor departments during this period. Members responded to requests for opinions very rapidly, which was necessary given the need for urgent decision making. I understand that DHSC felt a need to keep sources of advice focussed, but given the range and volume of scientific advice required, my personal view is that the committee could have been asked to take on more of the requests for advice that were dealt with mainly by the New and Emerging Respiratory Virus Threat Advisory Group ("NERVTAG").

4.2 Inequalities in many aspects of the COVID-19 pandemic were increasingly evident as it progressed. In the considerations of ACDP, as outlined above, there were no specific issues regarding such inequalities as the risks we were assessing applied to all members of the population and would not be subdivided further.

4.3 The work of the ACDP involves the whole of the UK. There are standing invitations to relevant members of the devolved administrations to attend ACDP meetings. In my experience, we did not encounter any issues with the committee's advice from any of the devolved administrations. My personal view is this is because it is clear the committee is independent of any government and that the scientific credentials of committee members are highly respected.

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: PD

Dated: May 29th 2025