Wednesday, 22 May 2024

(10.29 am)

Introductory remarks by THE CHAIR

LADY HALLETT: Good morning. This is the second preliminary hearing for Module 4, vaccines and therapeutics.

As ever, we have a great deal to get through today, so I must, I'm afraid, insist that core participants stick to the tight timetable and the timings they have been given. I don't want to intervene, and I know that some of our core participants have not been represented before, so -- I know the others all know how tight I can be on timetables -- so please, everybody, don't make me intervene, it would be bad for everybody.

Mr Keith will now outline the major issues that I shall have to be considering for this second preliminary hearing.

Statement by LEAD COUNSEL TO THE INQUIRY

MR KEITH: My Lady, since the first preliminary hearing last September, the Inquiry has moved at pace. Since then, you have concluded the hearings in Module 2, the module examining the UK Government's core political and administrative decision-making, and Modules 2A, 2B and 2C, the related modules in Scotland, Wales and Northern Ireland, and Module 2C, as you will recall only too well, finished just last Thursday.

I don't propose, my Lady, to reintroduce the core participants -- they were introduced at the last preliminary -- or their legal representatives, given the number of core participants and the shortness of time, but there are 33 core participants in Module 4 and all are legally represented.

Written submissions have been received from 12 of the core participants, and we're very grateful to all of them for the observations and insights which they have contributed, and I believe you'll be hearing from nine advocates.

My Lady, may I start, please, with the issue of the timing of this module. On 10 January, you announced that the hearing had to be put back from this July to next January, some six months. The Inquiry acknowledges that the putting back of the hearing has caused frustration and distress, and we're sorry for that. I want to emphasise, though, just how fast the Inquiry has been moving. You know that of course it opened on 21 July 2022, only five months following the end of the lifting of the Covid-19 restrictions on the UK population.

The first public hearing took place less than a year later, between June and July last year, and you've also conducted and concluded the hearings in 2, 2A, 2B

and 2C, as I've said.

Each of those hearings was necessarily preceded by an extensive and complex process of obtaining potentially relevant documents from various government bodies and other entities and persons.

Those materials have, as you know, to be examined by the Inquiry team, and then documents, those that are deemed to be relevant, are disclosed to the core participants to assist them in their preparation for the hearings.

The preparation for each hearing is demanding and difficult for material providers and the Inquiry alike. It relies to a very great extent on the material providers and their ability to make that material available. So, for departments like the Department of Health and Social Care, this is an extremely onerous task.

We have attempted to reduce the overall length of the Inquiry by allowing only for relatively short periods of time between modular hearings. With the best will in the world, it proved not to be possible to hold 2A, 2B, 2C, Module 4 and then Module 3 in quick succession in the course of a single year. The impact on the material providers in Module 3 was just too great, on account of having to deal with the demands of

Module 4 very fairly shortly before that module.

Rescheduling Module 4 to next January has enabled the material providers in Module 3 to give priority to the greater demands of that more complex and lengthier module in the autumn. The putting back of Module 4 by that six months is, I should say, relatively modest, it's a relatively modest delay in the general scheme of the overall length of the Inquiry.

As for the suggestion which one core participant has advanced in their written submissions for this preliminary hearing to the effect that there has been a general delay across the hearings, that is absolutely not the case. Having only just concluded Modules 2A through to C, you are already in the foothills of one of the lengthiest and most complex modules, Module 3, healthcare, which starts in the autumn.

Finally on this point, may I just say that it is obvious that Module 4 has been put back until after Module 3, but who is to say that Module 4, vaccines, was required to be dealt with before healthcare? It is no more and no less important a module. But the extra time that we now have will allow us to be better prepared and will make for a more effective hearing.

Since last September, a great deal of progress in this module has in fact been made. We've sent Rule 9

1 requests to 95 additional individuals and organisations,
2 and as at the date of the Counsel to the Inquiry note of
3 earlier this month, Module 4 has sent out over
4 120 Rule 9 requests for witness statements and
5 associated documents.
6 Details of those requests have been contained in the
7 update notes provided by the Solicitor to the Inquiry in
8 respect of this module. The core participants have
9 an overview of the topics which have been covered and of
10 the individuals and entities who have received Rule 9
11 requests, but they cover organisations such as the
12 UKHSA, the Vaccine Taskforce and its officials, the
13 Department for Science, Innovation and Technology,
14 ministers, former Scottish cabinet secretaries, of
15 course the former Chief Scientific Adviser,
16 Sir Patrick Vallance, key figures within the Antivirals
17 and Therapeutics Taskforce and its predecessor bodies,
18 the MHRA, pharmaceutical companies, JCVI, NICE, the
19 Department of Health and Social Care, and related health
20 departments in the Welsh, Scottish and Irish
21 administrations, as well as chief investigators and
22 those leading the platform trials for new and
23 re-purposed therapeutics.
24 So we have cast our net relatively wide.
25 We are very grateful to the recipients of those

1 requests for the efforts they've made so far to comply
2 with our demands. More than 80 draft statements have
3 been received and these are either being reviewed with
4 a view to giving the material providers feedback, or
5 have been finalised but are awaiting final confirmation
6 and/or signing.
7 We will of course be sending more Rule 9 requests
8 out, and the ones in the next month or so are likely to
9 include the former First Ministers of Scotland and
10 Wales, the chief pharmaceutical officers in all
11 four nations, senior responsible owners for vaccine
12 deployment, as well as, of course, those individuals and
13 entities who have been suggested to us by the
14 core participants.
15 In the autumn, decisions will then have to be made
16 as to whether there are follow-up Rule 9s and/or whether
17 or not further new Rule 9 requests are required to be
18 made.
19 Many thousands of documents and exhibits have been
20 received already, not all of them, of course, relevant
21 and disclosable. A significant amount of that
22 documentation has already been disclosed.
23 May I also say something about the targeted approach
24 to disclosure to which I made reference in the CTI note.
25 In the case of major government departments, it's

1 clear from the initial responses that many tens of
2 thousands of documents were potentially responsive to
3 our provisional outline of scope.
4 My Lady, the process of assessing such a large
5 quantity of material would lead to an unconscionable
6 delay in this Inquiry and its timetable, and would
7 render impossible your stated determination to produce
8 timely recommendations. So, with respect to some -- and
9 I emphasise only some -- document providers, we have
10 adopted a targeted approach by which, rather than simply
11 asking for all documents relevant in the opinion of the
12 material provider to particular broad themes or areas
13 arising in Module 4, we've instead sought documentation
14 specifically relating to key narrative events, core
15 decisions and to the processes and systems concerning
16 the development, procurement, approval, including the
17 hugely important issue of safety, and delivery of
18 vaccines and therapeutics.
19 My Lady, it would be an impossible task to seek and
20 wade through the millions of pages of potentially
21 responsive documents that relate to the production and
22 deployment of vaccines in the United Kingdom. We
23 applied a similar targeted approach in Module 2, and may
24 I say, despite some initial misgivings on the part of
25 core participants in Module 2, it is now, I think,

1 generally recognised that the Inquiry secured absolutely
2 everything that mattered for the purposes of that
3 module.
4 Turning to scope, a large part of the written
5 submissions that you have received address the issue of
6 scope and whether or not the net cast by this module is
7 sufficiently wide enough.
8 We're very grateful to the CPs for the thought and
9 energy that has gone into those submissions, and before
10 I attempt to address some of them, which I can answer
11 straightaway, may I make some preliminary observations.
12 As I've said, the Inquiry has neither the time nor
13 the resources to address every issue related to vaccines
14 and therapeutics, and the general public would not wish
15 it to. Choices have to be made, and your conduct, if
16 I may say so, of the five hearings that we have had so
17 far suggests that the Inquiry can be trusted to seek,
18 obtain and expose what really matters.
19 Module 4 must focus on matters of real importance.
20 We cannot scrutinise every aspect of development or of
21 delivery or deployment during the pandemic, or to
22 examine issues with the same degree of specificity as
23 forensic matters are examined in the course of
24 single-event Inquiries.
25 But it is not correct to say, as some

1 core participants have expressed in their submissions,
2 that there will not be an examination of vaccine safety.
3 On the contrary, the systems and processes which are the
4 centre of this module's focus are the backbone of the
5 framework that existed for establishing and monitoring
6 vaccine safety. We will be looking at critical aspects
7 of vaccine safety: the nature and the efficacy of the
8 regulatory regime for the approval of vaccines, the
9 considerations that underpinned relevant
10 decision-making, how risk/benefit assessments were
11 undertaken and applied, and of course the operation of
12 the post-approval monitoring system.
13 But what we cannot do is make precise determinations
14 in relation to whether a specific vaccine is safe or
15 determining matters of causation where death or injury
16 has resulted from specific vaccines. Safety is
17 a relative concept, and any determination, if it could
18 be made, would serve no sensible purpose. Were we to
19 engage in a process of expressing a determinative view
20 on the safety of specific vaccines and on causation, we
21 would be led into an enquiry into matters that would
22 risk a breach of section 2.1 of the Inquiries Act which,
23 as you know very well, provides an inquiry panel is not
24 to rule on and has no power to determine any person's
25 civil or criminal liability. Indeed, as you know,

1 litigation has already commenced in relation to one
2 pharmaceutical company.
3 In any event, the exercise of pronouncing the last
4 word on the efficacy and safety of specific vaccines may
5 prove to serve little purpose. Who is to say whether
6 past specific vaccines will be of any use in a future,
7 perhaps a non-coronavirus, pandemic?
8 So what really matters is: what were the systems and
9 decision-making processes for the development,
10 procurement, approval, eligibility for and access to
11 vaccines and therapeutics, and how can those systems and
12 procedures be improved? Only with that approach will
13 you have a sure foundation for the promulgation of
14 recommendations for the future.
15 But I wish to assure core participants, and it's
16 been made plain from the CTI note and from the
17 provisional outline, that we will be looking at,
18 of course, preparedness and core decision-making,
19 particularly in relation to the Vaccine Taskforce and
20 the Antivirals and Therapeutics Taskforce.
21 We'll be looking at the general impact of those
22 decisions, especially on marginalised groups and
23 communities. We'll be looking at specific
24 vaccine-related issues such as misinformation and
25 disinformation, the reasons for vaccine hesitancy or

1 lack of confidence, the steps taken to address vaccine
2 hesitancy and lack of confidence. We'll be looking at
3 post-marketing surveillance, including the Yellow Card
4 monitoring scheme and the UK Vaccine Damage Payment
5 Scheme. Insofar as therapeutics are concerned,
6 Module 4's examination will include specifically the
7 decision-making relating to the non-vaccine prophylactic
8 Evusheld.
9 In our note, my Lady, we've made plain that whilst
10 we will not be looking at matters such as costings or
11 supply chains or manufacturing processes or intellectual
12 property, we will be looking at, in an overall sense,
13 the amount that the United Kingdom spent on vaccines,
14 we'll be looking at the approach to discounted rates and
15 we'll be looking at the general system for liability and
16 indemnity arrangements.
17 In relation to issues of eligibility and priority
18 for vaccination, we will examine the processes by which
19 those were considered and decisions were reached, so
20 of course we will necessarily be looking at how the
21 balance was struck between relevant considerations such
22 as vulnerability, age, likely contraindications, as well
23 as diversity and ethnicity.
24 So may I respond to the submissions from the UK
25 Covid Vaccine Adverse Reaction and Bereaved groups, who

1 have stated that they're deeply disappointed and
2 concerned by what they perceive to be a suggested
3 narrowing of the scope of Module 4, in particular in
4 relation to vaccine safety.
5 They ask: how can the Inquiry assess regulation and
6 safety without understanding and scrutinising the
7 underlying data, the processes, scientific and
8 medicinal, and are we looking at vaccine safety with
9 a sufficient degree of specificity?
10 I want to assure them that we are. We will be
11 examining what was and is in the public domain about
12 vaccine safety. We'll be looking at the regulatory
13 processes concerning vaccine safety. We'll be looking
14 at the impact of the decisions on vaccine safety. And
15 we will adduce whatever data is necessary to scrutinise
16 those issues appropriately and proportionately.
17 May I then make a second point, a general point,
18 concerning scope.
19 My Lady, as you've noted in the course of earlier
20 preliminary hearings in other modules, the issues that
21 will be explored at the hearing depend to a very large
22 extent, of course, on the Rule 9 statements and the
23 documents which are disclosed. As they are disclosed,
24 the issues will become further distilled. That
25 distillation will be reflected in the provisional list

of issues and that will be made available in due course.
The core participants today have not yet seen the majority of the Rule 9 statements which will in due course be served, so the actual scope of Module 4 and the issues that will arise for scrutiny are not, of course, known to them yet through the Rule 9 material and the exhibits, but it will become clearer as they receive more and more of the documentation, and of course we remain open to suggestions that they may wish to make in due course.
My Lady, all that said, their submissions on scope have received the most careful consideration and you will, with your usual assurance that matters are kept under review, be continuing to look at those points.
Can I then turn to some of the many points which are raised specifically. I'm going to try to answer as many as I can in the time that I have, and to lay down what I hope are some general helpful markers.
Access to therapeutics. The Clinically Vulnerable Families group note the amendments to the provisional outline of scope and they ask whether we'll be obtaining data relating to the number of people who received antivirals and comparing it against those who were eligible according to national eligibility criteria.
We do not intend to seek specific data or such

specific data in the absence of a basis for believing that such data is reflective of a systems failure, but such data may well emerge in the course of the forensic process, and of course it's open to CVF to ask appropriate witnesses about data underlying or underpinning their evidence.
Long Covid. FEMHO seek clarification on whether the investigation will cover the interrelationship between vaccines and Long Covid. My Lady, the Long Covid groups are not, as you know, core participants in Module 4, but they are in Module 3, and they made submissions on the link between Module 3 and Long Covid at the recent preliminary hearing in Module 3 in April.
Our approach in Module 4 is not to actively investigate the interrelationship between vaccines and Long Covid, not least because the way in which the issue has been framed in the submissions seems to us to be too broad. But I can say that the expert report on vaccine safety is likely to address the issue of vaccine effectiveness against Long Covid.
And casting, my Lady, your mind back to Module 2, you'll recall that you received evidence from Professor Brightling and Dr Evans on Long Covid and on the impact of the pandemic on those who suffer from Long Covid. The issue has also been addressed in the

expert evidence in Module 3, so in due course it's open to you to admit that expert evidence if appropriate in Module 4.
Covid Bereaved Families for Justice Cymru repeat its request for reassurance that differences in approach to eligibility and prioritisation for vaccination in Wales will be properly considered. The short answer is: yes, it will, and you ruled on this in fact in the last preliminary hearing in September.
A number of the submissions relate to inequalities and barriers. In relation to eligibility and prioritisation, Covid Bereaved Families for Justice UK and Northern Ireland Covid Bereaved Families for Justice submit that it's crucial that prioritisation of key workers and discrimination should be key areas of focus.
My Lady, the Inquiry does intend to focus on the processes which led to decisions on prioritisation, including whether they were discriminatory, and we are absolutely confident that the evidence which will be adduced will be sufficiently reflective of that issue and also any scientific considerations which underpin that particular theme.
FEMHO reiterate that the Inquiry must state its resolute commitment to placing inequalities at the forefront of its investigation. They wish us to explore

whether institutional and structural racism played a part in the development, procurement and roll-out of vaccines. They ask us to look at all the Module 4 issues through what they describe as an inequality lens.
The British Medical Association wishes us to look at discrimination in the context of vaccine hesitancy, and the Traveller Movement submits that we should look at disadvantaged and discriminated against communities, again in the context of vaccine uptake.
My Lady, the issues around inequalities and barriers to uptake are being addressed in line with the ruling that you gave on this in September, and you made clear that Module 4 would be examining inequalities throughout its work.
The Inquiry has asked and will continue to ask recipients of Rule 9 requests about inequalities, barriers and discrimination.
We have also instructed two sets of experts (in the first part, Dr Kasstan-Dabush and Dr Chantler, respectively experts in health protection and vaccine roll-out at the London School of Hygiene and Tropical Medicine; and on the second part, Professor Heidi Larson, who is an expert anthropologist and director of the Vaccine Confidence Project at the London School of Hygiene and Tropical Medicine) to look

1 at issues such as disparities in coverage, the causes of
2 disparities, the reasons for barriers, the interplay
3 between the vaccines roll-out and pre-existing
4 inequalities and structural discrimination, and the
5 causes of vaccine hesitancy.
6 We will also be asking them and the Rule 9
7 recipients about the extent to which those issues were
8 foreseeable and what steps could have been taken to
9 address them.
10 So, my Lady, we believe that all those areas are
11 well covered by our requests of the Rule 9 recipients
12 and also in the expert evidence that we intend to
13 instruct and adduce.
14 We don't consider, however, that any purpose would
15 be served in formally identifying barriers to uptake as
16 being a separate theme or specific purpose of this
17 module. The issue will be thoroughly considered by the
18 experts and explored in the evidence, and it will be so
19 explored alongside the interrelated issues of
20 pre-existing inequalities and disinformation. So it
21 would be somewhat artificial and impractical, in our
22 view, for barriers to uptake to be treated as a discrete
23 issue, as requested by the Traveller Movement.
24 My Lady, turning to misinformation and
25 disinformation, Scottish Covid Bereaved submit

