Wednesday, 15 January 2025

(10.00 am)

LADY HALLETT: Ms Domingo. No, you're not ... no.

MS DOMINGO: Is that better?

LADY HALLETT: That's better.

Submissions on behalf of the National Pharmacy Association by MS DOMINGO

MS DOMINGO: The National Pharmacy Association, or NPA, is grateful for its designation as a Core Participant in Module 4 of the Inquiry.

The Inquiry will be aware of the NPA's role and interests from its participation in Module 3 but for the benefit of those Core Participants not involved in that module, and in brief, the NPA is a representative voice of independent community pharmacies across the UK, that is family-owned and run independent pharmacies through to small- to medium-sized regional chains. An estimated 50,000 people including around 15,000 pharmacists work in the NPA's 6,000 member pharmacies.

Community pharmacy is an integral part of the NHS and primary care networks, and it plays a crucial role in maintaining and improving the health of the communities it serves. Community pharmacies are embedded within their communities, and 96% of the population can reach their local pharmacy within

20 minutes.

Community pharmacy played a vital role in the delivery of the Covid-19 vaccination programme, and community pharmacists and their teams have delivered over 42 million Covid-19 vaccinations.

This opening statement seeks to highlight the NPA's significant role and interest in the delivery of the Covid-19 vaccinations across the UK, by recognising the success of the programme but also identifying a number of areas for improvement.

The Covid-19 vaccination programme in the UK operated at an unprecedented pace, scale and complexity, and was one of the success stories of the pandemic. Community pharmacy played a significant role in the delivery of the programme which increased over time as the value of the contribution of community pharmacy was recognised.

One community pharmacist in Macclesfield highlighted the importance of the programme and the commitment shown by community pharmacy teams in delivering it. To quote:

"I have been a pharmacist for 38 years and I can say the day when my pharmacy became one of the very first in the country to administer the Covid-19 vaccine was the biggest day of my career. It's been quite emotional at times for our patients. Some people have not been out

of their home since last March. They are hesitant to be outside and are not used to seeing people. They see being vaccinated as the start of the end of this grim existence ... A lot of work has been required of the team here but we are very excited about it ... Everyone here is part of something special. We're proud and honoured to be involved in this national effort to help protect the population of the country and hopefully return us all to some form of normality."

The NPA's vice-chair, Olivier Picard, has produced a witness statement for the Inquiry which is disclosed at iNQ000474318 and within which is an account of his experience of setting up a vaccination centre, reflecting the collaboration between community pharmacy teams and other healthcare workers.

Mr Picard has also highlighted the vital role played by volunteers in supporting the vaccination programme within local communities, remarking:

"I have never seen a community come together like this before, nor have I ever been involved in anything that meant so much to so many people at the same time."

The NPA respectfully asks the Inquiry to consider and recognise the invaluable contribution of volunteers to the success of the vaccination programme.

My Lady, the NPA acknowledges that the Covid-19

vaccination programme was an emergency response, that the lessons were learned and improvements implemented throughout the programme, and that overwhelmingly, it is one of the success stories of the pandemic. Nevertheless, it is important to reflect on the areas that could have been done better, and the NPA asks the Inquiry to reflect on the following points in its consideration of how the delivery of a vaccination programme could be improved in the future.

First, the need for effective planning and the involvement of community pharmacy from the outset. Community pharmacy should have been consulted and involved earlier in the planning process, particularly given its years of experience and expertise in delivering annual flu vaccinations and given the reach and resources of the approximately 13,000 community pharmacies embedded in communities across the UK.

Instead, community pharmacy was initially given a gap-in-service role which failed to utilise their experience, expertise and resource.

The NPA considers that the decision to limit the role of community pharmacy to gap-in-service provision, or where there was a need for additional capacity, was a missed opportunity to ensure wider public access to vaccinations through the extent of national community

pharmacy network, particularly as some patients were being asked to travel considerable distances to receive a vaccine.

Vaccination centres provide a capacity to deliver high volumes of vaccinations in dense population areas with good transport links, and this was an important part of the programme. But so too was the ability to provide vaccinations within communities, and to reach under-served communities. This balance needs to be better delivered in the future.

The ability of community pharmacy to participate in the initial phases of the vaccination delivery was significantly limited by certain requirements of programme participation, which were unnecessary, and arbitrary. For example, participation in phase I in England required the administration of at least 1,000 vaccination doses per week and opening hours of between 8 am and 8 pm, seven days a week. This unnecessarily prevented the participation of smaller pharmacies who did not have the physical space to deliver this volume of vaccinations or the staffing capacity to administer them.

Largely because of these restrictions, there were only six community pharmacy-led contributors to the first wave of phase I of the programme.

In January 2021, the NPA's chief executive wrote to the chair of NHS England, pointing out that community pharmacy was being under-utilised, and that "pharmacies can deliver so much more for the NHS if the potential for the network is recognised".

As requirements were relaxed, community pharmacy was able to make a much broader and more effective contribution. The role of community pharmacy increased throughout phases one and two, and on 3 June 2021, the Covid-19 vaccination minister announced that over 500 community pharmacies had delivered over 5 million vaccines in England.

This contribution continued to increase throughout the pandemic, and by 2023, 24% of all vaccinations had been provided by community pharmacy.

Other challenges faced by community pharmacy in anticipating in the vaccination programme from the outset included the different storage requirements for vaccines and the already stretched community pharmacy services as a result of the impact of the pandemic.

The second point is the need to improve operational delivery of the vaccination booking system. Two booking systems were utilised to make vaccination appointments: the national booking system was used by community pharmacy and vaccination centres, and a separate system,

Accurx, was often used by general practice. The NPA's view is that having a dual booking system was inefficient and wasteful.

The two systems did not share information, causing duplicate bookings, which resulted in missed appointments and adversely impacted efficiency.

This situation would have been worse but for the flexible and resourcefulness of frontline healthcare workers in sharing and sourcing unused vaccination supplies. Other challenges for community pharmacy related to PPE provision, high volumes of administration and bureaucracy, and poor communications, with vaccinators sometimes finding out about changes they needed to implement the next day on the evening news.

Thirdly, addressing barriers to uptake. The NPA believes that the significance of vaccine hesitancy as an issue was not appreciated early enough and there was a delay in recognising the positive role that community pharmacy was able to play in addressing this issue.

Approximately 50% of the NPA's membership are from ethnic minority backgrounds, which is reflected in the composition of the NPA's board. The role of community pharmacies as trusted healthcare professionals at the heart of their communities means they are ideally placed to respond to the needs and concerns of their patients,

and to address health inequalities and vaccine hesitancy within communities.

Community pharmacies play a particularly important role in deprived communities, which often have less access to other healthcare services. Over a third of the vaccinations provided by community pharmacy were delivered in the most deprived communities in the country.

On 7 January 2021, the NPA convened a ministerial round table with the minister for equalities, the minister for vaccine deployment, and the pharmacy minister, about reaching out to patients and communities who might otherwise miss out on vital care such as the Covid-19 vaccine, and to discuss how community pharmacy could help promote uptake of the Covid-19 vaccine, including how the high levels of trust in local pharmacists could be an important factor in overcoming doubts and misapprehensions about vaccination.

In addition, with Doctors of the World and NHS England, the NPA launched a toolkit for delivering an open access vaccination clinic to provide vaccinations for hard-to-reach groups, including asylum seekers and the homeless, and to promote a continuing focus on addressing vaccine hesitancy and reducing health inequalities more broadly.