1 the Inquiry should consider the use of social media, in
2 particular how protected or verified public health
3 messages can be sent online, and what steps can be taken
4 to gain the trust of those who may have concerns about
5 receiving vaccines, particularly in light of the lack of
6 regulation of the internet.
7 My Lady, that's a sensible and proportionate request
8 from the Scottish Covid Bereaved, and we agree.
9 The Inquiry has in fact received already a draft witness
10 statement from Meta, and we will be requesting witness
11 statements from a number of internet providers,
12 including X (previously Twitter), TikTok, YouTube and
13 Google.
14 Turning to roll-out and delivery, we've received
15 a number of submissions from the British Medical
16 Association and the NPA. They have made a number of
17 suggestions for areas concerning roll-out to be explored
18 by the Inquiry, in particular to do with workforce
19 planning and increased workload in the context of GPs
20 and community pharmacists.
21 My Lady, we have requested evidence from government
22 departments, the national health services, and senior
23 individuals within all those organisations about
24 roll-out and delivery, and we've specifically requested
25 information concerning operational challenges and what

1 systems were in place, in fact, to manage resources
2 required during the roll-out of the vaccines.
3 Global vaccine inequity. The Covid Bereaved
4 Families for Justice UK and the Northern Ireland Covid
5 Bereaved Families for Justice group have made
6 submissions that you should return, notwithstanding your
7 ruling of September, to look at global vaccine
8 inequality.
9 My Lady, in your ruling you noted that the issue of
10 global vaccine inequality was potentially a vast topic
11 and it would simply not be practical to examine it in
12 detail in the course of Module 4. You also noted that
13 the terms of reference of course oblige you to examine
14 the comparative differences between England, Wales,
15 Scotland and Northern Ireland. And so, my Lady, may
16 I just repeat what you said in your ruling, which is
17 that international comparisons will be appropriate only
18 where they're reasonable and where such comparisons are
19 relevant. We simply cannot delve headlong into the
20 issue of global vaccine inequality.
21 Vaccination as a condition of deployment (VCOD), the
22 UK Covid Vaccine Adverse Reaction and Bereaved group
23 express their gratitude for your ruling that this is
24 something that we will be exploring, and they ask in
25 particular whether we'll be looking at whether employers

1 have accepted responsibility for the subsequent
2 ill health suffered by their staff.
3 FEMHO have also asked whether we will be examining
4 whether VCOD was or would have been effective in
5 limiting transmission.
6 My Lady, employer liability and responsibility is
7 outside scope, but all VCOD and related issues are
8 within scope, and you ruled on this following the
9 preliminary hearing in September by noting that
10 an important topic for Module 4 included whether VCOD
11 was or would have been effective at limiting
12 transmission and also what impact the VCOD policy may
13 have had in exacerbating vaccine hesitancy.
14 My Lady, the reporting of vaccine injuries. The UK
15 Covid Vaccine Adverse Reaction and Bereaved groups make
16 a number of suggestions in relation to the obligation of
17 Module 4 to look at post-approval monitoring, phase 4
18 trials by manufacturers, and whether or not those trials
19 had sufficient sample size and diversity. We are
20 looking at phase 4 trials, that is to say
21 post-authorisation trials, at a high level, and we will
22 be examining the obligations on pharmaceutical companies
23 to conduct those trials.
24 Our expert witness, Professor Prieto-Alhambra, who
25 is an expert pharmaco- and device epidemiologist at the

1 University of Oxford, will be addressing those topics
2 and we'll also be asking relevant pharmaceutical
3 companies about the phase 4 trials.
4 The same group also asks us whether we'll be
5 exploring if the government adequately planned for
6 a clear diagnosis and care pathway for vaccine injured.
7 My Lady, the short answer is that the treatment of
8 vaccine injured is not something that Module 4 is
9 looking at. It would not only represent a massive
10 expansion in our terms of reference, but treatment is
11 very -- only tangentially connected to the broader issue
12 which lies at the heart of this module, which is the
13 examination of the systems and processes for the
14 development, manufacture, approval, safety and roll-out
15 of vaccines and therapeutics.
16 We are looking at the Vaccine Damage Payment Scheme.
17 We will be looking at household vaccination and
18 vaccination in rural areas, which are issues raised by
19 a number of core participants.
20 The UK Covid Vaccine Adverse Reaction and Bereaved
21 groups also invite us to call experts on the
22 psychological impact and treatment of what is known as
23 vaccine-induced thrombocytopenia and thrombosis, VITT,
24 and they ask whether we'll call an expert who has
25 collated the experiences of persons who have suffered

1 from VITT.
2 My Lady, again, in relation to impact and treatment,
3 Module 4 has to draw a line between examining the safety
4 regulatory systems, that is to say the processes for
5 identifying adverse effects, and specific treatment
6 issues relating to vaccine injury, that is to say the
7 care and treatment of those who have suffered.
8 We are, of course, looking at the Yellow Card
9 scheme, but the issue of whether or not -- or the degree
10 to which there has been psychological trauma and how
11 persons suffering from VITT have been treated is not
12 something that we can possibly look at in the course of
13 Module 4. It's a huge topic and it simply doesn't sit
14 naturally within our scope.
15 But I emphasise for those representing that
16 particular core participant group that it is quite
17 possible to investigate the effectiveness of the system
18 for side effect reporting without having to investigate
19 or call evidence on what treatments were given to those
20 who suffered from VITT and on whom that side effect
21 reporting process reported.
22 The National Pharmacy Association raise issues
23 concerning community pharmacies, and they've provided
24 a very helpful and thorough statement which covers the
25 position in each of the four nations. We will be

1 asking, and we have asked in fact, Rule 9 recipients
2 from NHS England, the DHSC, Scottish Health and Social
3 Care Directorate and the Welsh Government about
4 community pharmacies. Rule 9s have been sent to or will
5 be sent to the chief pharmaceutical officers, and
6 Dr Kasstan-Dabush and Dr Chantler will be addressing the
7 issue of GP surgeries, primary care networks and
8 community pharmacies in each of the four nations in
9 their reports.
10 So, my Lady, doing the best I can in the time, and
11 bearing in mind the complexity of some of the requests,
12 that I hope is a helpful summary of the Inquiry's
13 current position on some of the many points raised in
14 the written submissions, but I emphasise that, as you
15 have said repeatedly, all these matters are gratefully
16 received and they will of course be kept under review.
17 May I then turn to the issue of parliamentary
18 privilege. The core participant group, the Migrant
19 Primary Care Access Group, was good enough to give
20 the Inquiry advance notice of the points that it wished
21 to raise. We set out in the CTI note a detailed
22 response to their arguments as we understood them to be,
23 and then the MPCAG responded in their written
24 submissions, which you have before you today.
25 In short, its first written submissions indicated

1 that the group wanted to adduce in their own Rule 9
2 statement evidence of what its members had said to
3 a select committee as well as adducing the select
4 committee report itself.
5 What they wished to do was to adduce this evidence
6 in order to make the forensic point that the government
7 must thereafter be taken to have had direct knowledge of
8 what they describe as inequality in healthcare and
9 vaccine access amongst vulnerable migrants and asylum
10 seekers, and of what identifiable barriers there were
11 that existed which prevented access to vaccines and
12 therapeutics for such people.
13 It basically wants to attribute to the government
14 knowledge of what their position was by calling evidence
15 as to what was put into the public domain before the
16 select committee.
17 My Lady, we would gently question the forensic
18 utility of such a course. The government's knowledge at
19 the time is likely to be no less apparent from its many
20 policy and public statements on the matter.
21 Secondly, it is open to the MPCAG simply to ask
22 government witnesses what they knew at the relevant time
23 in relation to barriers and inequalities in relation to
24 vulnerable migrants and asylum seekers.
25 And lastly, we would gently enquire as to what

1 purpose would be served. Your primary aim, of course,
2 is to look to the future and make recommendations as to
3 how the system of vaccine and therapeutic roll-out can
4 be better improved. Spending time focusing on what the
5 government knew at a particular time in a particular
6 place may not advance that cause hugely.
7 But in any event, my submission is that the adducing
8 of such material is unlikely to amount to a breach of
9 parliamentary privilege, even assuming in law that that
10 privilege applies to this statutory tribunal. So there
11 is, shortly, no need for you to rule on the underlying
12 point of principle.
13 The purpose behind any intended reliance upon
14 parliamentary records or material is key. What is not
15 permitted is a challenge to the truth or worth or
16 validity of what has been said or done in Parliament.
17 So it's not permissible to draw inferences from such
18 material, to use it as evidence for or against disputed
19 factual matters or to challenge the truth of
20 a proposition. But in our view, simply adducing,
21 mechanistically, evidence of what was said or concluded,
22 merely to prove that the Government must be taken to be
23 aware of it, it is no breach.
24 My Lady, they raise a second related point which
25 requires your determination. They also ask whether the

1 group may be permitted to file its Rule 9 witness
2 statement in draft and for you to receive it
3 de bene esse so that they can be enabled to review later
4 the Home Office's Rule 9 as well as any further
5 follow-up questions that we may pose of the Home Office,
6 and to do so in light of their own draft Rule 9. They
7 want to re-edit or reformulate their own evidence in
8 light of the evidence received from other material
9 providers.
10 In my submission, the answer to their question,
11 their request, has to be, I'm afraid, no. We cannot
12 have a system in which material providers submit Rule 9s
13 in draft and then revise them following cross-service of
14 everybody else's draft Rule 9s. It would result, in my
15 respectful submission, in an endless forensic
16 roundabout, and it would greatly lengthen the Rule 9
17 process, as well as being an additional burden on the
18 legal team.
19 Shortly, it is for you to decide what, if anything,
20 needs to be followed up in each Rule 9 and then for that
21 Rule 9 to be finalised, signed and disclosed.
22 Turning, my Lady, to the issue of expert evidence.
23 We have set out in the CTI note the detail of the
24 experts who we propose to instruct. In relation to
25 vaccine hesitancy, it's Professor Dani Prieto-Alhambra,

1 the professor of pharmaco- and device epidemiology at
2 the Botnar Research Centre at University of Oxford. He
3 will be dealing with issues of vaccine safety,
4 regulation and monitoring, side effects, the Yellow Card
5 reporting system, vaccine regulation and surveillance.
6 In relation to vaccine roll-out and vaccine
7 hesitancy, the Inquiry's instructed
8 Dr Ben Kasstan-Dabush, the assistant professor of
9 medical anthropology at the London School of Hygiene and
10 Tropical Medicine and Dr Tracey Chantler, associate
11 professor of public health evaluation at the LSHTM and
12 co-director of its vaccine centre. They will cover
13 vaccine coverage, disparities, the methods used to
14 obtain data on vaccine coverage, disparities in coverage
15 and the causes of disparities, the foreseeability of
16 coverage issues, the interplay between roll-out and
17 inequalities and structural discrimination, and
18 of course, not least, the lessons that can be learnt.
19 In relation to vaccine hesitancy, or lack of
20 confidence, as some prefer to call it, the Inquiry's
21 instructed Professor Heidi Larson, the professor of
22 anthropology, risk and decision science, infectious
23 disease epidemiology and dynamics, and director of the
24 Vaccine Confidence Project, as I've said, at the London
25 School of Hygiene and Tropical Medicine. She will be

1 assisted by a number of other experts. They will deal
2 with an overview of general trends in the United Kingdom
3 and internationally in relation to vaccine hesitancy,
4 hesitancy in relation to the specific Covid vaccines,
5 differences between the four nations, common factual
6 inaccuracies and misconceptions, the policy of
7 vaccination as a condition of deployment and its impact
8 on vaccine hesitancy, and also, as I've said, the issues
9 of foreseeability and preventability.
10 Then there is the issue of therapeutics.
11 The Inquiry believes that it has identified a suitable
12 expert to deal with a report that seeks to cover all the
13 topics relating to therapeutics, such as an explanation
14 of what the non-vaccine prophylactics were, the
15 different types of therapeutics, an overview of the
16 pre-clinical trials, the clinical trials, the clinical
17 trial phases, the emerging science in relation to
18 therapeutics, and also, of course, the general impact of
19 their use and roll-out.
20 So, my Lady, the expert evidence covers potentially
21 a very broad scope, width, indeed.
22 A number of the core participants have set out
23 further issues which they advance with a view to
24 the Inquiry agreeing to include those issues in the
25 current instructions for those experts.

1 Children. The Clinically Vulnerable Families have
2 asked whether the expert evidence will cover vaccine
3 roll-out, hesitancy, misinformation and therapeutics in
4 the context of children.
5 My Lady, this is a difficult issue. It's difficult
6 because the issue of hesitancy applies to children to
7 some extent in the same way as to adults, and therefore,
8 to the extent that children are likely to have been
9 influenced by parental choices, that is likely to be
10 covered by our main expert evidence. But we will, in
11 respect of roll-out, provide a summary of the way in
12 which ages and dates and dosage intervals and so on were
13 adapted and modified in the position of children, and
14 we'll also call expert evidence in relation to the
15 system of vaccination in schools. And that, we hope,
16 will address the majority of the points which have been
17 raised in relation to children.
18 The clinically vulnerable, clinically extremely
19 vulnerable, and severely immunosuppressed group, CVF,
20 requests that the therapeutics expert addresses
21 particular challenges faced by those groups. We are,
22 of course, asking the therapeutics expert about the
23 particular challenges faced by high-risk and clinically
24 vulnerable groups.
25 The devolved administrations. We will be addressing

1 differences through the expert evidence between the
2 four nations.
3 In relation to inequalities, structural and
4 institutional racism, the Covid Bereaved Families for
5 Justice UK group and the Northern Ireland Covid Bereaved
6 Families for Justice say they welcome your indication in
7 the ruling following the last hearing that the question
8 of whether an expert in these matters is needed would be
9 kept under careful review, but they express their,
10 again, concern as to the extent to which we will call
11 specific expert evidence on structural and institutional
12 racism.
13 My Lady, Dr Chantler and Dr Kasstan-Dabush will be
14 looking at pre-existing inequalities and structural
15 discrimination, so that is the short answer to the
16 query, but also you will recall that experts were
17 instructed in Module 2 to provide reports on structural
18 inequalities in relation to ethnicity and race, gender,
19 age, disability and LGBTQ+ identity. If in the course
20 of preparing for Module 4 it becomes plain that there is
21 a lacuna in relation to expert evidence on inequalities
22 and structural discrimination, we have available that
23 expert evidence to be re-adduced in the course of
24 Module 4.
25 MPCAG requests that expert evidence be called on the

1 specific issue of migrants in the United Kingdom in
2 relation to the barriers and entrenched inequalities
3 that they face. My Lady, it is open to that
4 core participant group to summarise such evidence, which
5 we know they have available, in their own Rule 9
6 statement, and of course they can propose questions to
7 appropriate witnesses. In our view, however, it would
8 not be proportionate in the course of a hearing of the
9 length that it is to call experts specifically on the
10 particular topic of vulnerable migrants.
11 The disabled persons organisation group seeks
12 confirmation that Dr Kasstan-Dabush and Dr Chantler will
13 address the issues of prioritisation and the timing of
14 prioritisation for disabled people. Those experts will
15 be addressing the processes involved in the roll-out and
16 specifically how pre-existing inequalities impacted
17 a number of groups, including disabled people.
18 They will similarly be looking at the barriers faced
19 by marginalised or minority communities and that
20 addresses the submissions made by the Traveller Movement
21 core participant.
22 Finally, my Lady, on this topic, the UK Covid
23 Vaccine Adverse Reaction and Bereaved groups return to
24 the issue of the Vaccine Damage Payment Scheme, and they
25 ask whether or not we would call particular witnesses in

1 relation to the VDPS.
2 My Lady, we don't presently intend to call an expert
3 on the VDPS issue, our view and our submission is that
4 you will be able to come to a view on the Vaccine Damage
5 Payment Scheme, including whether it requires reform,
6 from the factual evidence that you'll receive through
7 the Rule 9 process. We have Rule 9ed
8 Professor Fairgrieve King's Counsel. We've also sought
9 and received a Rule 9 statement from Sarah Moore, who is
10 the litigator at Leigh Day who represents a number of
11 the bereaved and injured who have brought the litigation
12 against AstraZeneca.
13 Covid Bereaved Families for Justice UK and the
14 Northern Ireland group return to the issue of disclosure
15 of both the letters of instruction and the draft
16 reports.
17 My Lady, you've ruled on this in earlier modules.
18 Subject, of course, as ever, to your ruling, we don't
19 intend to provide the letters of instruction, because
20 of course we will be inviting comment on the draft final
21 expert reports in due course, so providing the letter of
22 instruction will not add anything.
23 My Lady, the next topic that I'm required to address
24 is the number of additional submissions which have been
25 made in relation to impact evidence.

1 My Lady, in brief, a number of the core participants
2 state that they wish you to call a number of witnesses
3 from their client groups who can give evidence about the
4 consequences and impact of the pandemic and the
5 government response in the particular context of
6 vaccines and therapeutics.
7 So, my Lady, it's the issue which you have addressed
8 now on a number of occasions concerning the extent of
9 relevancy of impact evidence.
10 You in fact ruled on this following the first
11 preliminary hearing by saying that the evidence of the
12 impact of the pandemic or the response may be admitted
13 only where relevant to possible systemic failure, and
14 of course in Module 4 our submission is that the
15 accounts of individual sufferers, however insightful and
16 terrible, are unlikely to be able to establish such
17 failings, because they can only ever report upon their
18 own individual experiences.
19 But in any event, we are, of course, going to be
20 asking appropriate witnesses directly about the
21 processes and systems concerning vaccines and
22 therapeutics. That is what Module 4 is about. But in
23 our note, my Lady, and I emphasise that we've made it
24 absolutely plain, that just as was the case in Module 2,
25 we will call impact evidence from representative

1 witnesses on behalf of appropriate core participant
2 groups, exactly as we did, I emphasise, at the beginning
3 of Module 2.
4 The purpose of that evidence, therefore, is not to
5 enquire into the impact on individuals but because those
6 representative witnesses can talk about not only their
7 own experiences but primarily the issues and the matters
8 which were raised by those groups with the government.
9 They can recount their dealings with the government in
10 relation to vaccines and therapeutics, and they can
11 summarise the body of material relating to the impact of
12 vaccines. And that, in my respectful submission, is
13 a far more effective and efficient way of adducing that
14 evidence.
15 My Lady, turning finally to the issue of the
16 timetable for the hearings.
17 Three weeks has been given to Module 4 in January.
18 Taking account of the opening and closing submissions,
19 and the impact film and the representative impact
20 evidence, there will probably be only 10 or 11 days
21 devoted solely to the calling of evidence. A number of
22 the core participants invite you to consider whether you
23 would allocate additional days or whether or not you
24 would generally lengthen the length of Module 4. In my
25 submission, the Inquiry must proceed at the pace that it

1 is, and must proceed to devote those three weeks only to
2 Module 4, because without such a rigorous timetable you
3 will not be able to make the timely recommendations
4 across all the modules to which you have committed
5 yourself.
6 There is no more time available in the overall
7 Inquiry timetable if you are to adhere to your stated
8 determination to produce timely reports and
9 recommendations, and I would remind the
10 core participants that of course the hearing is only one
11 part of the forensic iceberg. For the purposes of your
12 report, and your recommendations, you will, as you have
13 already done in relation to Module 1, consider all the
14 documentary material and all the voluminous material
15 which we have been provided with. So for those reasons,
16 we believe that the length of time allowed for Module 4
17 will be sufficient.
18 Every Story Matters. Module 4 has agreed that there
19 will be a report from Every Story Matters collating the
20 data in relation to the experiences of vaccines and
21 therapeutics. That report will be provided to
22 the Inquiry team, we believe, in the late summer.
23 Thereafter it will be finalised and we anticipate it
24 will be shared with core participants in the late
25 autumn.

1 UK Covid Vaccine Adverse Reaction and Bereaved group
2 seek confirmation that their key lines of enquiry were
3 included in the ESM process. They were.
4 In relation to the timetable and the preparation for
5 public hearing, we will circulate a provisional list of
6 witnesses along with a provisional list of issues in
7 September, and of course the core participants will
8 respond in the usual way.
9 The proposals for the Rule 10 process will be
10 circulated in advance of the third and final preliminary
11 hearing in October 2024, and there will, as with all the
12 preceding modules, be an impact film.
13 My Lady, that further preliminary hearing will be
14 here in October but the specific date will be provided
15 in due course, and as I've averred to and as the
16 material from the solicitor and counsel to this module
17 has made plain, the public hearing will be between
18 Tuesday, 14 and Thursday 30 January.
19 My Lady, those are all my submissions, and I hope
20 they address the vast majority of the points raised in
21 the quite extensive and complex written submissions from
22 the core participants.
23 **LADY HALLETT:** Thank you very much, Mr Keith.
24 May I just say in relation to a third preliminary
25 hearing: if there's going to be a third preliminary

1 hearing it will be on a date to be announced in the
2 autumn, but I'm only going to hold a third preliminary
3 hearing if I consider it necessary, so people need to
4 know there is a marker, because I only believe in
5 holding hearings if I see a point to it.
6 **MR KEITH:** My Lady, yes.
7 **LADY HALLETT:** Thank you.
8 Ms Munroe, you're going to take us up to the break.
9 **Submissions on behalf of Covid-19 Bereaved Families for**
10 **Justice UK by MS MUNROE KC**
11 **MS MUNROE:** Good morning, my Lady.
12 I represent, as you know, Covid-19 Bereaved Families
13 for Justice UK, instructed by Mr Elkan Abrahamson and
14 Nicola Brook, and I'm assisted today by Ms Brook and
15 counsel Ms Kate Stone.
16 My Lady, I'm grateful that you and the Inquiry team
17 have read the joint written submissions filed on behalf
18 of Covid-19 Bereaved Families for Justice UK and Covid
19 Bereaved Families for Justice Northern Ireland.
20 By way of general observations, I obviously will not
21 be reading out those submissions again. Any matters,
22 my Lady, that I don't allude to or emphasise now, it's
23 not because we resile from them or we do not think they
24 are important, but I'm mindful of the time and I seek to
25 highlight only those most pressing matters, particularly

1 in light of what has been said this morning.
2 My Lady, we've said this before, and I think it's
3 worth repeating again: we of course understand that
4 no one team can and should be expected to have all the
5 answers on how best to proceed, and that collaboration
6 and co-operation are the key here. That leads to better
7 outcomes and assists our families to feel that they are
8 in fact being heard and seen as an essential part of
9 this Inquiry.
10 My Lady, I hope that any suggestions that we make
11 are taken as constructive ideas and thoughts to enhance
12 the Inquiry both in terms of its investigative process
13 but also its outcomes and recommendations.
14 With that in mind, I intend to address you on four
15 points, my Lady, and one matter very briefly at the end
16 which we did not mention in our written submissions.
17 Firstly, scope.
18 The outline of scope is an area, of course, that is
19 developing. I'm mindful of what has been said this
20 morning. It is evolving and it will therefore be
21 necessary to keep matters under review, particularly
22 having regard to the large volume of material that is
23 yet to be disclosed to the core participants. With that
24 in mind, my Lady, may I just allude to paragraph 5 and 6
25 of our written document.

1 In paragraph 5, we reiterate the importance of
2 examining the differences across the UK in England,
3 Scotland, Northern Ireland and Wales. In our submission
4 guarding against an England-centric approach to these
5 issues is particularly important and we need to be
6 particularly mindful of that, given the limited
7 timeframe of the Module 4 hearings.
8 On the question that we raised in paragraph 6, where
9 we say that it is important to consider the UK global
10 vaccine inequity alongside the UK's international
11 collaboration in the development and roll-out of
12 vaccines and therapeutics, I note what has been said by
13 Mr Keith King's Counsel in addressing those matters this
14 morning.
15 Whilst of course the remit of this Inquiry cannot
16 and does not allow for an extensive exploration of
17 international issues, it is self-evident, we say, that
18 a topic such as vaccines and vaccination cannot be
19 solely considered within the confines of national
20 borders. We are not asking for the Inquiry to do that
21 which it cannot do, ie a full-scale international dive
22 into this topic, and we understand that the issue of
23 proportionality is important here. But what we do say,
24 my Lady, is simply this: that there will be instances
25 and areas where it is relevant to look at the

1 international dimension and the impact on the nations of
2 the United Kingdom, and this should not be lost within
3 the scope of this module.
4 Two, disclosure.
5 I'm sure during the course of today, my Lady, you
6 will be addressed doubtless times on this issue of
7 disclosure as you have been on numerous occasions in the
8 past. Going first, and at the risk of sounding like
9 a broken record, we reiterate our points that we always
10 do, that early disclosure is essential and important.
11 It is something that we all wish and we will all benefit
12 from. It is nonetheless worth saying again that it is
13 of huge assistance in the proper preparation and the
14 ability for those we represent to effectively
15 participate in the Inquiry process for us to have early
16 and timely disclosure. We do not for a second
17 underestimate the enormity of the task, though, the
18 handling, the marshalling, and the dissemination of the
19 material.
20 At paragraphs 11 and 12 of our written document, we
21 have set out with some data how, when and the
22 percentages of disclosure during the first two modules.
23 We hope that that's instructive and helpful to look at,
24 because it goes some way to showing how, in terms of
25 percentages, the vast majority of the disclosure comes

1 in very close in timing to the beginning of the modules,
2 which obviously puts everyone -- and when I say
3 everyone, I include CTI and all the core participants --
4 it puts us all and, indeed, my Lady, yourself, under
5 considerable pressure in terms of having to start the
6 module, hearing evidence whilst disclosure is still
7 ongoing, and having to respond and prepare accordingly.
8 This point about early and timely disclosure we say
9 perhaps ties in quite neatly with the issues around
10 targeted disclosure and transparency from the document
11 providers. Also, in the absence of disclosure of Rule 9
12 requests, early disclosure of witness statements and
13 relevant associated documents is particularly important
14 and pressing.
15 We welcome the observations about targeted
16 disclosure, and I also note the individuals and
17 organisations who have been highlighted this morning who
18 have received Rule 9 requests, and we of course look
19 forward to assisting with this in due course.
20 We understand the rationale behind targeted
21 disclosure, but in order for that to work the document
22 providers need to be transparent and they need to
23 respond to the Rule 9s in a timely fashion and with due
24 expedition.
25 It is vital that document providers do not in any

1 way try to use the opportunity to circumnavigate the
2 process on disclosure by choosing what the Inquiry can
3 see. Our families remain troubled about this.
4 My Lady, I know that the issue of position
5 statements has already been ruled upon as something we
6 put forward as a means of guarding against any sort of
7 circumnavigation and in order for there to be full
8 transparency. However, if there is another approach or
9 another means by which we can all ensure that
10 transparency, that needs to be explored in order to
11 preserve the integrity of the process.
12 Three, my Lady, discrimination.
13 We return to this topic noting again, and welcoming,
14 the observations made by Mr Keith King's Counsel this
15 morning. We are cognisant and appreciative of the
16 Inquiry's commitment to exploring issues of race and
17 discrimination and inequalities thus far in the Inquiry
18 in the previous modules, but we emphasise, my Lady, that
19 it is important to understand that these are not
20 standalone issues. Once they have been addressed in
21 a particular module, they cannot be simply marked and
22 checked off a list as completed. If there is a gap, it
23 is perhaps a little bit more nuanced than to say: well,
24 any gap identified can be filled with a previous report.
25 We say, my Lady, it is important that aspects and

1 the impact of structural racism and discrimination are
2 considered in each module, because they are relevant and
3 important to each module, they impact in different ways
4 according to the modules and the topics under
5 investigation. Ultimately, the evidence that is gleaned
6 from these feeds into the fundamental aspects of
7 the Inquiry's lessons to be learned and guarding against
8 repeating mistakes.
9 In the context of Module 4, this is particularly
10 relevant to the question of vaccine uptake amongst
11 minority and marginalised communities. There are known
12 historical causes for unequal vaccine uptake. We say
13 amongst those causes is structural racism and
14 discrimination and socioeconomic inequalities.
15 The issue of "vaccine hesitancy", which effectively
16 is a delay in acceptance or refusal of vaccines despite
17 availability of vaccination services, is a common term
18 used to describe this phenomenon. The term and the
19 terminology can perhaps lead one to an inference or
20 a suggestion that the issues lie with the individual
21 people themselves, that they are hesitant, and it does
22 not perhaps fully or adequately explain the historical,
23 cultural and socioeconomic context.
24 As we say, there has been a historical pattern
25 within this country where there are higher levels of

1 resistance and fears to new vaccinations amongst certain
2 sections of the population, particularly those from
3 a poorer income group and those who are from ethnic
4 minority groups, religious groups and other marginalised
5 groups.
6 We note with interest that, as early as
7 November 2022, this particular topic was addressed in
8 a briefing from the Runnymede Trust in
9 Manchester University entitled *"Understanding the*
10 *fundamental role of racism in ethnic inequities in*
11 *COVID-19 vaccine hesitancy"*. The authors are names now
12 familiar to this Inquiry, my Lady, Professors Bécares,
13 Dr Richard Shaw, Professor James Nazroo and
14 Dr Patricia Irizar.
15 The briefing note noted that by the time people were
16 deciding whether to have the vaccine, the conditions
17 that created lower vaccination uptake amongst ethnic
18 minority groups were already present. By ignoring the
19 impact of structural and institutional racism on
20 vaccination rates, vaccine hesitancy is misunderstood
21 and, crucially the opportunity to address inequalities
22 is missed.
23 As Professor Bécares very trenchantly opined,
24 "vaccine hesitancy" puts the blame on individuals
25 instead of addressing the historical and ongoing racism

1 that has contributed to the societal inequalities that
2 lead to ethnic inequalities in the distribution and
3 uptake of vaccines.
4 Now, we hear and we welcome of course that expert
5 reports will be provided by Professor Kasstan-Dabush and
6 Dr Chantler, and they will consider the interplay
7 between Covid-19 vaccine roll-outs and pre-existing
8 inequalities and structural discrimination, and this
9 morning we also are grateful for the information about
10 Dr Heidi Larson.
11 We would raise one further point, though, that there
12 is some force and sense, and I know that this will be
13 perhaps developed by other CPs, in seeking an addendum
14 report from Professor Nazroo and Professor Bécares. In
15 any event, my Lady, we look forward to providing further
16 submissions on these issues once the reports that have
17 been directed are disclosed and reviewed.
18 Four, impact evidence.
19 It is a recurring theme of our families that
20 the Inquiry needs to hear their authentic and effective
21 voice as part of the evidence in the modules. It is
22 a topic that greatly exercises many of them.
23 The Inquiry of course will be looking at systemic
24 failings, if any are there, but how does one evaluate
25 systemic failings? Well, one looks at structures, one

1 looks at policies, practices, how they have been
2 implemented or not as the case may be, but one also
3 looks at those directly impacted and affected within the
4 system. Lived experiences should not be underestimated.
5 My Lady, I know that you listened with great care to
6 those individuals who have given evidence in previous
7 modules and the impact that that has had upon literally
8 the hearing room and those who are present but on the
9 whole tenor of the hearing on those particular days.
10 So it's not simply a question of us seeking
11 the Inquiry to call evidence for any maudlin reasons or
12 any mawkish reasons of sentimentality or to hear people
13 go through terrible personal trauma. It is because we
14 say those lived experiences actually provide the Inquiry
15 with something concrete, evidentially, which assists in
16 the ultimate findings and recommendations.
17 Within our group of families, we have identified
18 a number of witnesses who would be able to illustrate
19 the broad consequences and impact of the pandemic and
20 the government response with particular regard to
21 Module 4.
22 My Lady will know that, just by dint of the size of
23 our group, it contains myriad individuals, professionals
24 in various jobs, at various levels, management,
25 frontline workers, those who had a personal as well as

1 the professional understanding of the impact of the
2 pandemic. So this is a group which, as I say and we
3 say, would provide a wealth and a breadth and depth of
4 evidence to the Inquiry.
5 We have provided in the written submissions
6 an addendum document setting out a number of those
7 individuals and why we say that they would be of
8 evidential value and bring real value to the Inquiry if
9 they are heard, and so I very much would commend that
10 list to my Lady. And our teams, both the Covid Bereaved
11 Families for Justice UK and Northern Ireland, are still
12 in the process of obviously exploring with other members
13 of our wider group those who wish to put themselves
14 forward and can put forward useful and cogent and
15 important evidence.
16 Finally, my Lady, on the question of parliamentary
17 privilege, it's something we did not specifically
18 address in our written submissions, and I briefly do so
19 now.
20 We note CTI's position on this as expanded upon this
21 morning by Mr Keith King's Counsel. We simply put it
22 like this: adducing what is said in Parliament for the
23 purpose of establishing when it was said and that the
24 government knew those facts at that time, we would say,
25 cannot be said to engage parliamentary privilege,

1 because it does not challenge what is being said. We
2 would respectfully agree that there is no need to rule
3 on this.
4 My Lady, those are our submissions.
5 **LADY HALLETT:** Thank you very much for your help, Ms Munroe,
6 very grateful.
7 Right, I think probably best to break now and return
8 at 12 o'clock.
9 **(11.42 am)**
10 **(A short break)**
11 **(12.00 pm)**
12 **LADY HALLETT:** Can I just say that I notice some members of
13 the public gallery are using crutches. When the usher's
14 cry goes up "All rise", I wouldn't consider it any
15 discourtesy if somebody who had difficulty standing
16 didn't stand.
17 Right, I think the next speaker is Mr Puar.
18 **Submissions on behalf of Covid-19 Bereaved Families for**
19 **Justice Cymru by MR PUAR**
20 **MR PUAR:** My Lady, I appear on behalf of the team
21 representing the interests of Covid-19 Bereaved Families
22 for Justice Cymru or CBFJ Cymru.
23 Your Ladyship has already received our written
24 submissions, and there is only one narrow point of
25 particular importance to CBFJ Cymru which I seek to

1 develop orally before you today, namely the Rule 9
2 requests which are set out at paragraphs 7 to 13 in our
3 written document.
4 CBFJ Cymru are a group who represent a broad
5 spectrum of families in Wales who have lost a loved one
6 or, in many cases, loved ones to Covid-19. They're
7 a group that formed in mid-July of 2021, and they have
8 worked tirelessly as a group dedicated to campaigning
9 and supporting those families by, amongst other things,
10 scrutinising the decision process in Wales.
11 One of their primary objectives is to understand why
12 certain decisions were made in Wales, and why and how
13 those decisions differed between the home nations.
14 We recognise the Inquiry's commitment and dedication
15 to date in seeking evidence from those jurisdictions, to
16 compare the contrasting approaches and thus learn
17 lessons for facing any future pandemic. However, it is
18 submitted that, in seeking to compare the contrasting
19 approaches, it is critical to ensure that the type and
20 quality of evidence sought from each of the home nations
21 are truly comparable.
22 We note from the CTI's note that since the first
23 preliminary hearing back in September 2023 over
24 120 Rule 9 requests have been made for witness
25 statements and associated documents, and those requests,