1 In Wales, community pharmacy was specifically
2 engaged to address vaccine hesitancy. In Northern
3 Ireland, community pharmacy was similarly engaged to
4 increase access to Covid-19 vaccines for priority groups
5 and in areas where vaccine uptake was lower than the
6 regional averaging. And in Scotland, community
7 pharmacies were commissioned to deliver vaccinations in
8 more remote areas.
9 The NPA acknowledges that lessons were learned over
10 the course of the programme and that governments quite
11 quickly came to recognise and utilise the strength of
12 the community pharmacy network, however, these issues
13 could have been better anticipated and this should be
14 key learning for the future.
15 Fourthly, the importance of utilising existing
16 resources and expertise. The NPA considers that it is
17 more effective and efficient to build and deliver
18 healthcare services such as a vaccination programme
19 through existing health infrastructure, which includes
20 the extensive community pharmacy network.
21 The Inquiry is invited to examine and consider
22 whether the creation of mass vaccination centres was
23 a further example of a broader tendency to overlook
24 existing NHS resource and expertise in favour of the
25 creation of expensive temporary systems and services

1 with little lasting utility.
2 Finally, reducing the unrealistic expectations on
3 healthcare workers and managing the impact on them.
4 The Inquiry is taking account of the impact of the
5 pandemic on healthcare workers within Module 3, but the
6 NPA suggests it will also be helpful to reflect on these
7 impacts within Module 4. Healthcare workers who are
8 already working in a system stretched to breaking point
9 by the pandemic provided crucial vaccination services on
10 top of existing commitments, many working almost
11 continuously, with little sleep or time to spend with
12 their families.
13 Feedback from an NPA member reflected the following:
14 [As read] "This has consumed my life. From hours
15 spent setting up, learning IT systems, training staff,
16 taking on volunteers, then dealing with the
17 ever-changing vaccination programme, the weekly Zoom
18 calls, the constant stream of emails with updates that
19 you need to read and action, the list goes on. The
20 second biggest enabler is my own team, who have stepped
21 up to literally double the ask of the day job. We have
22 vaccinated and run the pharmacy without compromising any
23 of the pharmaceutical services that we provide. I can
24 only hope that if this is rolled out as a 'business as
25 usual', it will be easier to put in place and operate.

1 Notwithstanding its success, this not a safe or
2 sustainable model for the delivery of future vaccination
3 programmes."
4 In conclusion, my Lady, the NPA is proud of the
5 contribution its members made in delivering tens of
6 millions of Covid-19 vaccines whilst continuing to
7 deliver the core role of pharmaceutical service
8 provision.
9 The importance of vaccination to the healthcare
10 system continues to grow, and the experience of the
11 pandemic demonstrates that community pharmacy can play
12 an expanded role in this area, drawing on the network's
13 accessibility and ability to reach communities that
14 often find it harder to receive health services.
15 Thank you.
16 **LADY HALLETT:** Thank you very much indeed, Ms Domingo, very
17 grateful.
18 Ms Drysdale KC? You're there, right.
19 Submissions on behalf of the Scottish Government by
20 MS DRYSDALE KC
21 **MS DRYSDALE:** Good morning, my Lady, can you hear me?
22 **LADY HALLETT:** I can, thank you.
23 **MS DRYSDALE:** I appear for the Scottish Government, with my
24 juniors Iain Halliday and Kenneth Young.
25 The aim of the Covid-19 vaccination programme in

1 Scotland was to save lives and to protect against
2 ill health. The early rollout of the vaccine programme
3 avoided deaths. A World Health Organisation study found
4 that between December 2020 and November 2021, an
5 estimated 22,138 deaths were avoided because of the
6 Covid-19 vaccination programme in Scotland.
7 The relationship between the UK Government and the
8 Scottish Government was at its best on the issue of
9 vaccines. The Scottish Government engaged both directly
10 and through four nations partners, as part of UK-wide
11 pandemic preparedness and resilience measures. There
12 were regular and candid discussions between officials
13 and ministers about the planning and deployment of
14 a Covid-19 vaccine. This included sharing of challenges
15 and advice on how to address them. This level of
16 openness and cooperation was a critical element to the
17 success of the programme in Scotland.
18 As the pandemic progressed, the scientific
19 understanding of the virus developed. This was an
20 ongoing process with work being carried out as new
21 variants emerged to understand the differences between
22 them. As a result, the vaccination programme had to be
23 flexible. It had to accelerate and decelerate to meet
24 demand.
25 The delivery and communication strategy had to adapt

1 quickly to consider new clinical advice. The vaccine
2 programme was able to respond to developments in
3 a highly dynamic way, throughout the pandemic, due to
4 the hard work and dedication of Scottish Government
5 officials and NHS partners.
6 The Scottish Government wishes to pay tribute to all
7 those who contributed to the development and deployment
8 of the vaccines, not only the scientists and the health
9 and social care staff who delivered the vaccines, but
10 all of those involved across society. That includes the
11 volunteers in clinical trials and the public, for their
12 often unseen contribution and their patience.
13 Many of those who worked on the vaccine made immense
14 personal sacrifices over a long period of time to
15 provide a vaccine and to save lives. They demonstrated
16 the very best of public service values and the Scottish
17 public owes them a great debt.
18 It's also appropriate, my Lady, to pause and
19 remember those who suffered from very rare cases of
20 injury or death following vaccination, and we remember
21 all those who suffered loss during the pandemic, and who
22 lost their lives due to Covid-19.
23 The Scottish Government is here to listen and learn,
24 to save lives in any future pandemic. It welcomes
25 scrutiny, both from the Inquiry, but also from Scottish

1 Covid Bereaved, the Scottish Vaccine Injury Group, and
2 all Core Participants in this module on vaccines and
3 therapeutics, so that injury is avoided and lives saved.
4 Turning now to Scotland's role in development of the
5 vaccines. The development of the vaccines, trials to
6 enable their use, and the Vaccine Damage Payment Scheme
7 were led by the UK Government. Scotland was not
8 responsible for the development of vaccines. Regulation
9 of medicines and vaccines are a reserved matter under
10 the Scotland Act 1998. The Vaccine Damage Payment
11 Scheme is also reserved. The Scottish government
12 liaised with the UK Government on these issues, and was
13 kept informed of progress.
14 The development of Covid-19 vaccines was the
15 responsibility of pharmaceutical manufacturers and was
16 led by a UK Government Vaccine Taskforce. It was a UK
17 body with no Scottish ministerial representation.
18 Decisions on vaccine supply contracts and investment
19 in manufacturing were taken by UK Government ministers.
20 An agency agreement was developed between the UK and
21 Scottish Government in August 2020 to allow the UK
22 Vaccine Taskforce to purchase vaccine stocks on behalf
23 of the Scottish Government.
24 This was agreed on the basis that Scotland's
25 percentage share of the vaccines would be based on

1 population, that is based on the Barnett formula. The
2 approach taken across the four nations was pragmatic.
3 Moving on to public messaging in Scotland about the
4 vaccine. Responding to the pandemic represented
5 a communications challenge. The pandemic itself was
6 dynamic, and misinformation and disinformation were
7 disseminated on social media. The Scottish Government
8 recognised that the way to counter this was to provide
9 transparent information to the public.
10 In the initial phases of the pandemic, messages were
11 aimed at the wider population, a national call for
12 action. The later phases of the programme, with a more
13 complex offer called for a more nuanced approach.
14 These stages were comprised of messages targeted at
15 discrete cohorts by age, occupation or characteristic.
16 Communications focused on each cohort as they were
17 being invited forward for a vaccination, delivering and
18 tailoring messages as appropriate for each audience.
19 A key element was the use of blue envelopes for
20 appointment letters to ensure that they were easily
21 recognisable. And the Scottish Government reviewed the
22 effectiveness of public messaging by commissioning
23 weekly polling.
24 It was recognised that, while many people obtained
25 information online using NHS inform, there would be

1 those who did not. Public messaging relating to
2 vaccines was delivered via a national door drop.
3 Advertising campaigns used TV, radio, press, digital,
4 and out-of-home formats such as billboards on bus
5 shelters. The national vaccination help line provided
6 information.
7 Trusted senior voices were deployed to deliver
8 information about vaccine safety in media appearances
9 and at the First Minister's daily briefings.
10 The cornerstones of the Scottish Government's
11 communications strategy were accuracy, honesty, and
12 openness. Messaging was revised continuously when new
13 information and data was received. This was always
14 transparent.
15 Turning now to delivery of the vaccine. Scotland
16 had a clear policy position on vaccination delivery
17 following a human rights-based approach guided by the
18 Joint Committee on Vaccination and Immunisation, JCVI.
19 This was set out and agreed to by the Scottish Cabinet
20 from the start of the programme. Scotland was well
21 prepared to vaccinate the population promptly due to the
22 structure of the NHS in Scotland, established
23 distribution routes through NHS National Services
24 Scotland, NSS, and a track record often openness to
25 vaccination among the Scottish population. There was

already a well-established flu vaccination programme being delivered by health boards and the necessary infrastructure was already in place.