1 as we understand it, extended to the Office of the Chief
2 Medical Officer and the chief medical officers of each
3 of the devolved nations. However, we note that the
4 Welsh Chief Medical Officer doesn't appear to have
5 answered that request. It's understood that the
6 proposal is that the Welsh Government corporate witness
7 will provide corporate evidence on behalf of the CMO
8 department, but it is submitted that if that is the
9 case, that this would be an inadequate way to deal with
10 such evidence and would perhaps make contrasting the
11 approaches taken by the home nations more difficult to
12 understand.
13 In particular, we make the following observations:
14 that although the CMO for Wales is a member of staff at
15 the Welsh Government designated by Welsh ministers, he
16 holds a unique position in that he holds a high degree
17 of independence from the concerns of the government. He
18 is free to provide advice without regard to government
19 policy or direction, and the CMO reports are published
20 without being vetted by special advisers or clearance by
21 ministers. Consequently, if the Welsh Government were
22 to give evidence on behalf of the CMO for Wales, we say
23 that there's a possibility at least that this
24 independence may become questioned.
25 Although it's understood that a Rule 9 request has

1 been made of the Deputy CMO, and that she may very well
2 have had a particular interest or role in the
3 vaccination roll-out in Wales, we note that that
4 appointment only took place in April of 2021, some
5 four months after the first Covid-19 vaccine was issued
6 in the UK outside of clinical trials.
7 In contrast, the CMO for Wales has been in post
8 since 2016, has had a significant role in the
9 decision-making process regarding the roll-out for
10 vaccines in Wales, and indeed made recommendations in
11 respect of the vaccination programme in his report
12 finished in January 2021, which of course pre-dates the
13 appointment of the Deputy CMO.
14 Further --
15 **LADY HALLETT:** I thought this matter had been resolved,
16 Mr Keith.
17 **MR KEITH:** It had been resolved. We had internally decided,
18 subject to your approval, that we would accede to my
19 learned friend's request to send a Rule 9 directly to
20 the Welsh CMO, but I didn't in fact address that point
21 in the course of my oral submissions this morning, and
22 my learned friend wouldn't have known that, of course.
23 So can I say, and I don't wish to cut him short, of
24 course, that the submissions were, in our opinion, well
25 made. We were told that the best person to deal with

1 the issues we wanted to be raised with the Office of the
2 Chief Medical Officer in Wales was in fact the
3 Deputy CMO for Covid-19 vaccines. However -- and
4 I should say that the draft responses have been very
5 thorough from the Welsh Government and from the DCMO,
6 but in light of the issues which were made in writing we
7 had already decided to send one specifically to the
8 Welsh CMO nevertheless, and that's in hand.
9 **LADY HALLETT:** Sorry to cut across you, Mr Puar, but you
10 were knocking at an open door.
11 **MR PUAR:** Very well, my Lady, then I can simply sit down.
12 **LADY HALLETT:** Thank you very much for your help.
13 **MR PUAR:** Thank you.
14 **LADY HALLETT:** Right, who is next?
15 Mr McCaffery.
16 **Submissions on behalf of Scottish Covid Bereaved by**
17 **MR McCAFFERY**
18 **MR McCAFFERY:** Thank you, my Lady.
19 I'm instructed by the Inquiries team at Aamer Anwar
20 & Company to make oral submissions on behalf of Scottish
21 Covid Bereaved, and I am accompanied today by Ms Murray
22 and Ms McQuade.
23 Scottish Covid Bereaved are once again grateful to
24 the Inquiry for being included as a designated core
25 participant in Module 4. Further, we are grateful to

1 Counsel to the Inquiry for providing his detailed note
2 setting out the matters which are to be addressed at
3 today's second preliminary hearing.
4 Scottish Covid Bereaved have, of course, already
5 submitted written submissions and we trust that those
6 brief submissions, together with today's oral
7 submissions, will be of assistance to the Inquiry in
8 respect of making progress towards the evidential
9 hearings scheduled for January 2025.
10 Following Counsel to the Inquiry's outline order of
11 submissions, those on behalf of Scottish Covid Bereaved
12 are as follows: in terms of scope, my Lady, the intended
13 scope of Module 4 is encouraging, together with the fact
14 that it will also look at medications and treatment of
15 Covid-19 in tandem with the vaccine programme, hopefully
16 to better inform future preparedness for the next
17 pandemic.
18 Members of Scottish Covid Bereaved particularly
19 welcome the examination of thematic issues, unequal
20 vaccine uptake, its causes, concerns about vaccine
21 safety and the redress scheme are all shared concerns of
22 Scottish Covid Bereaved members, and how the UK and
23 devolved governments responded to those issues.
24 However, we note Counsel to the Inquiry's submissions
25 this morning in that regard.

1 It is hoped that examination of all these issues
2 will include aspects particularly relevant to Scotland,
3 and shared to a large extent with our Welsh and
4 Northern Irish neighbours, of the added difficulties
5 arising out of the geography of our respective nations
6 and the rural nature of many of our communities.
7 Concerns raised by our members include scenarios
8 where members of traditionally isolated communities,
9 especially those who might have been shielding, either
10 for themselves or for family members, were often
11 required to potentially sacrifice the protection which
12 that feature of their communities naturally afforded
13 them by being asked to attend at large vaccination
14 centres, with all of the associated potential risks of
15 transmission which inevitably went with that, in most
16 cases, having to travel significant distances to attend,
17 then congregating and queuing -- albeit social distanced
18 it would be hoped -- with large groups of potentially
19 infected people, when local GP surgeries and other small
20 clinics might have been a better, safer and more
21 familiar and thus much less stressful environment to
22 deliver the programme in such areas.
23 Other areas of concern are the lack of provision of
24 vaccines to some frontline workers in the early stages
25 of its availability during the pandemic, issues which

1 arose with vaccine distribution and inevitable wastage,
2 and whether these were handled as expediently as they
3 could have been, all of which has led some to question
4 if decisions were made perhaps more for political
5 reasons rather than clinical.
6 Was the race to produce one of the first vaccines
7 purely to gain a march on the pandemic or was it
8 politically motivated to divert from what was
9 a tumultuous political time for the nation?
10 Albeit the scope of the Inquiry will not and,
11 indeed, probably could not be expected to extend to the
12 safety of specific vaccines or quantification of the
13 precise risks of vaccination, the recent withdrawal of
14 the AstraZeneca vaccine from production does raise
15 concerns, particularly in light of the acknowledged
16 issues which that vaccine had.
17 Accordingly, we welcome the Inquiry's intention to
18 examine vaccine safety issues and particularly the
19 suggested correlation between Covid-19 vaccines and
20 cardiovascular issues. However, we note that the
21 suggested correlation as referred to by Counsel to the
22 Inquiry appears now to be a matter of admission of fact
23 on the part of that particular vaccine manufacturer, who
24 has admitted as a fact that their vaccine was linked to
25 the rare and serious side effect of causing rare blood

1 clots or thrombosis with thrombocytopenia syndrome
2 (TTS), which can cause long-term disability and death.
3 We are reassured by Mr Keith's further submissions
4 in those regards this morning.
5 As we note in our written submissions, it is
6 welcomed that the spread of conspiracy theories and
7 anti-vaccination groups through disinformation is also
8 to be considered, as this was concerning not simply
9 because the content was widely disseminated but on
10 whether enough was done to counter such spread by way of
11 expert information being published on social media to
12 offer the public a balanced pool of information, thus
13 allowing them to make an informed choice and thereby
14 promoting trust in the safety of vaccines and in our
15 public services.
16 Scottish Covid Bereaved are further encouraged to
17 read your Ladyship's ruling following the first
18 preliminary hearing in Module 4, on 13 September 2023,
19 and particularly the final paragraph thereof, that the
20 Inquiry may, where it deems it to be of assistance to do
21 so, seek evidence from those members of core participant
22 groups who may be able to speak to the impact of the
23 decisions which were made at both UK and devolved
24 levels.
25 The wide membership of Scottish Covid Bereaved and

1 the professional experience which many of those members
2 bring to the group means that it is well placed as
3 a core participant to offer assistance to the Inquiry in
4 relation to the vaccine roll-out, the availability of
5 vaccines or lack thereof, and how that affected
6 vulnerable groups, particularly the elderly and those
7 vulnerable due to comorbidities, others affected by
8 particular physical or mental health issues, those who
9 were in ethnic groups or who had lost a partner of
10 a different ethnicity, or some who were simply
11 traditionally distrustful or suspicious of authority and
12 the difficulties which were experienced in Scotland
13 during that process.
14 The issues surrounding the development, testing and
15 eventual roll-out of vaccines were obviously critical
16 issues in terms of lifting of restrictions imposed by
17 lockdown and allowing families to return to levels of
18 interaction so critical for those vulnerable groups
19 through age, illness and/or physical and mental health
20 disabilities. We acknowledge the terms of paragraph 18
21 of Counsel to the Inquiry's note in respect of
22 eligibility and priority for vaccination and welcome
23 that inclusion.
24 A further concern was whether there was any attempt
25 to research then match particular vaccines with certain

1 groups in society.
2 On Rule 9 requests, my Lady, we have nothing other
3 to suggest in respect of these than simply to note that,
4 as with previous preliminary hearings in other modules,
5 the scope of the module is, of course, necessarily
6 provisional at this stage, and much will depend on the
7 evidence and material obtained during the Rule 9
8 procedure, as reflected in Counsel to the Inquiry's
9 note.
10 It is therefore to be hoped that recovery and
11 disclosure continue at a pace to allow sufficient time
12 for preparation for the Module 4 hearing in
13 January 2025. We appreciate the considerable efforts of
14 the Solicitor to the Inquiry's team in that task that
15 they are dealing with.
16 We are also mindful of the invitation to advance
17 suggestions as to additional recipients of Rule 9
18 requests once we become aware of those already in
19 receipt of same.
20 Parliamentary privilege, as concerns that we state
21 in our written submissions that we have no additional
22 observations in this regard, and the process in place
23 appears to be working well.
24 Disclosure to core participants, again as already
25 observed in respect of Rule 9 requests, and as Ms Munroe

1 King's Counsel has already flagged up, not wishing to
2 sound like a broken record, the sooner disclosure can be
3 made the more preparation time will be afforded to
4 core participants for the hearings which are now not
5 that far off in the future.
6 We also look forward to receiving the further
7 statements which have already been received in draft
8 form once these have been finalised.
9 In respect of expert witnesses, my Lady, we note the
10 instruction of the experts referred to in Counsel to the
11 Inquiry's note and await receipt of those notes in due
12 course. We will doubtless have further submissions to
13 make in that regard at the next scheduled preliminary
14 hearing in October, if indeed that is required.
15 Again, Every Story Matters, we look forward to
16 receipt of the Module 4 report in this regard when
17 available.
18 As far as timetabling is concerned, we await receipt
19 of the provisional lists of witnesses and issues and the
20 proposals for the Rule 10 process and responding to
21 those in due course.
22 We note the third preliminary hearing may be held in
23 October 2024 if required and the planned hearing dates
24 of 14 to 30 January 2025.
25 Finally, my Lady, we look forward to continuing to

1 operate with and assist the Inquiry are Module 4, as we
2 hope that we have been able to do so far with other
3 modules.
4 Those are my submissions on behalf of Scottish Covid
5 Bereaved, my Lady.
6 **LADY HALLETT:** Thank you very much, Mr McCaffery.
7 **MR McCAFFERY:** I'm obliged, my Lady.
8 **LADY HALLETT:** Mr Wilcock, I appreciate you hadn't asked to
9 make oral submissions. I take it that on behalf of
10 Northern Ireland you associate yourself with the
11 comments made by Ms Munroe earlier, and of course I have
12 your written missions?
13 **MR WILCOCK:** Indeed, and for those two reasons we decided to
14 say nothing, but I'm grateful to you for giving me the
15 opportunity of explaining to my clients why that was.
16 Thank you.
17 **LADY HALLETT:** Thank you.
18 Mr Wagner.
19 **Submissions on behalf of Clinically Vulnerable Families by**
20 **MR WAGNER**
21 **MR WAGNER:** Good afternoon, Chair. I make submissions on
22 behalf of the Clinically Vulnerable Families. I appear
23 with Hayley Douglas, instructed by Kim Harrison and
24 Shane Smith of Slater & Gordon solicitors.
25 We again thank you for giving us the opportunity to

1 be involved in this important module. As you know, CVF
2 was founded in August 2020 and currently represents
3 those who are clinically vulnerable, clinically
4 extremely vulnerable, and the severely immunosuppressed,
5 as well as their households across all four nations.
6 This group of vulnerable individuals were and remain
7 at higher risk of severe outcomes from the disease, such
8 as greater mortality and Long Covid, than the wider
9 population, and these individuals not only faced but
10 continue to face greater risks to their lives than any
11 other category of person, and their welfare during the
12 pandemic should be a central focus of this Inquiry and
13 certainly of Module 4.
14 I will make submissions in four areas: the scope of
15 Module 4, expert evidence and Rule 9s, the timetable for
16 the public hearings, and the approach to the provision
17 of documents.
18 So, starting with the scope of Module 4.
19 As you know, Chair, therapeutics and antivirals are
20 issues of critical importance to CVF and their members,
21 and CVF are grateful for your commitment in your ruling
22 following the last preliminary hearing that you will
23 ensure that this issue relating to therapeutics is
24 rigorously and comprehensively examined by the Inquiry.
25 We also welcome the confirmation in paragraph 13 of

1 CTI's note that Module 4 will include examination of the
2 decision-making relating to the non-vaccine prophylactic
3 Evusheld.
4 We note the amendment to paragraph 2 of the
5 provisional outline of scope so that it now reads:
6 "The development, trials and steps taken to enable
7 the use of new therapeutics and re-purposed medications
8 during the pandemic."
9 You may recall I made submissions at the first
10 preliminary hearing on the scope and the intended divide
11 between Modules 3 and 4, and I wish to revisit those
12 issues briefly in light of the amendment to the scope.
13 So, as we understand it, the Inquiry has now split
14 the consideration of therapeutics across Modules 3 and 4
15 so that Module 3, which comes first, will examine the
16 use of therapeutics, and Module 4 will examine the steps
17 taken to enable the use of therapeutics.
18 The Inquiry will be aware that there are potential
19 pitfalls to this approach, as we highlighted in the last
20 hearing. The major one is there will be two different
21 teams in two different modules considering what is
22 effectively one discrete issue. As you pointed out,
23 Chair, at the last hearing, there will of course be some
24 overlap. We're not aware of any other issue in this
25 Inquiry which is being split across two modules in this

1 way, as opposed to being separately considered from two
2 different perspectives, although we're not involved in
3 all the modules, so we stand to be corrected on that.
4 The sequencing is not ideal, because Module 3 will
5 now come before Module 4, meaning that the Inquiry will
6 first consider how therapeutics were used in the real
7 world, as it were, and then consider what steps were
8 taken to enable their use. This seems to be back to
9 front, and we suggest it's not the order the Inquiry
10 would choose if it was considering therapeutics in one
11 module.
12 As core participants in both Modules 3 and 4, CVF
13 will continue to try to assist the Inquiry in solving
14 the conundrum of how therapeutics will be rigorously and
15 comprehensively examined whilst also being divided
16 across the two modules.
17 In this regard, we raised in our written submissions
18 the issue of eligibility to therapeutics, as in which
19 categories of people were entitled to access
20 therapeutics. We submit that the Inquiry must ensure
21 that not only is national decision-making on eligibility
22 examined, but also how this translated to access to
23 therapeutics on the ground, which in CVF's experience
24 varied greatly. It's of course one thing being eligible
25 for something and it's quite another being able to

1 access it.
2 CVF have referred in their draft Rule 9 statement to
3 serious examples where things went wrong with access to
4 antivirals, and in some cases this had tragic
5 consequences.
6 We have requested, therefore, that the Inquiry
7 obtains data relating to the number of people who
8 received antivirals as against those who were eligible,
9 according to the national eligibility criteria, and we
10 say that information is critical in assessing whether
11 steps were, in fact, successfully taken to ensure the
12 use of new therapeutics during the pandemic.
13 We heard Mr Keith KC's submissions this morning on
14 the point, that you don't intend to seek specific data
15 in the absence of understanding whether it's a system
16 failure. We respectfully submit this sounds like it is
17 circular, as it's not possible to identify a system
18 failure without first obtaining the data.
19 CVF will highlight individual instances where there
20 was a disconnect between eligibility and access, but
21 whether this reflects a systemic issue is a matter which
22 can only be examined with representative data, and if
23 the Inquiry does not obtain this, the important issue
24 may not be resolved.
25 CVF are also concerned that the current wording of

paragraph 2 of the provisional outline of scope in relation to therapeutics may not allow for or at least does not clearly require a full examination of access to therapeutics and antivirals. It does not appear that this would come under the use of therapeutics in Module 3.

We are reassured to some degree by paragraph 12 of CTI's note, which refers to approval, eligibility for and access to vaccines and therapeutics. However, we want to emphasise the importance of Module 4 examining the issue of access separate from eligibility, both in order to understand the real lived experience of clinically vulnerable people, but, more importantly, for the Inquiry to make recommendations that can improve the process for accessing antivirals, which is an issue for CVF not just of historic importance but of current importance too.

Taking all that into account, we make two requests, Chair. First, that paragraph 12 of CTI's note is formally reflected in your ruling and that "approval, eligibility for and access to vaccines and therapeutics" is either included in an amended scope or confirmed to be in the upcoming issues list. And, secondly, we request that the Inquiry set out a plan for investigating therapeutics across two modules, because

at present what is proposed is a recipe for confusion, and may lead to therapeutics falling between the cracks.

We propose that this could be by way of a therapeutics-specific issues list which applies to both modules. We appreciate that's not the Inquiry's usual practice, but, in relation to an issue which is across two modules, we say it is necessary in order to make sure that the two modules work in tandem on this important issue.

So that's my point on scope.

The other three issues I'll take in a shorter way.

First of all, expert witnesses and Rule 9 requests. Two of the requests we made in our written submissions relating to expert evidence considering children and the clinically vulnerable have been accepted, and we're grateful for the indications Mr Keith KC made earlier.