The Scottish Government developed a flu vaccine/Covid-19 vaccine programme to administer the Covid-19 vaccine alongside the flu vaccine. In February 2021, considering the significant emerging demands, a separate vaccinations directorate was established within the Scottish Government.

The Scottish Government was keen to ensure that its approach was aligned, if possible, across the four nations on the delivery timetable and cohort prioritisation. The four nations worked together to ensure that the first dose of the vaccine was administered on the same day in each of the four nations on 8 December 2020.

Where there were differences in approach, this was usually due to Scotland's different infrastructure and geography. Scotland's vaccine delivery programme was health board led. This model of vaccine delivery allowed Scotland to co-administer the Covid-19 vaccines alongside the winter flu vaccine from 2021 using mass vaccine clinics.

Critically, the more limited use of GPs and community pharmacists to deliver the vaccine in Scotland

allowed those services to focus on supporting the wider pandemic response and delivering essential primary care services. Scotland was able to use the established distribution routes and channels and the experience and expertise of NSS.

Turning now to prioritisation decisions. Vaccination and immunisation policy in Scotland is based on the advice of the JCVI in liaison with the Chief Medical Officer, as it is in each of the four nations. JCVI advice is not legally binding in Scotland but was generally followed, except where deviation was necessary to meet the needs of the Scottish population.

Vaccinating island communities in line with the JCVI priorities would have meant frequent reliance on small quantities of vaccine with multiple trips to remote destinations. Rural health boards were able, instead, to vaccinate across cohorts, sometimes out of priority order, where it would make operational sense.

Scotland also adopted a slightly different approach to the vaccination of unpaid carers, prisoners and prison staff and people with learning disabilities.

The Scottish Government expanded JCVI priority group 6 to include people with mild or moderate learning disabilities to ensure that, in the absence of a learning disability register in Scotland, no one was

excluded.

Another difference was that the Scottish Government took the decision to vaccinate care home staff at the same time as care home residents. This led to higher uptake among care home workers in Scotland.

Moving now to barriers to uptake. The Scottish Government recognises that there were barriers to uptake for vulnerable and at-risk groups across the UK. It responded to challenges in uptake through inclusive delivery, tailored communications, and working with partners through the Scottish Vaccine Inclusive Steering Group.

There was lower uptake in the most deprived areas and from those in certain minority ethnic communities. An inclusive framework was developed. There were health board inclusion plans with assertive outreach and clinics in suitable community locations. Funding was delivered through black and ethnic minority infrastructure in Scotland. There was the introduction of ethnicity data collection and the National Contact Centre as an alternative to digital.

The Scottish Government undertook extensive work to address concerns around vaccine hesitancy while recognising there was a very small minority who would likely refuse any offer of vaccination irrespective of

how much work was undertaken to improve vaccine confidence.

Engaging with communities through local organisations was critical to understanding and addressing high levels of mistrust. The Scottish Government recognised the importance of engaging with those representing communities experiencing barriers.

Finally, turning to lessons learned. Scotland's vaccination response to the pandemic has led to ample learning and experience which may be drawn on in the case of another pandemic. The technical report on the Covid-19 pandemic, published by the UK's four chief medical officers, is informing the Scottish Government's future pandemic preparedness plans for vaccines and therapeutics.

The Standing Committee on Pandemic Preparedness has been established as a permanent advisory group to the Scottish Government. This committee brings together scientists and technical experts to advise the Scottish Government on the future risks from pandemics and to ensure that Scotland as is well prepared as possible.

The Scottish Government carefully considered mandating vaccination for health and social care workers, but ultimately decided that the Covid-19 vaccine should remain voluntary. Engagement with

1 employers and trade unions in Scotland indicated strong
2 opposition to the proposals of mandatory vaccination.
3 There were possible ethical and human rights concerns
4 arising.
5 The Scottish Government considered the fact that
6 some staff would still refuse to be vaccinated even if
7 it was made mandatory. In all the circumstances, the
8 Scottish Government considered that it was not
9 proportionate to mandate vaccination. It focused
10 instead on working with health and social care
11 employers, providers, trade unions, and professional
12 organisations to encourage uptake of the Covid-19
13 vaccination.
14 A range of digital improvements were made during the
15 pandemic such as the introduction of a new National
16 Vaccination Scheduling System, with an online booking
17 system. The Scottish Government also introduced the
18 Vaccine Management Tool (VMT), which is used to record
19 vaccines administered. Ethnicity data was gathered in
20 Scotland by including a question on ethnicity within
21 the VMT, and statistics were routinely published by
22 Public Health Scotland and allowed both the public and
23 decision makers to understand differences in vaccine
24 uptake by population demographics.
25 My Lady, in conclusion, time does not allow me to

1 address all of the topics covered in our written opening
2 statement which covered these and other issues in more
3 detail. We hope that the Inquiry will find this opening
4 statement a useful insight into the vaccination
5 programme in Scotland, as well as providing some detail
6 as to how the Scottish Government handled specific
7 aspects of that programme.
8 There are opportunities for improvement that should
9 be taken in preparation for future pandemics. The
10 Scottish Government repeats its commitment to the
11 Inquiry and to learning of ways in which lives can be
12 saved and injury avoided with the use of vaccines and
13 therapeutics in the next pandemic.
14 **LADY HALLETT:** Thank you very much indeed, Ms Drysdale.
15 Mr Rawat.
16 Submissions on behalf of the United Kingdom Health Security
17 Agency by MR RAWAT
18 **MR RAWAT:** I hope your Ladyship can hear me.
19 **LADY HALLETT:** I can, thank you.
20 **MR RAWAT:** My Lady, I'm here on behalf of the United Kingdom
21 Health Security Agency, or UKHSA as it's been called
22 during the course of the Inquiry. I may end up calling
23 it UKHSA.
24 You will be aware of the role of UKHSA, but for
25 others here today, UKHSA is an executive agency of the

1 Department of Health and Social Care and became
2 operational during the pandemic. Its role is to protect
3 the public from infectious diseases as well as external
4 hazards including biological, nuclear, and environmental
5 threats.
6 UKHSA brings together expertise from several
7 predecessor organisations, including Public Health
8 England and the Vaccine Taskforce.
9 The Inquiry will, in this module, hear evidence of
10 the impact that the successful deployment of vaccines
11 against Covid-19 had on the direction of the pandemic.
12 They prevented over 100,000 deaths in the United Kingdom
13 alone, and they allowed for the relaxation of other
14 control measures.
15 All Core Participants in this module will want to
16 assist your Ladyship in making practical recommendations
17 that contribute to pandemic preparedness for the future.
18 We must recognise that risk appetites are different
19 during an emergency compared to in peace time, but with
20 vaccines in mind and looking forwarding, UKHSA wants
21 today to highlight four key capabilities which, taken as
22 a whole, underscore the importance of maintaining
23 appropriate baseline capabilities to allow for faster
24 scaling in an emergency. And in so doing, I will say
25 something about the work that UKHSA is undertaking in

1 these areas.
2 Of course a number of different bodies contribute to
3 the development and delivery of a national vaccination
4 programme. Your Ladyship is already aware of the Joint
5 Committee on Vaccination and Immunisation,
6 an independent expert group that gives advice on
7 immunisations and their use in the prevention of
8 infectious disease.
9 Second, as the independent regulator, the MHRA is
10 the lead agency for monitoring vaccine safety, and for
11 any regulatory response to safety signals. The MHRA
12 provides vaccine safety information to JCVI.
13 Healthcare being a devolved responsibility, it's
14 NHS England that's responsible for commissioning the
15 immunisation programme in England which is administered
16 at a local level by healthcare providers. NHS England
17 has responsibility for the overall performance of
18 immunisation programmes, including measures to address
19 inequality.
20 And finally, UKHSA. UKHSA provides a secretariat
21 for JCVI, but also provides expert support to
22 NHS England in its programme implementation, ensuring
23 that the deployment of an immunisation programme aligns
24 with the rationale developed by JCVI and also delivering
25 operational advice and supporting materials.