We make two further requests, the first of which was in our written submissions and has not been answered, and the second arises from Mr Keith KC's oral submissions.

Now, the Inquiry, as you will be very aware, Chair, has consistently said it won't disclose Rule 9 requests to core participants, but this does sometimes mean that it's not possible for core participants to understand exactly what is being asked, and in relation to the

issue of children, which is very close to CVF's heart, we simply ask that if key witnesses haven't been asked about the impact of therapeutics and vaccines on children, that they are asked that question in the same way that the experts will be asked.

The second point is CTI said earlier that it may be necessary to recall the experts that were instructed in Module 2 in relation to structural inequalities if, in the preparation of Module 4, it becomes clear there is a lacuna, a gap, in relation to expert evidence on inequalities and structural discrimination.

We have raised before, I think in the last two preliminary hearings in Modules 3 and 4, that the clinically vulnerable should be included as a specific group that suffered structural inequalities. Of course the clinically vulnerable was a group that, in the context of Covid, emerged during the Covid pandemic because they were the definition of the people who were the most vulnerable to Covid-19. They cross over into a number of other inequality groups, but we submit -- and have submitted before -- that it's a helpful lens to understand structural inequality to consider the clinically vulnerable and the clinically extremely vulnerable and immunosuppressed as a separate group, because they were undoubtedly disadvantaged in a very

specific way.

We ask that the Inquiry use the opportunity in Module 4, and perhaps even in Module 3, to revisit the inequalities expert evidence and include the clinically vulnerable.

Finishing with two short issues. Timetable for public hearings. A number of other core participants have raised the point, if there's only going to be 10 or 11 days of evidence in this module, we are concerned that it will impact particularly on the consideration of therapeutics, which is extremely important but risks being overwhelmed by the evidence relating to vaccines, which obtained a very significant public interest during the pandemic but are of no more importance than therapeutics.

So we would be grateful if the Inquiry could set out at an early stage, and perhaps even as part of the plan that we have requested across Modules 3 and 4 on therapeutics, that the Inquiry sets out how it intends to give sufficient billing to therapeutics in Module 4 by way of a timetable.

The final issue is the approach to the provision of documents. CVF noted the indication in paragraphs 26 and 27 of CTI's note, the targeted approach that the Inquiry is adopting in relation to some document

1 providers, and of course there is a practical reason for
2 that, that there will be many, many tens of thousands of
3 documents and the Inquiry needs to get through them
4 somehow, and is therefore going to request themed
5 document disclosure.
6 We note and we submit that that may lead to some
7 skewing of the documents that the Inquiry receives, and
8 gives quite a lot of discretion to the individuals and
9 organisations that are being requested for the
10 documents. So simply we ask that there is further
11 clarification from the Inquiry as to how that proposed
12 framework will ensure relevant documents are obtained,
13 and also we do ask for a rough date at the least for
14 when the final disclosure is likely to be received, not
15 least because the autumn will be dominated, for CVF, by
16 Module 3 and it's important that we are able to plan.
17 But that will be gratefully received.
18 Unless I can assist you further, those are my
19 submissions on behalf of CVF.
20 **LADY HALLETT:** Thank you, Mr Wagner.
21 **MR WAGNER:** Thank you.
22 **LADY HALLETT:** Ms Morris.
23 **Submissions on behalf of Vaccine Injured and Bereaved UK,**
24 **Scottish Vaccine Injury Group and UK CV Family by**
25 **MS MORRIS KC**

1 **MS MORRIS:** Thank you, my Lady.
2 My Lady, alongside Mr Bradley and Mr Weaver of
3 counsel, instructed by Mr Wilcox of Hudgell Solicitors,
4 I represent three core participant groups: the Vaccine
5 Injured and Bereaved UK, the Scottish Vaccine Injury
6 Group and the UK CV Family. You have our written
7 submissions and I'm grateful that they have been
8 considered carefully by Counsel to the Inquiry and for
9 the responses provided this morning. We have in turn
10 listened carefully to Mr Keith King's Counsel's
11 submissions this morning and I would like to emphasise
12 a few key points.
13 I will deal with the most practical point first,
14 my Lady, the timetabling of hearings, because for those
15 I represent the delay in substantive oral hearings from
16 July this year to January next year has a significant
17 impact. It may be seen as modest in the Inquiry's
18 timings but it's significant to those I represent. The
19 delays only serve to further exacerbate the feelings of
20 marginalisation within the groups and has caused
21 considerable stress to people who have also already
22 faced significant challenges.
23 There are several significant implications. Members
24 of our groups have serious degenerative conditions and
25 will face deterioration in their health over the next

1 six months. Others are still enduring a long wait for
2 treatment that is being denied to them, meaning that
3 their conditions will increasingly impact on their
4 ability to participate and engage. And I ask my Lady to
5 bear in mind that the fact that the hearings will now be
6 in the middle of winter also means that those with
7 respiratory conditions will find travelling difficult or
8 impossible.
9 The delay in the substantive hearings and the
10 establishment of a clear factual narrative around the
11 Covid-19 vaccines maintains a large lacuna in the public
12 understanding within which important questions continue
13 to go unanswered and within which further serious
14 mistrust of government and healthcare institutions may
15 grow.
16 The delay in the Inquiry recording a clear factual
17 narrative also undermines its ability to make meaningful
18 recommendations for change, which we know are important
19 to you, my Lady. We have impressed on you before the
20 sheer number of people in the UK likely to have been
21 injured by the Covid-19 vaccines. As of 10 May 2024 we
22 understand the Yellow Card system to have received 2,688
23 reports of fatalities and 486,250 individual reports,
24 over 300,000 of which were reported as serious.
25 These weren't just injuries reported in relation to

1 vaccines that have now been withdrawn from the UK, and
2 it's important to note that the Covid-19 vaccine
3 programme continues in the UK for some cohorts.
4 The groups that I represent have urged you, my Lady,
5 to make critical recommendations in key areas that
6 significantly impact their lives. These include the
7 need for medical, financial, emotional and cultural
8 support. A pressing example of this is the need for
9 reform of the Vaccine Damage Payment Scheme. And
10 without reform, thousands of people are being left
11 without proper recourse to compensation or financial
12 support, and are exposed to ongoing disbelief and
13 a continued lack of medical and emotional support for
14 their injuries and online abuse.
15 Therefore, my Lady, given the delay as the Inquiry
16 receives and considers evidence, we are urging you to
17 consider making interim recommendations, particularly
18 focused on the provision of medical, emotional and
19 financial support for the vaccine injured and bereaved.
20 In addition to the concerns I've set out regarding
21 delay, we echo the concerns raised by others in relation
22 to the duration of the oral hearings. Even on the scope
23 now proposed in the recent CTI note and outlined by
24 Mr Keith this morning, we submit that a thorough and
25 adequate investigation cannot be achieved within 11 or

1 12 days. The Inquiry has currently requested statements
2 from over 120 witnesses. We simply ask: how is it
3 possible to hear that significant evidence in that
4 timescale?
5 May I then turn to the issue of scope, my Lady, and
6 this will be the main focus of my oral submissions.
7 Dealing first, please, with vaccine safety, we
8 of course are pleased to hear that the Inquiry considers
9 the issue of vaccine safety as a hugely important issue.
10 We agree.
11 Mr Keith has reiterated this morning that it will
12 not be possible to examine matters in the level of
13 a single-issue inquiry, but, my Lady, it's important to
14 note at the outset that over 100,000 members of the
15 public, via parliamentary petition, called for such
16 a single-issue inquiry regarding the safety of the
17 Covid-19 vaccines. The government has to date refused
18 to establish such an inquiry, citing the fact that
19 my Lady's Inquiry would examine the Covid-19 pandemic.
20 It was said by Counsel to the Inquiry in their
21 written note and this morning again that they want to
22 focus on systems, processes and outcomes and how they
23 can be improved. Our first submission, and it may
24 simply be a use of language but it bears stating, is
25 that any focus on outcomes of the vaccine must

1 acknowledge and record the facts that, for many people,
2 those outcomes were injury or bereavement from the
3 vaccine.
4 The Inquiry states that it will examine the nature
5 and efficacy of the regulatory regime for the approval
6 of vaccines, but we have raised the question: how can
7 the Inquiry assess regulation without understanding and
8 scrutinising the underlying data before the regulators?
9 And Mr Keith agrees that this is a necessary examination
10 within the Inquiry's approach.
11 But we urge the Inquiry to approach with a forensic
12 and critical mind to the data it's presented with. Who
13 was presenting the data to the regulators? Was it
14 accurate? Was it adequate? Did the regulators properly
15 explore or test that data in making their determinations
16 on vaccine safety?
17 In their written note, Counsel to the Inquiry also
18 stated that it would address the safety-related debate
19 over vaccines but will not reach a concluded view on the
20 safety of specific vaccines or attempt to quantify the
21 precise risk of vaccination.
22 My Lady, I make the simple point that this is not
23 a debate for those I represent; the vaccine was not safe
24 for them and it has caused physical injury and/or
25 bereavement. In our submission, the role of this

1 Inquiry is not to address the safety debate, it is to
2 find facts and record an accurate narrative of vaccine
3 safety. The Inquiry states it is concerned with
4 specific vaccine-related issues such as misinformation
5 and disinformation. However, if the Inquiry does not
6 record an accurate public narrative of vaccine safety,
7 then a vacuum remains with a lot of probing, unsettling
8 and unanswered questions within which further
9 misinformation and disinformation can be spread.
10 The Inquiry also wants to understand vaccine
11 hesitancy and how to improve vaccine confidence.
12 However, without an accurate narrative of vaccine
13 safety, the Inquiry will not be able to understand what
14 the factors impacting on confidence might have been in
15 the past, which are highly likely to include concerns
16 around safety. In our submission, any analysis of
17 vaccine confidence is fundamentally flawed without
18 understanding the true impact and risk of the vaccine
19 and what was known about that risk at the time of the
20 roll-out as well as how that risk was perceived.
21 The groups that I represent are concerned that
22 throughout the pandemic there was a persistent narrative
23 that vaccines were safe and that the benefits outweighed
24 the risks. In our submission, the Inquiry should
25 examine what is meant by a vaccine having a "favourable

1 safety profile" and how these safety profiles are
2 assessed and, for example, what criteria were used.
3 Moreover, a genuine concern arises regarding what we
4 perceive as a significant deficiency in the
5 dissemination of vaccine risk information, both
6 generally but in particular among individuals from
7 minoritised backgrounds, potentially attributed to
8 structural discrimination.
9 This discrimination, potentially evidenced by
10 factors such as access to healthcare resources, language
11 barriers and distrust in medical institutions, may have
12 hindered some communities' understanding of the risks
13 associated with the vaccine.
14 I now turn to my second issue in relation to scope,
15 that is the vaccine as a condition of deployment, for
16 which we include employment and enrolment, and we're
17 grateful to the Inquiry for ruling that this issue is
18 something that Module 4 will explore.
19 We have raised that there are many groups for whom
20 work was a reason to get vaccinated, as they're employed
21 within the care sector, and I represent those who were
22 healthcare workers within the NHS, some worked in
23 schools and other public institutions. All were made
24 aware that their job would be at risk if they did not
25 have the vaccine. They were asked to do so and asked to

1 put their own health at risk and the health of others
2 before their own.
3 We are concerned that there were methods used by the
4 government, the NHS and private companies to ensure that
5 all employees were vaccinated, and this may have had the
6 desired effect for some people, who responded to the
7 campaigns by getting vaccinated, but we ask at what cost
8 to the individual, to the employer's work environment
9 and to society as a whole?
10 It's crucial for the Inquiry to explore how VCOD,
11 its causal impacts, affected individual decisions,
12 potentially causing them to prioritise external
13 pressures over their own health needs. It will also be
14 important for the Inquiry to examine the degree to which
15 the Scottish, Welsh, Northern Irish and Westminster
16 governments differed in their position and messaging to
17 their populations around whether vaccines were
18 mandatory.
19 Within our groups there are also numerous doctors
20 within the NHS who had concerns about the vaccine but
21 were instructed to keep those concerns from the public,
22 including their own patients. This form of censorship,
23 which we will term "cultural censorship", is deeply
24 troubling. It has forced doctors to hide their own
25 injuries even now. These doctors, who are often

1 responsible for administering the vaccine to others,
2 faced immense pressure to receive it themselves and,
3 despite their enhanced understanding of their own bodies
4 and the potential impact of the vaccine, they very often
5 felt compelled to prioritise external pressures.
6 And this leads to my third issue, that of reporting
7 of vaccine injury.
8 The Inquiry's consistently stated that the operation
9 of post-approval monitoring system and how relevant
10 bodies identified and responded to reports is within its
11 scope and we're grateful for that reiteratation this
12 morning. But in our submission the scope of the Inquiry
13 so also include whether the healthcare system was
14 adequately prepared to properly identify, monitor and
15 report vaccine injury.
16 Medical professionals should have been provided with
17 information and treatment protocols about possible
18 suspicious side effects to look out for before the first
19 vaccines were administered. Side effects were
20 anticipated. Medical staff should have been given
21 directives which required them to identify any
22 conditions which appeared following vaccinations and to
23 immediately report these for best treatment protocols
24 and for data collection of emerging side effects,
25 for example via the Yellow Card scheme.

1 Those we represent also express genuine concern that
2 vaccine injuries among individuals from minority
3 communities may have gone unreported due to structural
4 discrimination. This is likely to translate into
5 an incomplete understanding of national vaccine injury
6 incidents, any relevant data analysis by ethnicity or
7 other protected characteristic, and this undermines any
8 proper understanding of risks for future mass
9 vaccination programmes.
10 In our submission, any effort to address vaccine
11 safety remains incomplete without consideration of
12 factors such as discrimination hindered certain groups
13 from effectively reporting vaccine-related injuries.
14 The bereaved that we represent also have serious
15 concerns about how the deaths of their loved ones
16 following a vaccine injury were investigated and
17 recorded. Hospitals, GPs and coroners were not
18 adequately prepared to fully investigate deaths where
19 bereaved raised concerns about a connection with the
20 vaccine, in our submission.
21 This is vital. Given the importance of accurate
22 reporting of deaths caused by the vaccine by the ONS and
23 other data and statistical bodies, the Inquiry should,
24 in our submission, examine these post-death processes
25 carefully, with a view to making recommendations that

1 will ensure a more robust and compassionate reporting
2 system for the future.
3 Compassion must be something, in our submission,
4 the Inquiry takes seriously, which leads me on to my
5 fourth topic on scope: the provision of medical,
6 psychological and financial support to the vaccine
7 injured and bereaved.
8 Mr Keith has said this morning that the treatment of
9 the vaccine injured is not something that Module 4 is
10 looking at and that it would represent a massive
11 expansion in terms of reference, and that its treatment
12 is only tangentially connected to the broader issues
13 which lie at the heart of this module.
14 We respectfully disagree.
15 It's clear, in our submission, that rapid diagnosis
16 is important for accurate vaccine safety tracking, which
17 benefits the whole of society and not just the
18 individual patient. If there is no care diagnostic
19 pathway, there is no efficient reporting. It is not
20 tangential, in our submission.
21 Proper diagnosis and treatment of the vaccine
22 injured should be at the heart of the reporting of
23 vaccine injury, and also part of the examination of the
24 Vaccine Damage Payment Scheme. Put simply, my Lady, if
25 people do not believe there is adequate care in place

1 for the vaccine injured, it will impact on their
2 confidence in reporting vaccine injury and it will
3 impact on their confidence in having future vaccines.
4 The Yellow Card system and other reporting systems are
5 intertwined with diagnosis and care by doctors.
6 In our submission, the Inquiry should investigate
7 why the government did not adequately plan for clear
8 diagnostic pathways to ensure people were treated
9 quickly and that appropriate medical and emotional
10 support was provided promptly across the country to all
11 those who needed it.
12 As part of the risk assessment, what were the known
13 risks? Was that risk assessment adequate? And if there
14 were known risks of injury or death, what were the risk
15 mitigations put into place? That mitigation, a horrible
16 word as it may sound, should have taken the form of
17 proper diagnosis and treatment for those who were
18 vaccine injured.
19 Mr Keith has said this morning that the Inquiry has
20 to draw a line and that the issue of whether or not
21 there has been any psychological trauma is not something
22 the Inquiry could possibly look at. Again, we
23 respectfully disagree and urge you, my Lady, to
24 recognise that understanding the trauma of vaccine
25 injury and bereavement is the only way of understanding

1 the significance of poor reporting and the inadequacies
2 of the Vaccine Damage Payment Scheme.
3 My fifth issue, my Lady, in respect of scope is that
4 of discrimination. I have sought to interweave some of
5 my submissions into my other submissions on scope, but
6 may I just deal shortly with a point raised by Mr Keith
7 this morning in relation to the reintroduction of the
8 evidence from Professors Nazroo and Bécares from
9 Module 2, and I wanted to echo and support Ms Munroe's
10 submissions that Module 4 and looking at discrimination
11 is not a simple check list or tick box exercise; any
12 evidence that looks at structural discrimination must
13 address the fundamental issues that each module is
14 tackling.
15 Finally then in terms of scope, the Vaccine Damage
16 Payment Scheme. In our written submissions we propose
17 that the Inquiry obtain expert evidence on the scheme
18 and use a comparative approach with other no fault
19 payment schemes developed in other countries.
20 We've noted that a Rule 9 statement has been
21 requested from Professor Duncan Fairgrieve KC. There
22 was some suggestion this morning by Mr Keith that he may
23 not need to be called but we would wish to revisit this
24 position, if in fact that is the position, once we have
25 sight from his Rule 9 statement. In our submission, he