1 UKHSA also monitors and evaluates all routine
2 immunisation programmes.
3 If I return to the four capabilities that we wish to
4 draw to your Ladyship's attention, the first is
5 sustained investment in research and development.
6 As Counsel to the Inquiry observed yesterday,
7 whether a vaccine can be developed in response to
8 a novel pathogen and in what time scale is inherently
9 uncertain. The Inquiry has evidence that the time
10 between work beginning on a vaccine for Covid-19 and the
11 launch of a vaccination programme was unexpectedly
12 short, but the contrasting example often given is that
13 of HIV, for which a vaccine remains elusive.
14 But the extent to which the UK can develop
15 pharmaceutical countermeasures for a future pandemic
16 will depend on continued investment in scientific
17 research and development. The Oxford AstraZeneca
18 vaccine was in part made possible through work funded to
19 develop a vaccine against MERS, and that funding came
20 from government research bodies and the work was in
21 progress several years before the pandemic.
22 UKHSA itself is not a research funding body. It
23 undertakes research and its laboratories are recognised
24 as centres of excellence. UKHSA bids for research
25 funding and works with academia and industry to lead,

1 promote, and deliver research and development that can
2 contribute to future vaccine development, and in that
3 regard we can mention the 100 Days Mission.
4 UKHSA provides a secretariat for the
5 United Kingdom's participation in the 100 Days Mission
6 which is a global initiative to better prepare the world
7 for the next pandemic, by driving the development of
8 diagnostics, therapeutics, and vaccines, so that they
9 can be rapidly made available within the first hundred
10 days of a future pandemic threat being identified.
11 Further, the capacity to sequence and analyse the
12 genome of a pathogen is a vital element of the modern
13 response to any infectious disease, and UKHSA has
14 a pathogen genomic strategy which seeks to establish
15 a programme which, working with academia and the NHS,
16 will increase our understanding of the characteristics
17 of those pathogens that pose the greatest risk, to then
18 offer opportunities to support the development of new
19 therapeutics and vaccines.
20 And, of course, you will hear, my Lady, of the
21 involvement of UKHSA in its current oversight of the
22 strategic partnership with Moderna.
23 But if I move on to the second capability, and that
24 is strengthening partnerships between government,
25 industry and academia.

1 The work of the Vaccine Taskforce benefited from the
2 willingness of decision makers responding to an
3 emergency to rapidly commit significant resource based
4 on imperfect information and to take the risk that not
5 every initiative would yield success.
6 Such conditions are unlikely to pertain in peace
7 time and therefore UKHSA seeks to develop and maintain
8 systems which can be scaled up in the event of a future
9 pandemic, as well as the key technical skills which will
10 be necessary.
11 UKHSA cannot do and does not do this in isolation.
12 After all, its total budget is comparable to that of
13 a district hospital. The VTF, however, demonstrated the
14 benefit of closing working between government, industry
15 and academia, and UKHSA is committed to maintaining and
16 embedding such working.
17 To give your Ladyship an example, there are now 14
18 health protection units, research units, across England.
19 Funded by NICE, these units are partnerships between
20 UKHSA and the university, and they include a unit which
21 is currently researching immunisation coverage in
22 children, and how to increase vaccine uptake in adults,
23 and reduce inequalities in the vaccine service.
24 Science is always an international endeavour and,
25 looking forward, the UK will want access to innovative

1 products that can be developed swiftly, evaluated,
2 licensed, and delivered, and the opportunity to develop
3 products itself.
4 UKHSA's Vaccine Development Evaluation Centre, or
5 VDEC, seeks to work with industry, academia and the
6 matters to identify the most promising vaccine
7 candidates, support their development and to provide
8 pre-clinical and clinical trial testing.
9 The third capability we would highlight today is
10 that routine vaccination work in peacetime provides the
11 bedrock from which to scale in a pandemic.
12 The Covid-19 vaccination programme benefited from
13 the infrastructure already in place for the delivery of
14 routine immunisation programmes, and such programmes are
15 delivered at local level and that has prove highly
16 effective. For example, the over-65 seasonal influenza
17 programme has been recognised for achieving an
18 exceptionally high level of coverage by international
19 comparison. The benefit of working at local level,
20 mainly through general practice but, as your Ladyship
21 has heard, through community pharmacies, is that you
22 have a high level of patient registration and also the
23 technology allows for the rapid identification of
24 particular clinical risk groups.
25 What we mustn't forget is that sometimes being able

to receive a vaccine in a familiar environment can support public confidence.

Immunisation programmes in the United Kingdom are built on the principle of informed consent. Providing accurate information on the benefits and risks of any vaccine is critical, not only to inform choice, but to maintain confidence. And to support a robust consent process, UKHSA provides training and evidence-based resources for healthcare professionals, as well as public-facing resources, and these, of course, need to be available in a variety of format and languages, they need to be available for different age and risk groups. The information provided must be consistent across different formats and updated.

And so we say that maintaining and improving the infrastructure for routine immunisation would be fundamental to mitigating potential harm from a future pandemic, because it provides a starting point for any scaling up of a vaccination programme.

And that is particularly true at the early stage of any response to a pandemic before, if they are needed, mass vaccination centres are established.

My Lady, the final capability we would speak about today is this: that surveillance of the real world effectiveness of a programme and the presence of

a robust system for safety monitoring are vital to both informed future policy and to sustain public and professional confidence in the programme.

Of course, all pharmaceutical products are associated with side effects, and that includes vaccines. And where you have a mass vaccination campaign, assessing the benefits is at a population level, and that is the role of others, such as JCVI, and the role is to make an overall assessment for different population groups based on different levels of risk.

Now that will be informed of course by the MHRA's assessment of adverse effects and also any consideration of individual factors.

Where -- taking on the work of Public Health England, but now carried out by UKHSA, where the agency comes in is that it has established expertise in the surveillance, monitoring, and evaluation of a routine vaccination programme. And the work in this area has often led the way for other countries.

That expertise brings wider benefits. Firstly, it can inform the design and planning of a massive vaccination campaign. If you have surveillance data, that allows, for example, JCVI to better review its policy advice in realtime.

Second, Public Health England, and now UKHSA, has,

over many years, surveyed the public's understanding of, and attitudes towards, vaccination, and that work is reinforced by activity across the public health system.

At the start of the pandemic, public confidence in vaccination was strong. But retaining that confidence through local and national engagement, by studying and listening to concerns, and by the generation of high quality evidence on risks and benefits, is a prerequisite to any successful future rollout.

Analysis of surveillance data informs the production of accurate information, vital at a time when inaccurate information about a vaccine's effectiveness or safety can be so easily spread. And it allows for consideration of factors that influence confidence in particular vaccines.

Vaccine hesitancy and vaccine confidence are complex issues, the course of which can be multifactorial and emerge over time.