1 is an expert and it's likely to be our subsequent
2 submission that he be treated as such.
3 Still on this topic, it's important to underline at
4 this stage that the vaccine adverse impacted and
5 bereaved do not have any confidence that outside this
6 Inquiry that comments made by the current government
7 regarding reform to the VDPS will result in any
8 meaningful change. Their concern is that it's an easy
9 election promise that will not materialise into any
10 formal review. This Inquiry, now seized of the issue
11 within Module 4, must be, we say, the robust independent
12 investigation that makes clear recommendations for any
13 government to act upon.
14 We've seen this week in the Langstaff Inquiry into
15 the infected blood scandal making interim
16 recommendations for compensation, now a recommendation
17 urgent establishment of a compensation scheme for those
18 victims, which the government has said it will honour.
19 This underlines that public inquiries have a significant
20 role to play in establishing the truth, away from party
21 politics, and making concrete recommendations that
22 governments take action.
23 The victims of the infected blood scandal had to
24 campaign for decades to achieve justice, decades of
25 physical and mental suffering for patients and their

1 families to obtain recognition, treatment and
2 compensation. We ask this Inquiry to prevent the groups
3 I represent from going through the same tortured
4 experience.
5 May I then move on to some submissions on the
6 instructions of experts, and I can take this quite
7 shortly. In our written submissions we have proposed
8 a number of additional experts for the Inquiry to seek
9 evidence from, and we have also requested that each of
10 the experts already instructed be provided with copies
11 of the statements provided to the Inquiry by each of our
12 groups.
13 Impact evidence. We've heard this morning that
14 impact evidence from representative witnesses on behalf
15 of appropriate core participants may be called, as it
16 was in Module 2. It's firmly submitted that it's
17 impossible to comprehend the impact of the pandemic
18 without understanding the impact of the vaccine. Absent
19 the insights of our groups, an accurate depiction will
20 not be possible. It's an uncomfortable truth for many,
21 but vaccine injury and death are, very sadly, a part of
22 the pandemic story.
23 My Lady, you said in 2022 that loss and suffering
24 would be at the heart of your Inquiry. Prior to that,
25 on 11 August 2021, the then Prime Minister Boris Johnson

1 wrote a letter to a VIBUK member which read:
2 "I am deeply sorry to read about Jamie's condition
3 and the immense consequences for you. You have suffered
4 a heartbreaking and frightening change, but I would like
5 to pay attribute to your strength in proposing changes
6 which you think could improve the situation. You're not
7 a statistic and must not be ignored. I am deeply
8 touched by your story."
9 This Inquiry has a unique opportunity to ensure that
10 the Covid vaccine adverse reaction and bereaved are not
11 ignored. To not hear evidence from them as part of the
12 oral evidence hearings would be to simply reduce them to
13 an inaccurate and under-reported statistic. This
14 Inquiry cannot allow this to happen and we say that they
15 must be included with the witnesses that the Inquiry
16 hears from.
17 Which leads me on to censorship. My Lady, to
18 exclude the groups that I represent would add to the
19 extensive censorship they already experience. The Covid
20 Vaccine Adverse Reaction and Bereaved have been largely
21 ignored by public services, with their experiences not
22 recognised or validated by those who should be in
23 a position to help them.
24 This censorship manifests itself in our clients'
25 engagement with this Inquiry. YouTube removed a video

1 of my oral submissions to you, my Lady, on the last
2 occasion, in September of last year, and despite
3 requests for a thorough review by our clients, YouTube
4 cited a violation on its medical misinformation policy
5 as grounds for removal.
6 Sadly, this incident of censorship is not
7 an isolated occurrence but rather a part of a broader
8 pattern of treatment our clients have endured. Such
9 censorship not only stifles the voices of those directly
10 affected but also sends a chilling message to potential
11 witnesses who may consider sharing evidence that is
12 critical of the vaccine from their own lived experience.
13 The fear of reprisal, whether in the form of
14 censorship, social backlash or professional
15 repercussions looms large for individuals who may have
16 valuable insights to contribute to this Inquiry. This
17 fear may lead individuals to hesitate or withhold candid
18 evidence, undermining the Inquiry's own integrity and
19 depriving it of the diverse perspectives necessary for
20 a comprehensive examination of the issues.
21 Addressing censorship is crucial not only to protect
22 the rights of those affected but also to foster an
23 environment where individuals feel safe, their
24 experiences openly and honestly expressed within this
25 inquiry and elsewhere. It is imperative therefore that

1 individuals providing evidence feel confident they will
2 not face repercussions for their evidence and that it is
3 valued by the Inquiry.
4 To restore confidence in the Inquiry process, our
5 clients respectfully request you, my Lady, to establish
6 a clear protocol for reporting to you any instances of
7 Inquiry material being removed from social media and
8 reporting any incidents of reprisal to those who have
9 provided evidence to the Inquiry, which, in my
10 submission, my Lady, are essential for you to ensure the
11 independence and credibility of your Inquiry and the
12 evidence it hears.
13 I'll move on, then, please, to some shorter topics.
14 **LADY HALLETT:** I'm afraid I'm going to hurry you, Ms Morris,
15 I did give everyone a warning earlier.
16 **MS MORRIS:** You did, my Lady.
17 Disclosure, my Lady, I won't repeat what's in my
18 written submissions. Likewise parliamentary privilege.
19 My Lady, you have my submissions in respect of
20 support for my clients during the oral evidence
21 hearings, and I'm grateful for the provision that's been
22 provided today. It's just a recognition that there are
23 certain issues around light sensitivity, chemicals and
24 water filtration and frequent breaks.
25 My Lady, I have sought to elicit the key points from

1 our written submissions, which we have no doubt you have
2 read in full, and I commend them fully to you. But in
3 short, and in conclusion, this Inquiry has a historic
4 opportunity to critically examine and record the facts
5 about the Covid-19 vaccine. It cannot simply accept the
6 pandemic narratives perpetuated during an unprecedented
7 period to ensure maximum compliance. This thorough
8 examination must include facts and evidence that are
9 uncomfortable for some but are a reality for many. This
10 Inquiry must carefully listen and meticulously record
11 them and have the courage to make recommendations for
12 reform.
13 My Lady.
14 **LADY HALLETT:** Thank you, Ms Morris.
15 I will not have applause. I appreciate how people
16 care about this issue, but I'm afraid this is a formal
17 hearing of a statutory inquiry. So can I just make that
18 plain.
19 Right, Ms Banton, will you take us up to lunch,
20 please.
21 **Submissions on behalf of the Federation of Ethnic Minority**
22 **Healthcare Organisations by MS BANTON**
23 **MS BANTON:** My Lady, good afternoon. I, along with the
24 counsel team of Mr Philip Dayle, Mr Ifeanyi Odogwu --
25 **LADY HALLETT:** Is your microphone on?

1 **MS BANTON:** No, it's not -- it's on now, I think.
2 **LADY HALLETT:** It is now.
3 **MS BANTON:** That's much better.
4 Good afternoon, my Lady. I along with a counsel
5 team of Mr Philip Dayle, Mr Ifeanyi Odogwu and
6 Ms Una Morris, represent the Federation of Ethnic
7 Minority Healthcare Organisations, FEMHO. We are led by
8 Mr Leslie Thomas KC and instructed by Cyrilia Knight and
9 Isabel Gregory of Saunders Law.
10 FEMHO is the voice for a large multidisciplinary
11 consortium advocating on behalf of ethnically diverse
12 black, Asian and minority ethnic health and social care
13 workers.
14 FEMHO remains steadfastly clear in its intention to
15 address inequalities and indeed inequities experienced
16 by ethnic minorities within health and social care in
17 the United Kingdom.
18 My Lady, I am most grateful that many of the factors
19 that we have raised previously have been incorporated
20 and for the opportunity to address you today. We have
21 provided submissions in writing and I will highlight
22 some aspects now.
23 As my Lady is aware, FEMHO's client base is made up
24 of highly skilled and knowledgeable healthcare workers
25 involved at the coalface of the roll-out of vaccines and

1 treatment of Covid, and so it is helpful to provide
2 their insights at this juncture.
3 Providing the ethnic minority healthcare
4 perspective, FEMHO is able to speak to how the workforce
5 culture of the public health and coronavirus response
6 structures impacted disproportionately harshly on
7 minority ethnic healthcare workers, including in respect
8 of discrimination, disproportionate rostering to high
9 risk areas, inadequate PPE, lack of risk assessment,
10 lack of proper epidemiological data, mapping and more.
11 Moving on to update on scope, which is the most
12 substantial of my submissions. On the provisional scope
13 outlined, FEMHO particularly welcomes the assurance that
14 the Inquiry will expressly address the impact of all
15 decisions on marginalised groups and communities. We
16 welcome coverage as to whether VCOD was or would have
17 been effective in limiting transmission and its impact
18 on vaccine hesitancy or lack of confidence. We note
19 that regarding VCOD, care workers were treated
20 differently and that VCOD continued to operate within
21 that sector.
22 We are also most grateful that our concerns made at
23 the last preliminary hearing regarding the use of
24 terminology that better reflects the sensitivities and
25 complexities of the issues at play have also been

1 addressed.
2 FEMHO note and are encouraged by the Yellow Card
3 scheme and UK Vaccine Damage Payment Scheme being
4 included. We welcome the commitment to place possible
5 inequalities at the forefront of this investigation,
6 which we believe must involve an unflinching and
7 thorough exploration of whether institutional and
8 structural racism and inequality played a part in the
9 development, procurement and use of Covid-19
10 therapeutics and vaccines, including the employment
11 implementation of the vaccine roll-out programme.
12 Regarding crucial exploration through an inequality
13 lens, as Counsel to the Inquiry referred to this
14 morning, we hope it will be helpful to provide a few
15 illustrative examples of the approach we submit should
16 be taken towards this investigation.
17 We consider it vital that the examination of the
18 development, trialling and procurement of Covid-19
19 vaccines and the implementation of the vaccine roll-out
20 programme investigates if and how pre-existing knowledge
21 in the identification of and any pre-emptive and/or
22 mitigating action was taken in respect of ethnic groups
23 which were the subject of unequal uptake, and whether
24 there was sufficient effort to ensure equitable
25 representation and diversity within trials, as well as

1 the position of minority ethnic healthcare workers
2 and/or communities in the light of pre-existing known
3 risk factors. Further, how the consideration of at-risk
4 groups was approached by vaccine manufacturers and
5 decision-makers, including in relation to ethnic
6 minority groups and in relation to other linked
7 vulnerabilities, for example higher rates of conditions
8 such as sickle cell and other clotting diseases.
9 Further, in considering the issue of vaccine
10 confidence, a careful examination of the multifactorial
11 underlying issues surrounding confidence in black, Asian
12 and minority ethnic healthcare workers and communities
13 to include the extent to which pre-existing knowledge
14 was taken into account and the role which thematic lack
15 of data played and whether data disaggregated by
16 ethnicity was available, collated and analysed to
17 identify disparities and risks, or not, as the case may
18 be. Also: whether the Vaccine Damage Payment Scheme has
19 been equitable in its application by reference to data,
20 again disaggregated by ethnicity; accessibility and
21 cultural competence in surveillance, including the
22 Yellow Card scheme and community outreach; and
23 engagement should be examined so that vital
24 recommendations may be made to improve preparedness for
25 any next pandemic.

1 And when considering the role of communication and
2 messaging, and decisions taken by the Vaccine Taskforce
3 regarding the roll-out: linguistic accessibility,
4 cultural competence, and the approach to dealing with
5 poorer uptake; ensuring accessibility to vaccine
6 centres; the spread of misinformation and the use of the
7 "hard to reach" mantra must be carefully examined, as
8 well as what efforts have continued since the pandemic
9 and may be added to now on how trust can be rebuilt for
10 the future.
11 Finally, by way of example, it should be recognised
12 that thematic issues of trust run as a thread throughout
13 all of the above matters regarding key issues around
14 engendering, maintaining and rebuilding trust within
15 such communities.
16 An analogy may be made with the example of the MMR
17 vaccination. If trust is not cultivated and diverse
18 communities are not included in these matters,
19 confidence and take-up will not be improved and
20 an opportunity may be lost.
21 Moving on to Rule 9 requests, FEMHO requests that
22 the Inquiry reconsiders the position not to disclose
23 Rule 9 requests to core participants in the interests of
24 transparency and more timely and effective participation
25 by CPs. We submit that if this position is not

1 reconsidered, the Inquiry runs the risk of having
2 insufficient time for any gaps within the evidence to be
3 addressed, given the speed of disclosure and the tight
4 timetable that we are all working to.
5 FEMHO are concerned that from the information we
6 have been provided via update notes from the Inquiry
7 team, inequalities are at times not given sufficient
8 consideration in Rule 9 requests.
9 Additionally, the subject of inequalities appears
10 notably absent from some significant Rule 9 requests.
11 For example: entry to HM Treasury inequalities were not
12 directly mentioned; entry 4, the Scottish Government,
13 inequalities were not directly mentioned; and entry 6,
14 the same in respect of the Department of Health and
15 Social Care, where inequalities were not directly
16 mentioned.
17 Further, where inequalities are mentioned, there is
18 often scant detail as to what exactly the recipient is
19 being asked to comment on. Rather, it often appears, as
20 seems to have been the case in previous modules, as
21 a final catch-all topic, for example, the Cabinet Office
22 summary, where inequalities and vaccine safety appeared
23 at the very end.
24 The same is true of lessons learned, also often seen
25 as a final topic. Such placement raises a concern that

1 insufficient contextual exploration may be being
2 afforded to vital inequality issues, and there's a risk
3 that inequalities may not receive the consideration that
4 it deserves.
5 FEMHO has specific concerns that opportunities have
6 been lost to ask the Joint Committee on Vaccination and
7 Immunisation, JCVI. For example, we have indicated
8 previously that we are keen to explore what if any
9 consideration and/or steps were taken by government, in
10 particular the Joint Committee on Vaccination and
11 Immunisation, to address the points in relation to
12 making the Yellow Card scheme more accessible and
13 effective for ethnic minorities.
14 FEMHO welcomes the confirmation that impact
15 witnesses from core participants will be called to give
16 evidence at the hearings. However, we urge the Inquiry
17 to prioritise calling a proportionate number of
18 witnesses who are from diverse backgrounds, disciplines,
19 and locations across the UK who can speak to a range of
20 systemic issues relevant to Module 4, as FEMHO members
21 would be more than willing to assist.
22 We echo submissions from Anna Morris KC on the need
23 for an urgent compensation scheme and recommendations to
24 avoid a repeat of the experiences of victims' long wait
25 in the Infected Blood Inquiry.

1 Moving on to disclosure, FEMHO welcomes the
2 confirmation that disclosure will continue to be
3 released on an ongoing basis. We respectfully suggest
4 that disclosure may be made incrementally as soon as
5 material becomes available rather than waiting to
6 release it all at once in a single bulk, in order to
7 prevent delays and to enable parties to front load their
8 preparation.
9 We suggest that failure to adopt this method risks
10 placing concerned CPs in a position where they may be
11 unable to adequately digest, analyse and contribute
12 meaningfully to the hearings. This problem is
13 exacerbated where many CPs will be actively
14 participating in and working on concurrent back-to-back
15 modules.
16 Moving on to expert witnesses, we would like to
17 reiterate our previous request, also echoed this morning
18 by Allison Munroe KC, that Professor James Nazroo and
19 Dr Laia Bécares be instructed to produce a joint
20 addendum report addressing the race inequality issues
21 pertinent to Module 4. We consider there would be high
22 value in their providing such an addendum report to
23 the Inquiry specifically addressing issues relating to
24 vaccines and therapeutics, and that they should be made
25 available for questions during the evidential hearings

1 in this module.
2 In the alternative, as a minimum we ask that all
3 experts, including those already identified and any
4 further experts instructed, be explicitly instructed to
5 consider and address inequalities as it pertains to
6 their remit, such as the equity and representation as
7 well as any bias in vaccine and therapeutic development,
8 trials and clinical use, assessment of data on antiviral
9 and other treatments given to ethnic minority
10 populations, and accessibility and cultural competence
11 of messaging in the roll-out and communications and
12 surveillance systems.
13 We acknowledge and welcome Mr Keith KC's comments
14 this morning in relation to the two sets of experts that
15 have already been instructed to consider issues of
16 inequalities and discrimination. However, as stated in
17 our written submissions, we firmly consider that all
18 experts in Module 4, not just these two experts, should
19 be instructed to cover such issues.
20 We are grateful for confirmation that the experts on
21 vaccine safety will report on vaccine effectiveness on
22 Long Covid, and the utilisation of Module 2 and 3 expert
23 evidence focused on Long Covid.
24 Further, we seek confirmation that the other experts
25 will similarly be asked to address the issues detailed

1 in our previous submissions.
2 It remains crucial regarding lessons learned that
3 the Inquiry examines and embeds further whether, and if
4 so how, structural inequalities and cultural
5 competencies influenced issues such as vaccine roll-out,
6 VCOD and the Yellow Card system alongside other central
7 matters to Module 4. This must be considered together
8 with the extent to which due regard was given to the
9 public sector equality duty to eliminate discrimination
10 and concomitant equality impact assessments undertaken.
11 The Inquiry, with the assistance of evidence from
12 FEMHO members, will need to grapple with how structural
13 and systemic, economic, political and social factors
14 coalesced to produce these adverse racialised outcomes
15 during the pandemic.
16 Moving on to timetable of future hearings, despite
17 the CTI's statement that morning, FEMHO does maintain
18 a genuine concern as to the limited time afforded to the
19 evidential hearings for Module 4 given the breadth of
20 the scope and issues to be investigated. We are mindful
21 that with the Inquiry's practice of sitting four days
22 a week and incorporating opening and closing
23 submissions, this would likely leave a mere ten days or
24 so for questioning of witnesses. We respectfully seek
25 that the Inquiry allocates additional days for Module 4