The third point to make is that UKHSA's surveillance and analysis functions can support decisions as to which vaccines should be deployed and to what schedule. It contributes to the overall health system's work in developing more tailored outreach services and in understanding the reasons why specific population groups may not be receiving immunisation.

And that, of course, contributes, importantly, to tackling to health inequality.

My Lady, those are brief submissions on behalf of UKHSA. You have submissions in written form as well, but can I conclude in this way: that, on behalf of UKHSA, I would like to repeat the agency's commitment to continuing to assist the Inquiry with its work and particularly in this module.

Thank you.

LADY HALLETT: Thank you very much indeed, Mr Rawat.

Mr Hill.

Submissions on behalf of the Department for Science, Innovation & Technology by MR HILL

MR HILL: My Lady, I appear for the Department for Science, Innovation & Technology, and in these submissions I will summarise, briefly, the role the Department and its witnesses played before turning to the four themes relevant to evidence you will hear in the coming weeks.

The Department is a Core Participant as a successor to BEIS. The Government Office for Science sat within BEIS during the pandemic and sits within the Department now.

As you know, the Government Office for Science was headed by the Government Chief Scientific Adviser, the GCSA, Sir Patrick Vallance as he was then, Lord Vallance

1 as he is now.
2 That explains why we are here but it does not
3 explain what we did. The role often BEIS, the
4 Government Office for Science, and the GCSA was limited
5 in relation to the subject matter of Module 4 but
6 nonetheless important.
7 It is best explained by reference to the three
8 witnesses whose evidence will be considered as part of
9 this module.
10 Lord Vallance gives evidence about his central role
11 in the ideation, inception, and establishment of
12 the Vaccine Taskforce, the VTF. I will return to that
13 shortly.
14 Following the establishment of the VTF, his role on
15 matters relating to the day-to-day work on vaccines was,
16 by design, limited.
17 Lord Vallance also coordinated and encouraged the
18 work of scientists, government and funders in the early
19 weeks of the pandemic, which is of relevance to both
20 vaccines and therapeutics.
21 He is not being called to give oral evidence but has
22 provided a detailed witness statement which we suggest
23 is essential reading to anybody who wishes to understand
24 how the VTF came into being and the early impetus that
25 drove the development of vaccines and therapeutics.

1 Alexandra Jones was the Director of Science,
2 Research and Innovation at BEIS. She is being called
3 and will speak to her personal role in the establishment
4 of a VTF, as well as the wider involvement of BEIS in
5 matters relating to vaccines, therapeutics, of
6 a national core studies programme.
7 Lord Sharma was, as Sir Alok Sharma,
8 Secretary of State of BEIS between February 2020 and
9 January 2021. He too is being called and will give
10 evidence about his role in supporting the work of the
11 VTF, about international collaboration on vaccines, and
12 about the Department's work on therapeutics.
13 Two functions were at the heart of what BEIS, the
14 Government Office for Science, and the GCSA did in
15 respect of vaccines and therapeutics.
16 The first was to help identify, encourage,
17 coordinate, and direct the extraordinary talents of the
18 UK science and engineering base in academia and in
19 industry. The second was to assist the government in
20 making best use of that science and engineering base.
21 These are, you may feel, matters of considerable
22 importance. But more so, given the speed with which
23 that work was initiated.
24 On 27 January 2020, before the first documented case
25 of Covid in the UK, the first of a series of meetings of

1 science funders was convened by Lord Vallance. At his
2 request, and that of the Chief Medical Officer,
3 a £30 million fighting fund was quickly established by
4 the Treasury. This was used to invest in both the
5 Jenner Institute's work on what became the Oxford
6 AstraZeneca vaccine, and the COG-UK sequencing
7 consortium which, by May 2020, was responsible for half
8 the world's Covid-19 genome sequencing.
9 Concurrently, work was ongoing on mapping the global
10 R&D landscape on vaccines and therapeutics.
11 These were efforts to identify and utilise both
12 public and private sector, and we respectfully agree
13 with CTI that the role of industry in this story must be
14 emphasised.
15 Those efforts took place outside of a public gaze,
16 and may have been underappreciated as a result, but they
17 were the foundations of the success that followed.
18 Having provided much of the early impetus and
19 co-ordination, the Department's official role in
20 vaccines and therapeutics was thereafter limited. Other
21 bodies and departments were more directly involved in
22 policy and operational matters of concern in Module 4,
23 and you will hear from those.
24 My Lady, we know that you're not assisted by us
25 repeating what is in our written opening and instead we

1 use this time to highlight four themes.
2 First, the establishment of the Vaccine Taskforce
3 and its subsequent success resulted from a willingness
4 to step outside the norm. As you will hear, the VTF was
5 the idea of Lord Vallance, who identified the need for
6 a dedicated expert and operational group with a single
7 point of accountability to work on the vaccine response.
8 The VTF drew upon private and public sectors and
9 remained under ministerial oversight throughout.
10 It was novel and it was innovative, but it was not
11 a leap in the dark. The VTF drew on ideas set out in
12 a paper co-authored by Lord Vallance in 2019, which
13 itself formed part of a Science Capability Review, about
14 which you've previously heard evidence. It was
15 a combination of forethought and flexibility.
16 Our second theme is that the VTF succeeded because
17 it was prepared to fail. Scientific innovation is
18 inherently uncertain. Any project will carry risk.
19 This is particularly so for vaccine development.
20 The CTI said yesterday a regularly cited figure is a 10%
21 prospect of success measured in a period of years. It
22 was an extraordinary achievement to develop an effective
23 vaccine within a year, thereby abating a pandemic
24 mid-course. That achievement should not be diminished
25 by familiarity of the ultimate outcome.

To make this happen, the VTF, and the government that backed it, had to accept that there was a very real possibility that it would not succeed. As Lord Vallance says in his statements, and I quote:

[As read] "It is not possible to have innovation without accepting the risk of failure."

The risk was, however, carefully mitigated. The VTF deliberately adopted a portfolio approach to vaccine development to maximise the prospects of achieving its goal. The lesson to be drawn for government is of how to develop informed innovation and risk management in the future.

There is also, we suggest, a wider lesson for society about how it encourages an environment where such innovation has the greatest prospect of success.

To quote Lord Vallance again:

[As read] "Had the VTF not achieved its central purpose, it would have been 'lambasted as a huge waste of public money'. The fear of censure when innovation fails is a deterrent to taking innovation risks in the Civil Service."

The question of how innovation risk is treated in value for money calculations by the Treasury, the National Audit Office, the Public Accounts Committee, and more widely by parliamentarians, the media, and even

lawyers at public inquiries, is both under-considered and important.

In any future pandemic, there will be a need for innovation, and that will inevitably require an acceptance of risk and uncertainty of outcome.

Our third theme is that the development of vaccines and therapeutics revealed national strengths and national weaknesses. Foremost among the strengths were the UK science base, which includes for links between both scientists and their international colleagues, and of tradition of evidence-based medicine within the NHS, of which the RECOVERY Trial was the exemplar. The weaknesses included the limited domestic capacity for scaling up vaccine development and production.

The response to Covid-19 also meant decisions that to be made by prioritisation, for example, by suspending some non-Covid clinical trials and focusing on phase III trials ahead of phase II.

The third and final theme concerns lessons for the future. Considerable work has been undertaken in this field, informed by expertise and experience. It cannot be properly summarised here but it can be found in the witness statements of Ms Jones, Lord Vallance and Lord Sharma, and of course in the published work of the 100 Days Mission, which was started during the UK's

2021 G7 presidency. CTI referred to the 100 Days Mission yesterday and Mr Rawat has done so just before me.

The three key lessons from that mission are, first, to invest in and re-stock the armamentarium during peacetime.

Second, to embed best practice in business as usual activity, for example, in the day-to-day work of the NHS and, as Mr Rawat has said, in the ongoing vaccination programmes.

Third, to agree the rules of the road in advance. At paragraph 149 of his statement Lord Vallance also proffers seven additional reflections that he has drawn from his evidence to this Inquiry. We invite all of those concerned to read this body of evidence carefully.

My Lady, in conclusion, the UK's efforts in vaccines and therapeutics saved millions of lives and livelihoods worldwide. These are remarkable collective achievements.

This Inquiry will hear evidence from some of those involved but many thousands of others are also owed recognition and thanks. The scientists and the technicians of the lab benches, the administrators who enabled their research, the engineers, and those who worked to manufacture the vaccines, those who

administered the vaccines, as we hearing from Ms Domingo earlier, and the members to the public who volunteered for the clinical trials and the vaccine delivery programmes.

The success of the vaccines and therapeutics was a consequence of the excellence, depth and sense of public duty within its science and engineering base.

That was, in part, a result of long-term funding for discovery research. In a future pandemic, the strength of the UK's response will correlate closely to the strength of that same body of expertise.

That, we say, is a lesson for government and society alike.

Thank you, my Lady.

LADY HALLETT: Thank you very much indeed, Mr Hill.

And to complete the opening submissions, Ms Bicarregui. There you are.

I hope I got the pronunciation right.

Opening submissions on behalf of the Welsh Government by MS BICARREGUI

MS BICARREGUI: Bore da, my Lady.

My Lady, you've received ten witness statements from the Welsh Government for this module. Those statements and the written opening statement provide a substantial amount of detailed information, so in this brief oral

1 statement the Welsh Government will make two overarching
2 points and then address some of the key issues from its
3 perspective but certainly not all of the key issues,
4 my Lady.
5 The first overarching point is that the vaccine
6 rollout in Wales was, overall, a success. The Inquiry
7 has a variety of written evidence before it which show
8 that Wales managed to vaccine its population
9 efficiently, equitably, and at pace.
10 That overall success, my Lady, does not mean of
11 course that there are not lessons to be learned for the
12 future. It's always possible to do better and some
13 important points, many important points, have been made
14 in these openings.
15 At the end of this brief submission I will set out
16 some of the steps that the Welsh Government has taken to
17 date to learn from the experience of the vaccine
18 rollout, and it's anticipated of course that the report
19 from this module of the Inquiry will provide helpful
20 learning to further improve the planning and the
21 processes involved in vaccine and therapeutics.
22 My Lady, the second overarching point is something
23 which echoes what my learned friend from the Scottish
24 Government said, which is that, from the perspective of
25 the Welsh Government, four nations working in respect of

1 vaccine development and supply and the development of
2 supply and therapeutics, was, again, overall,
3 a successful.
4 While some frustrations and disagreements are
5 evident in the written evidence, and you'll no doubt
6 wish to consider some of that, overwhelmingly, the Welsh
7 Government is of the view that the four nations worked
8 in a collaborative and a constructive way to make
9 vaccines and therapeutics swiftly available.
10 My Lady, if I might address the context in which the
11 Welsh Government is able to help the Inquiry in respect
12 of this module. As the Inquiry is aware, healthcare is
13 a devolved function in Wales and has been since 1999.
14 However, in relation to vaccines and therapeutics, the
15 position is somewhat more nuanced, with certain
16 functions being reserved to the UK Government.
17 So the regulation of healthcare professionals,
18 medicines, vaccines, and their authorisation and vaccine
19 damage payments, are all matters in respect of which
20 legislative competence is reserved to the UK Government.
21 As your Ladyships is aware, but those listening may
22 not be, the Vaccine Damage Payment Scheme is
23 a UK-administered scheme and is a matter reserved to the
24 UK Government.
25 You've heard already, my Lady, the MHRA is

1 a regulator for medicines, medical devices, and blood
2 components for transfusion in the UK, which includes all
3 relevant vaccines and therapeutics in respect of
4 Covid-19, and pharmacovigilance is also the
5 responsibility of medicine regulators and is undertaken
6 by the MHRA on behalf of the whole of the UK.
7 Separate and distinct to those reserve matters are
8 those functions for which responsibility was devolved to
9 the Welsh Government, but in the specific context of the
10 Covid-19 vaccine procurement, a decision was taken to
11 agree that the UK Government would exercise those powers
12 on behalf of the Welsh Government.
13 This was led by the UK Government's Vaccine
14 Taskforce, as you've just been hearing about, on behalf
15 of all four nations.
16 In agreeing this, the Welsh Government chose to
17 allow its consequential share of vaccine funding to
18 remain with the UK Treasury with a Barnett share, which
19 you've heard about, of the vaccine supplies guaranteed
20 to Wales. And, my Lady, I'd like to address you very
21 briefly on the issue of vaccine allocation a little bit
22 later in this submission.
23 The operational delivery, my Lady, of the
24 vaccination programme in Wales fell to the seven local
25 health boards, but, and I should emphasise this, the

1 rollout was overseen and supervised by the Welsh
2 Government, and the detail of that oversight, my Lady,
3 is in our written evidence.
4 My Lady, the Welsh Government does invite you to
5 consider the basis upon which vaccine supply is shared
6 between the four nations. In the circumstances of the
7 pandemic as it progressed, a decision as to allocation
8 of supply had to be made very quickly and on a readily
9 understandable basis, and really the only options
10 available in the circumstances were for each -- for
11 sharing to occur according to, with reference to the
12 Barnett formula, which was already familiar to all of
13 the governments as the basis upon which funding
14 decisions were made.
15 But, my Lady, in order to ensure that vaccines
16 reached those in the greatest need first, the Welsh
17 Government submits that a needs-based formula is needed
18 to determine the allocation of vaccines in the future.
19 There was simply no realistic possibility for this to be
20 calculated, agreed, and implemented in the time
21 available during the pandemic, but now is the time, we
22 would submit, to revisit this issue as part of our
23 preparedness for the next pandemic.
24 As you'll have seen set out in the Welsh
25 Government's written evidence, the use of the Barnett

formula created the potential for a vaccine supply shortfall in Wales during the early stages of vaccine delivery. That was because Wales had a disproportionately larger share of older people in its population who, as you know, my Lady, were a major part of the initial priority groups.

So the ingenuity, my Lady, of those in the Welsh healthcare system meant that a shortfall in supply was avoided. There were several elements to this, but a key factor was the steps taken to avoid vaccine waste, with vaccinators in Wales identifying early on how to extract six doses per vial from the Pfizer vaccine instead of five doses, which was originally intended, and achieving this, my Lady, quickly at scale.

So this ingenuity and some other steps taken in Wales should not detract from the need to consider the fairness and the appropriateness of the Barnett formula in deciding population share of UK vaccine stock, and that's because, my Lady, as I've said, it doesn't take account of the relative size of the population at risk in terms of what vaccination is needed. And it's submitted that vaccines could and should in future, where possible, be allocated according to need.

Your Ladyship will be considering the important issue of equity in the rollout of the vaccine. The

question of health, socioeconomic, and other inequalities has been the focus of successive Welsh Governments since the outset of devolution in 1999 and, my Lady, that prior focus meant that the Welsh Government had an early understanding that Covid-19 would produce disproportionately adverse effects on those already disadvantage or from suffering some other pre-existing health condition.

So, my Lady, the Welsh Vaccine Equity Committee was established in March 2021 with its impact and influence increasing as the pandemic evolved. It involved representatives from the under-served groups themselves, from third-sector organisations, as well as experts from Public Health Wales and the NHS in Wales, and it sought to understand the barriers to uptake of Covid-19 vaccinations in marginalised groups, and to work to remove those barriers.