1 within the Inquiry timetabling.
2 My Lady, FEMHO appreciates the full consideration of
3 the Chair given to all the matters raised in my
4 submissions. We are grateful for the attention paid to
5 these important matters, and remain hopeful that they
6 will be carefully addressed within the Inquiry process.
7 Unless I may assist you further, my Lady, those are
8 my submissions.
9 **LADY HALLETT:** Thank you very much, Ms Banton, I'm very
10 grateful.
11 We'll break now until 2.10.
12 **(1.12 pm)**
13 **(The short adjournment)**
14 **(2.10 pm)**
15 **LADY HALLETT:** Ms Naik.
16 **Submissions on behalf of the Migrant Primary Care Access**
17 **Group by MS NAIK KC**
18 **MS NAIK:** Thank you very much. I hope you can hear me now.
19 I appear with Ms Sardar of counsel instructed by
20 Ms Ellen Fotheringham of the Public Interest Law Centre
21 today, and I represent, as my Lady knows, the Migrant
22 Primary Care Access Group, which consists of Doctors of
23 the World, the Joint Council for the Welfare of
24 Immigrants, Kanlungan and Medact.
25 My Lady, you have our two sets of written

1 submissions, the first, in relation -- which was on
2 10 April, which addressed the submissions directly to
3 the Inquiry on the issue of privilege, and the second,
4 in relation to this hearing, on 14 May.
5 And we're very grateful to the Counsel to the
6 Inquiry and the note of 2 May and also for inviting the
7 wider engagement and submissions from the other
8 core participants insofar as they have on the issue of
9 parliamentary privilege. And I think the issue has
10 moved on somewhat since we first raised the question but
11 I just wanted to outline in very brief terms what the
12 issues are and how we got where we are now.
13 So the first issue on privilege is as to how to deal
14 with questions of privilege that arise in the context of
15 the Inquiry. Does the issue of privilege arise here?
16 Should there be a ruling? And importantly -- and
17 I think this is where we are at now -- the consistency
18 of the application of those principles and the proposed
19 workaround by the Inquiry across the modules both past,
20 present and future. And one issue that that leads us to
21 is to whether there should be or is there a need for
22 a protocol from the Inquiry as to how that should be
23 applied. And that's not something we previously
24 foreshadowed in our written submissions, but it seems to
25 be a matter that deals with how the matters have emerged

1 so far.
2 We start, as Counsel to the Inquiry notes in his
3 written submissions for this hearing at paragraph 33,
4 that the issue of parliamentary privilege is a complex
5 and difficult issue, and we recognise that. There's
6 also now, as my Lady may be aware, a House of Lords
7 committee on statutory Inquiries which was appointed to
8 examine the efficacy of the law and the practice in
9 relation to statutory inquiries which opened at the end
10 of January this year. And as, again, just a further
11 observation in opening, that Mr Keith notes in his
12 written submissions that if we were to proceed down the
13 path of a ruling, that the Speaker's counsel might be
14 required to participate. And again their position, as
15 recorded in, for example, the Heathrow Hub case, is that
16 it's important for the court and Parliament to agree as
17 far as possible as to what the ambit of the privilege
18 rule is.
19 So, in summary, our position as it was set out on
20 10 April arose in response to the requests from
21 the Inquiry to amend our draft Rule 9 witness statement
22 and indeed the engagement in correspondence that we had
23 with the Inquiry, at some length, before we got to the
24 position that we did. And the first question is whether
25 there should be a ruling on whether privilege applies or

1 whether, if privilege in principle applies, there are
2 any exceptions to that usual rule, which would then
3 require consideration of the case law and some of the
4 familiar carve-outs that already exist in the case law.
5 In those submissions, we then invited the Chair to
6 either permit us to exhibit or refer to our select
7 committee evidence and to put us on a similar footing to
8 some of the CPs in Modules 1 and 2, with reference to
9 the examples, I think ten examples we gave in our
10 written submissions at paragraph 23, of where we said
11 a difference of approach had been applied, and we said
12 there we wanted to refer to, cite and exhibit our
13 evidence, which was largely for Doctors of the World,
14 JCWI and so on, in the form of submissions and briefings
15 to the select committee, and also in relation to the
16 recommendations that they had made in response, that the
17 committee had made in response to the reports that were
18 made to them.
19 Now, in light of the development of the position, as
20 we see it, and the engagement of the Inquiry and Counsel
21 to the Inquiry's position as to the workaround, we now
22 recognise, and I think it's clear from both sides, that
23 we can exhibit our evidence that was made to the select
24 committees in a new statement, and that this then really
25 only leaves the question of what should happen to the

1 evidence as to the recommendations that were made by the
2 select committee reports in response to our submissions.
3 That's important for my clients, or for our clients,
4 because they seek to demonstrate that the government
5 knew the issues around structural inequality and
6 barriers to vaccine take-up for migrant communities, in
7 particular because of the already in place hostile
8 environment which had existed for some years before the
9 pandemic started.
10 So, for those reasons, we propose the further
11 practical workaround -- again, Counsel to the Inquiry
12 invited the Migrant Primary Care Access Group to propose
13 an alternative workaround if we weren't satisfied with
14 the one that we had been offered -- or had been
15 clarified, rather, perhaps late in the day, and we
16 suggested the de bene esse approach. And we referred,
17 you don't need to go to those now, but in -- how that
18 approach had been used, for example, in the
19 Administrative Court, in the submissions we've referred
20 to in paragraphs 12 and 13 as to admitting in the
21 evidence and then allowing the responses to come from
22 government, and then to allow the --
23 **LADY HALLETT:** I'm sorry to interrupt.
24 **MS NAIK:** Yes.
25 **LADY HALLETT:** I'm really sorry, I try not to do it unless

1 I have to, but one of the first pieces of advice I was
2 given when appointed a judge is: don't rule on an issue
3 unless you have to. And at the moment I can't see any
4 necessity to rule on the issue. It may be it will come,
5 I don't know, but at the moment you have the agreement
6 of Counsel to the Inquiry that you can put in the
7 evidence you wish. When it comes to the recommendations
8 of the select committee, at the moment I can't see
9 a problem, but if there were a problem, surely that is
10 something I'd come to when I'd started hearing the
11 evidence. Isn't this premature?
12 **MS NAIK:** Well, my Lady, I'm grateful for that indication,
13 and of course Counsel to the Inquiry identifies that we
14 shouldn't rule unless we have to. There has been an --
15 in the history of the correspondence between my clients
16 and the Inquiry, there has been a reasonable amount of
17 confusion and there has been what we've said is
18 an inconsistency of application -- it may be
19 an approach, but there has been an inconsistency of
20 application for the reasons we set out in our original
21 submissions.
22 The question of the recommendations is key to the
23 way my clients put their case or put their evidence to
24 the Inquiry, and if the Inquiry isn't minded to rule on
25 it now, we certainly want to use this process to flag

1 the issue, and if that's all that's required at this
2 point in time, then we would be satisfied with that.
3 But we --
4 **LADY HALLETT:** Consider it flagged.
5 **MS NAIK:** Thank you very much.
6 We just note that in the correspondence it was
7 suggested that this isn't a straightforward matter and
8 we did have a lot of back and forth with the Inquiry
9 team in relation to how it should be developed, and we
10 do posit at least the idea of a protocol to ensure
11 consistency across the modules, and we say that because
12 I think Counsel to the Inquiry suggests that our
13 concerns are overstated, but we do -- well, we flagged
14 them, and I use the language advisedly.
15 I do also want to emphasise that it was the Migrant
16 Primary Care Access Group's intention -- the primary
17 objective of raising this issue and following through
18 with it was to foster clarity, certainty and fairness
19 across the Inquiry, and importantly, from my clients'
20 position, because their joint statement of course
21 identifies barriers to inequalities that prevented
22 access to the Covid vaccine and therapeutics for
23 a significant proportion of the migrant community, and
24 in particular the hostile environment. And so the --
25 where this matter was most importantly addressed was in

1 the select committee, that was the key forum for those
2 non-state actors to try to impact government
3 decision-making about the pandemic response at the time.
4 So we want to emphasise to the Inquiry the -- to examine
5 very carefully the extent to which the government
6 engaged with and considers the terms that -- considered
7 the evidence that was before them.
8 So I don't necessarily need now to go to the detail
9 of what the various workarounds were that were proposed,
10 but we say that we would -- we wanted in the proposal
11 that we suggested to have the opportunity to finalise
12 our Rule 9 before -- after, sorry, after the Home Office
13 had made their response.
14 Counsel to the Inquiry says that's an unworkable
15 position, but that is the position that logically
16 follows from the de bene esse approach. We don't
17 suggest that to be applied to all core participants.
18 It's only those who seek to rely on such material that
19 is otherwise going to be difficult to elicit/excluded on
20 the grounds of privilege.
21 So we don't try to impose an unreasonable or
22 unworkable burden on the Inquiry, we just identify it
23 for this CP and any others who are similarly situated
24 who wish to rely on such material. So we leave that
25 point there, if I can.

1 The second point is in relation to the expert
2 evidence, and again we've had some engagement with
3 the Inquiry as to the nature of what that will look like
4 and the shape of it.
5 Just responding to Mr Keith's point this morning, as
6 a CP, we will endeavour to update our Rule 9, of course,
7 as to the history and the evolution of the hostile
8 environment, but we still maintain our request for
9 an expert. First of all on the basis that there's
10 a distinction to be made between an organisational
11 expert and an academic expert, for obvious reasons. And
12 secondly because, I think in line with the submissions
13 made by Ms Munroe KC and Ms Banton earlier before lunch,
14 there are differences in relation to the impact of the
15 structural racism as being a barrier to vaccine take-up,
16 and in particular -- and that there's a specific subset
17 to migrants who are -- particularly those who are
18 subject to hostile environment, and we observe and
19 support Ms Munroe in her analysis or description that
20 vaccine hesitancy is insufficient to address
21 state-imposed structural barriers and discrimination,
22 and in particular and further our case is about access
23 to the vaccine in the context of data sharing with the
24 Home Office and the subjective fears that certain
25 migrants or indeed many migrants would have in that

1 context.
2 So whilst we recognise that these experts are
3 welcome, we need to ensure that the expert reports cover
4 the particular situation of migrants in the UK who faced
5 unique barriers and entrenched inequalities in accessing
6 vaccines and therapeutics.
7 So we propose two further experts which we would
8 like the Inquiry to keep under review if they're not
9 going to consider that question today or now, but as we
10 indicated that once we've updated our Rule 9 we do
11 invite the Inquiry to keep that matter under review.
12 The third issue is in relation to the timing. And
13 again we don't need to say much more about it, other
14 than we propose or support the observations made by the
15 other CPs in relation to the timetable and the timescale
16 of the 13 days with 10 or 11 allocated to witness
17 evidence.
18 We understood, I just wanted to make sure I had
19 understood correctly, my Lady, that when we were
20 originally allocated -- in July we had 20 days, I had
21 understood, and that's gone down to 13 days, and as far
22 as we're aware, or I'm aware, there is no reasons that
23 have been given for a truncated listing, aside from
24 those that Mr Keith advanced today more generally about
25 the timetable for the Inquiry as a whole.

1 So ... but given that the issues as identified
2 previously were for 20 days, we just pray in aid that we
3 haven't seen any justification in relation to the ambit
4 of this module to justify a reduction in time.
5 So those are all the things I wish to say. Thank
6 you very much.
7 **LADY HALLETT:** Thank you.
8 Right, Mr Jacobs.
9 **Submissions on behalf of the Traveller Movement by MR JACOBS**
10 **MR JACOBS:** My Lady, I appear for the Traveller Movement and
11 I'm instructed by Howe & Co.
12 As we've set out in our written submissions, the
13 Traveller Movement is a charity which represents the
14 interests of the Gypsy, Roma and Traveller
15 communities -- I'll refer to them as GRT -- in the
16 United Kingdom. It was designated as a core participant
17 in this phase of this Inquiry on 17 July 2023.
18 Traveller Movement's position is that the
19 GRT population in the United Kingdom was largely ignored
20 in the vaccine roll-out programme during the Covid-19
21 pandemic. And this is a matter of concern because, as
22 we told the Inquiry I think back in September at the
23 last preliminary hearing, the population of those
24 communities has been estimated by the ONS as potentially
25 as high as 500,000 people, so up to one in ten of the

1 population.
2 Now, there are a number of reasons why such large
3 numbers of GRT were disregarded in the pandemic. Many
4 of them, around 10,000, are forced to live on
5 unauthorised sites as a result of failure by local
6 authorities to meet their spatial planning duties, and
7 such people were unable to register with GPs or access
8 the vaccine programme through the medical authorities.
9 There's also the question of digital exclusion.
10 Only one in five GRT has access to the internet.
11 My Lady, also it's right to say that large numbers
12 of Travellers were unsure about the health effects of
13 vaccines and reluctant to engage with the programme
14 because the messages that were circulated by the
15 authorities didn't address their particular concerns.
16 Traveller Movement says that there was no culturally
17 sensitive education on vaccines given to GRT people.
18 Yet, my Lady, possibly the greatest reason why GRT
19 suffered from unequal vaccine uptake is the
20 institutional and societal discrimination, the long-term
21 oppression that this group has faced over many
22 generations.
23 I sit with Martin Howe and Aylin Howe of Howe & Co
24 today, and they tell me that Howe & Co are currently
25 acting for hundreds of Travellers who have been refused

1 access to restaurants, public houses and holiday camps.
2 All routine events in the lives of GRT members: they're
3 told they can't come in because they're Travellers. So
4 Travellers are culturally conditioned to being
5 marginalised; consequently and unsurprisingly, they are
6 distrustful of the authorities in the United Kingdom.
7 The Traveller Movement says all of this should have
8 been known, it should have been acted upon, yet no
9 adequate adjustments were made during the vaccination
10 programme to account for these cultural trust issues
11 which were clearly a barrier to vaccination uptake.
12 The experience of many Travellers, and we've spoken
13 to one particular member of the community, during the
14 pandemic is that, instead of any guidance or assistance,
15 the only interaction with the authorities that
16 Travellers experienced took the form of heavy police
17 presence at funerals, in circumstances, in many cases,
18 where the numbers of police officers were often greater
19 than the number of mourners.
20 So the GRT community was seen as problems, law
21 enforcement problems, and not as a vulnerable community
22 in great need of support and help.
23 We anticipate and hope that the Inquiry will receive
24 impact evidence from Travellers on these relevant
25 issues. We say it's very important that the Inquiry

1 looks into all of these issues in relation to this
2 community, not least because the **de facto** exclusion of
3 such large numbers of people from a vaccination
4 programme did and would undermine the integrity of any
5 national vaccination programme.
6 The emerging picture from the evidence disclosed
7 thus far is supportive of Traveller Movement's position.
8 Howe & Co have looked at some of the documents and it's
9 clear at this preliminary stage that there was a degree
10 of institutional acceptance during the pandemic that
11 GRT, particularly those who led nomadic lifestyles,
12 found it more challenging to reach vaccine centres and
13 GPs.
14 Furthermore, the evidence shows that vaccine uptake
15 for GRT in the 12-15-year age bracket was particularly
16 low and fell below 30%. We say it's very important that
17 the Inquiry experts address the particular barriers
18 faced by GRT people in relation to vaccine uptake during
19 the Covid-19 pandemic. Those experts should go on to
20 consider whether the government planned and responded to
21 the particular situation that this group faced.
22 Moving on to expert evidence. My Lady, we note that
23 the Inquiry has instructed or is in the process of
24 instructing Professor Kasstan-Dabush and Dr Chantler to
25 deal with the issues of vaccine roll-out. They will

1 also look at existing inequalities and structural
2 discrimination. Professor Heidi Larson, along with
3 other experts, will look at vaccine hesitancy and
4 misinformation.
5 Our primary submission in relation to these experts
6 is their instructions must make it clear that they are
7 to consider the particular cases of GRT communities, not
8 just generically minority groups. There are separate
9 issues for separate minority groups and communities.
10 We have heard what Mr Keith King's Counsel said this
11 morning, that the experts will not deal with barriers to
12 uptake as a discrete issue or the Inquiry won't do that
13 as suggested by the Traveller Movement. We respectfully
14 disagree with this approach, but if the die is cast on
15 this point and the Inquiry's not going to look to look
16 at barriers as a discrete issue, we ask that the experts
17 are instructed to deal with barriers to uptake in
18 detail.
19 Notwithstanding that there will be expert evidence
20 from the Inquiry's own experts, we additionally maintain
21 that focused evidence might be needed because the NHS
22 does not record GRT in its data directory, so the impact
23 of Covid-19 on this group is not easily seen from
24 statistics.
25 We remind the Inquiry that at the previous

1 preliminary hearing we suggested that the Inquiry calls
2 evidence from witnesses who can speak as to the barriers
3 that GRT people faced in relation to the vaccination
4 programme. We suggested Mary Foy MP, who is the
5 co-chair of the all-party parliamentary group on GRT,
6 Dr Pauline Lane from the faculty of health education,
7 medicine and social care at Anglia Ruskin University,
8 and Yvonne MacNamara, who is the director of the
9 Traveller Movement. These people would be well suited
10 to assisting the Inquiry in this regard.
11 In relation to timescales, we've heard what Mr Keith
12 has said today but we respectfully submit that 10 to
13 11 days of evidence, if I've recalled it correctly, is
14 unrealistic for an inquiry of this kind, and we do urge
15 that you reconsider. It's very often in other inquiries
16 witnesses have to come back the next day or be
17 rescheduled. It is a very short timescale for
18 an inquiry with so many core participants and so many
19 important issues.
20 Quickly on parliamentary privilege, in our speaking
21 note we've said that the Traveller Movement would wish
22 to rely on evidence given by a GRT group in the
23 House of Commons to a select committee in July 2020.
24 That evidence highlighted a number of problems that the
25 Traveller community faced during lockdown.