The Welsh Government published a vaccine equity strategy in June 2021 to ensure all people in Wales who were eligible for Covid-19 vaccination had fair access and a fair opportunity to receive their vaccination, again by addressing barriers to uptake, which disproportionately affected under-served population groups. And very briefly, my Lady -- and this doesn't go anywhere near to answering much of what was said

yesterday -- but the strategy did refer to asylum seekers and it did refer to those from Traveller communities as requiring a particular focus to ensure that they could access the vaccine.

The Welsh Government implemented various measures to ensure the accessibility of the vaccine too, and to encourage take-up amongst those communities.

Just to give a few examples, measures included the appointment of outreach and engagement workers within each local health board to support with engagement and advocacy relating to the vaccination programme; and the use of community champions or trusted voices, comprising of faith leaders, community leaders, sports and cultural figures, health professionals, academics, and peers of eligible and vaccine-hesitant groups in a range of communities.

In addition to the Vaccine Equity Committee, DNA, which is -- "did not attend", a DNA group was also set up to specifically target the issue of hard-to-reach groups.

The Welsh Government also held specific events intended to target those harder-to-reach communities for those who were vaccine hesitant, including an online vaccination roundtable to permit representatives from multi-cultural faith community and business

organisations from across Wales to ask questions, and to hear from a panel of experts.

My Lady, very briefly vaccine misinformation was a concern, and was identified as a key theme in the All Wales Equity Action Plan, with significant efforts made to promote accurate information to the public in Wales, which included the establishment of a community engagement group to work with community leaders and organisations representing particular communities.

My Lady, the Welsh Government enjoyed relatively high levels of trust from the Welsh public which meant the public were generally responsive to its public messaging on vaccine-related matters and that ensured that the Welsh government measures were generally well supported, but misinformation is a difficult issue and one which is increasingly hard to target as people source their information in increasingly fragmented ways, and the Welsh Government is keen to hear any suggestions which the Inquiry has on this complex topic.

My Lady, briefly on lessons learned, which I mentioned at the beginning. The Welsh Government has sought to learn lessons from the rollout of vaccinations during the pandemic to support delivery of all of its ongoing vaccination programmes. It carried out an assessment of vaccination priorities and expectations

1 for the future, and on 25 October 2022, it published the
2 National Immunisation Framework. The framework is
3 intended to pave the way for a transformation of the
4 vaccination programme in Wales, enabling exemplar
5 delivery of vaccination and immunisation programmes with
6 uptake and with equity at its core.
7 It aims to make it easier for people to know the
8 vaccinations they are eligible for, how to receive them,
9 and it uses digital vaccination records.
10 Local health boards are also required to have
11 a vaccine equity strategy and a programme of work
12 applying the framework's principles. And again, my
13 Lady, to ensure that vaccine equity is considered at
14 every stage and to protect the "no one left behind"
15 principle which was part of the Welsh Government's
16 vaccine strategy published during the pandemic, the
17 Welsh Vaccine Equity Committee is part of the new
18 governance arrangements under this framework, with an
19 expanded remit to deal with all vaccination programmes.
20 Lastly, my Lady, whilst most of this submission
21 deals with the undoubtedly positive effects of the
22 vaccine rollout at a population level, the Welsh
23 Government of course acknowledges that some individuals
24 were harmed by the vaccine, and again, for some of those
25 people, those harms are ongoing, and we say it's

1 important, as Mr Keith KC set out, to acknowledge that
2 and to listen to those affected in that way.
3 The Welsh Government also wishes to acknowledge the
4 very hard work of GPs and many others within the Welsh
5 population. My Lady, you saw an example of a Welsh GP
6 in the impact video that was shown, many of those people
7 who sought to reassure and to reach communities who were
8 worried about having the vaccine. Again, with respect,
9 we agree with Counsel to the Inquiry and other Core
10 Participants that it is important that this work on
11 vaccine equity and reaching hard-to-reach groups is
12 ongoing and survives the pandemic.
13 And as I mentioned, also at the beginning, my Lady,
14 the Welsh Government acknowledges that there are further
15 lessons to be learned, not only from what went well, but
16 also what we could have done better, and we welcome the
17 Inquiry's analysis of those lessons to be learned, and
18 improvements that can be made to ensure the success not
19 only of future vaccine programmes but also of the
20 delivery of therapeutics.
21 Diolch, my Lady.
22 **LADY HALLETT:** Thank you very much indeed.
23 That I think completes the submissions and some
24 extremely helpful and interesting submissions have been
25 made, and I shall undertake to consider them all very

1 carefully with Counsel to the Inquiry, and also to
2 ensure that I read all the written statements again very
3 carefully.
4 Mr Keith, I think we now move to the first witness.
5 **MR KEITH:** My Lady, yes.
6 **LADY HALLETT:** And I believe we have undertaken to hear her
7 before the break.
8 **MR KEITH:** Indeed. So may we have our first witness,
9 please. Jean Rossiter.
10 If she could be sworn ...
11 **MRS JEAN ROSSITER (sworn)**
12 **Questions from LEAD COUNSEL TO THE INQUIRYfor MODULE 4**
13 **MR KEITH:** My Lady, we're not going to seek in relation to
14 any witness your permission specifically each time for
15 statements to be published --
16 **LADY HALLETT:** No, by default.
17 **MR KEITH:** -- unless we raise something -- by default, thank
18 you.
19 **LADY HALLETT:** Mrs Rossiter, thank you very much for coming
20 to help us, I hope it's not too difficult for you, and
21 we will obviously take any care we can to make sure that
22 it's a relatively pain-free experience.
23 **THE WITNESS:** Thank you.
24 **MR KEITH:** Mrs Rossiter, thank you very much for attending
25 today and assisting the Inquiry. You have very kindly

1 provided two witness statements, INQ000398406 and
2 INQ000474666 -- dated -- both -- I think dated
3 December 2023 and December 2024. I'm sure you've read
4 them both in advance of attending today.
5 You are a member of the group Covid-19 Bereaved
6 Families for Justice UK, and we heard -- I had the
7 privilege of hearing in Module 1 from Matt Fowler, from
8 Joanna Goodman in Module 2, and Mr Sullivan in Module 3,
9 although as we know, he sadly passed away.
10 So I'm not going to spent any time asking you about
11 the nature of your group, because we know a great deal
12 about it already, other than this: it came into being,
13 did it not, around about the end of April 2020, after
14 Ms Goodman lost her father and Mr Fowler lost his
15 father, and they liaised online, came together, and
16 realised there was a very significant need for such
17 a group to be founded; is that right?
18 **A.** That's correct.
19 **Q.** I think it has almost 7,000 members now from across the
20 United Kingdom and of course the terrible link between
21 you all is that you all lost loved ones to Covid or
22 suffered some form of harm in the course of the
23 vaccination or therapeutic programmes.
24 Mrs Rossiter, may I ask you please about your son
25 Peter, whom I know you lost on 11 August 2021 when he

1 passed away having suffered from Covid. He was a very
2 remarkable musician, I gather.
3 A. Yes, he was. Peter was -- sorry.
4 Q. It's quite all right.
5 LADY HALLETT: You're bound to get distressed, we do
6 understand, so just take your time, drink some water.
7 I sometimes find that just having a break by drinking
8 some water helps. But please don't apologise. There
9 are tissues there if you need them.
10 MR KEITH: Was he, Mrs Rossiter, in fact Young Musician of
11 the Year in high school?
12 A. Yes, he was a very talented classically-trained pianist.
13 Q. And he studied at the Royal Northern College of Music?
14 A. Yes.
15 Q. And I think in the Franz Liszt Academy of Music in
16 Budapest?
17 A. Yes.
18 Q. And he was working, was he not, at a school where, at
19 the time of his death, he was head of a particularly
20 important part of the music structure there?
21 A. Yeah, Peter, he originally worked on supply, as
22 a teacher, and once he qualified, and he had some
23 difficulty initially getting a job but he secured this
24 job mainly as a maternity leave job, providing cover for
25 that teacher, who then decided not to go back to school.