1 Now, the Traveller Movement doesn't want to be
2 constrained by parliamentary privilege if it wants to go
3 further than merely relying on such evidence for fact
4 and context, and we accept that the issue is difficult
5 and complex, but we agree that there may be some need
6 for an Inquiry protocol, we agree with Ms Naik of
7 King's Counsel, and some legal argument might be needed
8 at some stage, and of course -- as you've indicated --
9 if you have to. There may come a time in which
10 core participants may be compromised or prejudiced
11 potentially by a lack of clarity in this area but, as
12 you've stated, this matter has been flagged and I'm just
13 perhaps reflagging it.
14 My Lady, to conclude, we submit the Inquiry must
15 take steps to ensure that there is sufficient evidence
16 and in particular expert evidence for it that relates to
17 the plight of GRT in the Covid-19 pandemic. It's only
18 through doing this that the Inquiry can fulfil aim 2 of
19 its terms of reference: to identify the lessons to be
20 learned and inform preparations for future pandemics
21 across the UK.
22 We also submit that the Inquiry should take steps to
23 ensure it meets its obligation under paragraph A of
24 those terms to consider any disparities, evidence on
25 different categories of people, including those who have

1 protected characteristics under the Equalities Act 2010.
2 The primary concern of TM is that if this Inquiry is
3 not in the position to make robust findings and
4 recommendations, there is a real risk that GRT will
5 again be ignored, misunderstood or discriminated against
6 in any vaccine roll-out programme in a future pandemic.
7 My Lady, they were the forgotten people in the Covid
8 pandemic, they were invisible to policymakers and
9 providers. Traveller Movement's position is that this
10 must not happen again.
11 My Lady, there is a final point, and we appreciate
12 that you may well be inundated with procedural matters,
13 however, we request that Traveller Movement's section 40
14 funding application is moved up to the top of
15 your Ladyship's to-do list. Can we also ask that it is
16 underlined and highlighted on that list. Those who
17 instruct me are very anxious to begin the work of
18 preparing for the hearings in January 2025, and wish to
19 assist the Inquiry in its important work. A brief check
20 of the documents now disclosed shows that over
21 4,000 documents concern the Traveller communities.
22 My Lady, January will soon be upon us and there is
23 substantial work to be done. You will appreciate that
24 it's important that those who instruct me are in
25 a position where they are properly funded and able to

1 start this work soon.
2 Thank you.
3 **LADY HALLETT:** Thank you, Mr Jacobs.
4 Mr Stanton, I think you're the last to speak.
5 **MR STANTON:** Yes, my Lady, thank you.
6 **LADY HALLETT:** And wearing two hats, I think.
7 **Submissions on behalf of the British Medical Association and**
8 **National Pharmacy Association by MR STANTON**
9 **MR STANTON:** Yes, thank you, my Lady.
10 I have two short submissions on behalf of the
11 British Medical Association and National Pharmacy
12 Association, which are both concerned with delivery of
13 the vaccination programme. There are some areas of
14 overlap, but in the main they highlight separate issues
15 for inclusion and examination within the Module 4
16 hearings.
17 Taking the BMA first, the BMA views the Covid-19
18 vaccination programme as one of the biggest successes of
19 the pandemic response, in large part due to the efforts
20 of healthcare workers, including non-clinical staff and
21 also volunteers. General practice in particular played
22 a key role and, in England, a significant majority of
23 vaccines were administered by GPs and community
24 pharmacies.
25 The unprecedented scale of the vaccination programme

1 saved countless lives and enabled the beginnings of
2 a return to business as usual healthcare. A study by
3 the World Health Organisation, published earlier this
4 year on 13 January, provides estimates for the number of
5 lives directly saved by Covid-19 vaccination programmes
6 in the European region between December 2020 and
7 March 2023. It estimates that vaccination in the UK
8 reduced mortality by 70% in adults aged 25 and over, and
9 saved hundreds of thousands of lives. It also found
10 that countries that implemented vaccination programmes
11 early, such as the UK, saw the greatest benefit in terms
12 of the number of lives saved overall through
13 vaccination.
14 However, despite the success of the programme, there
15 are some significant areas of learning for the future.
16 Insufficient consideration was given to workforce
17 planning. The delivery of the vaccination programme
18 further reduced already limited workforce capacity with
19 healthcare workers, including GPs, who were required to
20 work additional hours to administer vaccinations whilst
21 still continuing to deliver Covid and non-Covid care.
22 These pressures, over prolonged periods, led to stress,
23 burn-out and fatigue. A GP from Northern Ireland
24 commented in response to a BMA survey:
25 "We have been stretched so thin covering Covid

1 centres and also delivering vaccination programmes, this
2 has had a huge impact on our staff."
3 The BMA has asked the Inquiry to include
4 consideration of levels of staffing for future
5 vaccination programmes, to ensure sufficient declaratory
6 relief capacity in the system and safe working
7 environments, and we're grateful to you and to Mr Keith
8 for the indication given earlier today that this issue
9 is being pursued.
10 There were also challenges for clinicians in respect
11 of the IT structure used, for example, the Covid-19
12 vaccination system was not immediately or easily
13 operable with existing GP IT systems. There were also
14 different booking systems operated by GPs on the one
15 hand and community pharmacy and vaccination centres on
16 the other, leading to double bookings, unattended
17 appointments and wastage of valuable vaccinations.
18 In early 2021, concern was raised by BMA members
19 about irregular and insufficient supplies of Covid-19
20 vaccinations for patients, which resulted in the need to
21 reschedule appointments due to failed deliveries. These
22 problems were further compounded by the fact that any
23 additional doses left over at the end of a session were
24 not authorised to be administered to anyone outside
25 specified eligible groups. BMA members reported widely

1 that vaccine doses were being discarded if first dose
2 appointments could not be fulfilled rather than being
3 administered as a second dose to available healthcare
4 staff or other frontline workers, because of the
5 unnecessarily strict policy relating to dosage
6 intervals, which stated that second vaccine doses would
7 be audited to ensure that no second doses were
8 administered prior to the 12-week interval.
9 Later NHS England introduced a golden rule not to
10 waste a dose, which allowed vaccinators more flexibility
11 in the provision of vaccines. The BMA suggests that
12 the Inquiry examines this issue in detail in the
13 Module 4 hearings.
14 My Lady, prior to the Covid-19 vaccination
15 programme, it was known via studies on vaccination
16 intention and learning from other vaccination programmes
17 that there may be lower rates of uptake of vaccines
18 among ethnic minority groups. Given this knowledge, the
19 BMA believes that the potential risk of disparity in
20 vaccine uptake should have been better anticipated.
21 People from ethnic minority groups and deprived
22 communities also had worse health outcomes before the
23 pandemic, and with this in mind there should have been
24 greater consideration of these groups in the planning of
25 the vaccine roll-out.

1 It will also be important to consider the
2 effectiveness of public communications in addressing
3 barriers to vaccine uptake, including within specific
4 groups. For example, there was significant confusion
5 about the safety of the vaccine among those who were
6 pregnant or considering pregnancy, and some instances
7 where individuals who were pregnant and wanted to be
8 vaccinated were unable to do so. This confusion should
9 have been avoided through clear, early advice and
10 guidance, as people who were pregnant were at higher
11 risk of severe disease from Covid-19. However, it
12 wasn't until April 2021 that the government clarified
13 its advice, confirming the safety of the vaccine in
14 pregnancy and its effects on fertility.
15 My Lady, the BMA hopes that these short submissions
16 will assist in highlighting areas of focus for
17 the Inquiry, all of which are more fully expanded in the
18 BMA's written statement recently submitted to
19 the Inquiry.
20 Turning to the National Pharmacy Association, in
21 common with the BMA they consider the Covid vaccination
22 programme to have been broadly successful, again in
23 large part due to the efforts of the healthcare workers
24 involved in administering vaccinations, together with
25 the many people who made significant commitments and

1 contributions as volunteers.
2 Within the written statement of the NPA's
3 vice chair, Olivier Picard, there is an account of the
4 experience of setting up a vaccination centre which
5 includes reference to the fact that he and his pharmacy
6 colleagues worked together alongside surgeons, doctors,
7 nurses and paramedics, and that they enjoyed
8 an unparalleled sense of unity and co-operation as
9 healthcare workers.
10 The vaccination programme was widely recognised by
11 communities across the UK as the way out of
12 restrictions, and the NPA would encourage the Inquiry to
13 consider ways in which the contribution of volunteers
14 within their communities can be reflected.
15 In Mr Picard's statement, he describes how, on
16 23 December 2020, he reached out to his local community
17 via social media to seek help in acquiring premises from
18 which to run a vaccination centre and by the next day,
19 which was Christmas Eve, he had received numerous
20 offers, including from a local IT company that allowed
21 him to operate the centre from their premises free of
22 charge.
23 Shortly afterwards, he reached out again, this time
24 on Boxing Day, to seek the help of volunteers in running
25 the vaccination centre, and within just two days he had

1 received over 600 offers of assistance.
2 Reflecting on this experience, Mr Picard remarks:
3 "I have never seen a community come together like
4 this before, nor have I ever been involved in anything
5 that meant so much to so many people at the same time."
6 That said, similar to the BMA submissions, the NPA
7 considers that there are some aspects of the programme
8 that can be improved upon.
9 The most significant of these for the NPA are as
10 follows. First, planning. Community pharmacy should
11 have been consulted and involved earlier in the planning
12 process, particularly given its years of experience and
13 expertise in delivering the annual influenza vaccination
14 programmes, and the reach and resources of the
15 14,000 community pharmacies across the UK, which are
16 firmly embedded at the heart of their communities.
17 Instead, community pharmacy was initially given a gap in
18 service role, which failed to fully utilise their
19 experience, expertise and resource.
20 In England, the arbitrary and unnecessary early
21 requirements of having the capacity to deliver
22 1,000 vaccinations per week and to open 12 hours a day,
23 seven days a week prevented many community pharmacies
24 who desperately wanted to help from participating
25 because they didn't have the physical space or personnel

1 to deliver this number and to remain open for the hours
2 required.
3 It is acknowledged that lessons were learned as the
4 programme progressed, and from just six pharmacy-led
5 participants in January 2021, community pharmacy was
6 able to increase its contribution to 500 pharmacies by
7 June 2021, and by 2023 almost half of vaccinations were
8 being administered by community pharmacy.
9 It is acknowledged also that the programme was
10 delivered at unprecedented pace, and that the priority
11 was to administer the largest number of vaccinations as
12 quickly as possible, but still the potential of the
13 community pharmacy network was not recognised or
14 utilised early enough.
15 My Lady, regarding the use of existing healthcare
16 infrastructure and resources, the Inquiry is invited to
17 consider whether this failure in respect of community
18 pharmacy is part of a broader tendency, seen also during
19 the pandemic in the failure to properly harness the
20 potential of local public health services, to overlook
21 existing NHS resource and expertise in favour of the
22 creation of expensive temporary systems and services
23 with little lasting utility.
24 In this respect, it's important that the community
25 pharmacy network is not taken for granted. Due to

financial pressures, they are currently closing at the rate of ten per week, and maintenance of the community pharmacy network will be essential to ensure a permanent accessible resource for the delivery of future vaccination programmes.

The second point relates to operational challenges. As already mentioned in the BMA's submission, probably the biggest operational problem encountered was the disjointed booking systems, with pharmacies and vaccination centres required to use one system while GPs had to use a separate system. This led, as already mentioned, to large numbers of double bookings, failures to attend appointments, and the wasting of valuable vaccinations.

There were also operational problems with the provision of PPE, high levels of unnecessary administration, and poor communications.

The third point is vaccine hesitancy and inequalities. The significance of these issues was not appreciated early enough, and nor was the positive role that community pharmacy was able to play in addressing them. Community pharmacies are trusted healthcare settings at the heart of their local communities, ideally placed to respond to the needs and concerns of their patients. Community pharmacy is also

disproportionately located in poorer areas, and it played a significant role in addressing health inequalities.

Together with Doctors of the World and NHS England, the NPA launched a toolkit to support its members to provide open access vaccination clinics to provide vaccinations for those with insecure NHS status and hard to reach groups, including asylum seekers and the homeless.

Governments did come to recognise the value of community pharmacy in addressing issues of equality and vaccine hesitancy, but again this recognition should have been sooner, and there should have been earlier and more comprehensive consultation with community pharmacy on these issues.

Finally, my Lady, the Inquiry will be taking account of the impact of the pandemic on healthcare workers within Module 3, and the NPA suggests that it will also be helpful to reflect on these impacts within Module 4. Healthcare workers who were working in a system already stretched to breaking point provided crucial vaccination services on top of existing commitments, many working almost continuously with little sleep or time to spend with their families. This is not a sustainable model for the delivery of future vaccination services.

Thank you, my Lady.

LADY HALLETT: Thank you very much, Mr Stanton, very grateful.

Do you have anything by way of reply, Mr Keith?

Reply statement by LEAD COUNSEL TO THE INQUIRY

MR KEITH: My Lady, may I just pick up one or two of the points that have been made.

In relation to Mr Wagner's submissions on behalf of Clinically Vulnerable Families in relation to the risk of therapeutics falling between the cracks, it would be quite impossible to have a module that dealt only with therapeutics, and therefore the split between addressing safety related issues, trials and regulatory approval and such matters in Module 4 and dealing with the operational healthcare aspects of therapeutics in Module 3 is specifically designed to ensure that nothing does fall between the cracks; and those whom Mr Wagner represents are also core participants in Module 3 and, in addition, of course, the way in which the report writing structure will work is that there will be an overlap. So if there are any problems which do arise, they can be accommodated by the Inquiry.

In relation to the submissions to the effect that there should be an expert report in relation to the position of the clinically vulnerable, I would just note

that clinical vulnerability is not a protected characteristic. The definition of that unhappy group of people who suffered is that they were clinically vulnerable, and therefore there's no anthropological expertise which we could adduce in order to be able to provide further information to the Inquiry in relation to their position.

Submissions were made as to whether or not you should order there be interim information provided as to the extent to which therapeutics would be addressed in the course of the actual hearing. The way, my Lady, in which the provisional witness list process works is that the core participants will know from the moment that they see the provisional witness list which witnesses are dealing with therapeutics, which with vaccines, and therefore they will know the general division of attention.

Submissions were made in relation to whether or not the targeted disclosure approach was in fact a misstep on the part of the Tribunal, and then it was suggested that the vice of targeted disclosure is that it's disclosure by virtue of themes. It's not. The whole point about targeted disclosure that it ties the disclosure obligation to specific events, key decisions, key issues, so it provides a clearer structure for the

1 material providers to apply by which they can discharge
2 their disclosure obligations. So there's no question of
3 giving them a greater discretion.
4 May I say something about the submissions from
5 Ms Morris to the effect that the vaccine injured and
6 bereaved fear marginalisation. My Lady, everything that
7 the Inquiry is doing in Module 4 is designed to bring
8 them into the light. That is what our examination of
9 the safety issues and the general impact of vaccinations
10 is all about. I'd like to reassure her that, as you've
11 demonstrated in relation to past modules, this Inquiry
12 will of course be applying a rigorous and critical
13 approach.
14 Ms Morris also advanced some submissions in relation
15 to impact evidence. May I reiterate that experience
16 from Modules 1 and 2 has shown that the process of
17 calling a representative witness from each of the
18 core participant campaigning groups, if I may call them
19 that, shows that the Inquiry has been provided with
20 extremely powerful, cogent and clear evidence as to the
21 impact in whatever area their evidence concerns; and
22 also, of course, you will be receiving in Module 4
23 evidence from the Every Story Matters project which
24 brings together data and information on an anonymised
25 basis in relation to the impact of vaccines on the

1 injured and of course the bereaved.
2 Finally, in relation to the issue of censorship and
3 the important issue that Ms Morris raised concerning the
4 incident, if I may call it that, in which a reporting of
5 this Tribunal's affairs was removed, no court or
6 tribunal can possibly police derivative reporting; no
7 court or tribunal has power over the internet or
8 social media, or can do anything about removal from the
9 internet of second-hand derivative reporting of its
10 affairs. What this Tribunal can do, and does, is
11 provide a livestream of the evidence, and of course,
12 through its own website and YouTube, transcripts and
13 recordings of the evidence that has been given, and no
14 Inquiry can do more than that. It's certainly not open
15 to you to police, in individual cases, instances where
16 internet companies have refused to allow other people to
17 upload to their own accounts derivative reporting of the
18 affairs of this Tribunal.
19 My Lady, I think those are all the points that
20 I wish to respond on.
21 **LADY HALLETT:** Thank you very much, Mr Keith, and thank you
22 to everybody for their submissions.
23 I will consider them all, the oral and the written
24 submissions that I have received, and then I will
25 discuss with Counsel to the Inquiry team and make my

1 decision. I will, if necessary, issue a determination
2 on various aspects, but I wish to emphasise I will only
3 issue a determination if I consider it necessary to the
4 efficient progress of this Inquiry.
5 Thank you all very much. I think I sit again
6 tomorrow at 10, I think.
7 **MR KEITH:** Yes, please.
8 **(2.56 pm)**
9 **(The hearing concluded)**
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