1 So he started as a teacher, and he very quickly
2 progressed to become head of music in that school.
3 At the time, when Peter first started music,
4 although it was being presented in the school, it wasn't
5 really taken up that much by the kids. He actually
6 managed to bring that subject right up, and he really
7 made it into a very popular subject. He even actually
8 managed to get kids to take part in the school concerts,
9 which they wouldn't do before. He arranged bands, he
10 got them into groups, and he even managed to get some of
11 the staff to actually form a group as well, and take
12 part in the concerts with the kids. So it became a very
13 popular subject in the school.
14 Q. And he was the subject leader, he was head of the music
15 department?
16 A. He was the subject leader, yeah.
17 Q. We understand that he continued to work there throughout
18 the pandemic?
19 A. He did, yeah.
20 Q. And the school had obviously remained open for the
21 children of key workers, and looked after, I think,
22 other children who had SENs.
23 He had to wait for a while until he was called up
24 for his first dose, he received a vaccine on
25 14 May 2021. But I think that there were problems

1 getting a second dose, the process by which he came to
2 be invited for a second dose wasn't very
3 straightforward, was it?
4 A. No, it wasn't. He only got his first vaccine in May.
5 And I have to add at this point, when Peter actually got
6 his first vaccine, this was at a point when everything
7 in the country was starting to open up, and shops, and
8 restaurants and, you know, the schools had gone back,
9 were all open. People were allowed to gather. The
10 European Cup final was on and people were gathering to
11 watch that, and Peter only then was getting his first
12 vaccine. He had had to wait until May, despite the fact
13 that he as a teacher was a key worker and, you know, he
14 was looking after children of other key workers, and
15 those key workers were actually in contact with Covid
16 cases, or some of them were. You know, the children
17 were seen at the time to be carriers of the virus, and
18 to this day, I can't understand why teachers were not
19 given priority for that virus, for the vaccine.
20 Q. And notwithstanding that he did receive a second dose,
21 he caught --
22 A. He only --
23 Q. -- Covid afterwards?
24 A. He only received his second dose eight weeks after the
25 first dose, that was in the July, and I was really very

1 concerned about this because I thought that the -- you
2 know, the manufacturers of the Pfizer vaccine had said
3 that ultimate -- for protection, they should have had --
4 that you should have the vaccine within three weeks, and
5 yet Peter waited eight, because the science, so
6 I believe, said that you were okay up to 12 weeks.
7 Now, Peter had his second virus -- second vaccine
8 within -- in eight weeks, and, yes, even his first
9 vaccine hadn't protected him.
10 Q. And one of the important issues, of course, we're
11 looking at in the course of this module, Mrs Rossiter,
12 is the dosage interval.
13 A. Yes.
14 Q. So we'll be hearing plenty of evidence on that topic.
15 After he received his second dose he nevertheless
16 got Covid, and very sadly fell very seriously ill very
17 quickly.
18 A. He did.
19 Q. He was taken to hospital, he was placed in an ICU, and
20 I'm very sorry to say that, despite being intubated and
21 looked after there, he passed away on 11 August.
22 So you've obviously got some very serious concerns
23 about the key worker issue, whether or not he should
24 have been offered a vaccination earlier, and the dosage
25 interval as well.

1 **A.** I'd also query, if I could, about the quality of the
2 vaccine, and, you know, whether or not -- was there
3 something wrong with that vaccine that it didn't protect
4 Peter? I don't know. I've no way of checking on that.
5 Nobody was able to tell me.
6 I even contacted Pfizer themselves about the
7 vaccine, and they actually told me that when Peter had
8 his second vaccine, because he actually tested positive
9 so soon afterwards, he wasn't fully protected.
10 **Q.** Mm.
11 **A.** It just didn't make sense to me --
12 **Q.** Vaccines --
13 **A.** -- on what we'd been told.
14 **Q.** -- we will hear, don't provide a hundred per cent
15 protection, but we will be calling evidence about the
16 degree of protection and effectiveness and the sort of
17 protection they provide, and that's another important
18 issue we will look at.
19 Mrs Rossiter, given the large membership of Covid-19
20 Bereaved Families for Justice Group, your members have
21 obviously raised a wide variety of issues, and you have
22 taken the care to identify some of those issues and
23 concerns in your witness statement.
24 I'm just going to run briefly through and identify
25 some of the major points which are raised in your

1 statement, and if you just agree, if you'd be so kind,
2 as to whether or not they are indeed matters which have
3 been raised by you through your members.
4 Going beyond, obviously, the tragedy of individual
5 cases where people died from Covid, we can't do about
6 investigating in individual cases, but the issues which
7 are raised in general terms by your members are delays
8 in receiving vaccines, so a question about the delivery
9 of vaccines and how quickly they were made available,
10 concerns about poorly communicated public health
11 guidance, quite a few members have raised concerns about
12 this issue of the dosage interval.
13 **A.** Absolutely.
14 **Q.** And also between the -- the gap between the second and
15 third doses, between the second and the booster doses.
16 In your legal team's opening submissions, questions
17 have been raised about specific prioritisation, for
18 example, there's one particular boy who had complex
19 needs, but didn't appear to have received early
20 vaccination. There is the general issue of availability
21 of and access to antivirals and therapeutics; that's
22 been raised by quite a few of your members, hasn't it?
23 **A.** Yes. Yes, it has.
24 **Q.** You've mentioned the issue of whether or not key workers
25 should have been prioritised for early access to

1 vaccination, beyond working in the health and care
2 sectors. Do quite a few of your members ask why
3 particular sectors of the population, such as transport
4 workers and teachers, didn't receive priority
5 vaccination?
6 **A.** Yes, indeed.
7 **Q.** And also, very credibly on the part of these members,
8 quite a few of your members have asked questions about
9 whether other people in the United Kingdom, but
10 particularly members of the ethnic minorities, properly
11 received access to vaccination, to vaccines, and also
12 whether or not the system equitably allowed for them to
13 receive vaccines when they were due to receive them?
14 **A.** Yes, that's --
15 **Q.** That seems to have been a point of particular concern
16 for your members --
17 **A.** (Witness nodded)
18 **Q.** -- that everybody had a fair crack of the whip?
19 **A.** Yes.
20 **Q.** Right.
21 Mrs Rossiter, that's extremely helpful. Thank you
22 very much. That allows us to understand more clearly
23 the main areas of concern that your members have had.
24 **A.** Thank you.
25 **LADY HALLETT:** Ms Rossiter, I too am the mother of two sons,

1 and of similar age to Peter, so I can only imagine the
2 pain and the grief that you're going through. So thank
3 you so much for coming along to help us. I know you've
4 already done a lot to ensure that his memory doesn't
5 die, and I hope that your remarks today, your helpful
6 evidence, will help keep him alive as well.
7 And I think as well as the important points that
8 Mr Keith has just taken you through, I think one of the
9 most important points from my point of view is that so
10 many people said Covid-19 only affects the older people.
11 **THE WITNESS:** Exactly.
12 **LADY HALLETT:** You had a fit and healthy young son,
13 under 40, and so it helps remind people that we're not
14 just about protecting people who some may think have had
15 a good innings, we're about protecting the whole
16 population.
17 **THE WITNESS:** Indeed, yes. Yes, Peter was -- he always kept
18 himself fit. And he followed the rules. We all did.
19 And it just seems to us, as parents, is that we did
20 everything right, and yet Peter lost his life still. As
21 did so many of similar families who are in our group,
22 and I believe all of our families really deserve to be
23 heard, and for those cases to be taken into account.
24 Thank you very much for letting me come.
25 **LADY HALLETT:** Well, thank you very much for all the help

1 you've given and having the courage to come along and
2 help me. And I know that when I break your legal team
3 will ensure that you have the support that you will
4 need, but also the Inquiry, as your legal team know,
5 provide support if you need it as well.
6 So thank you very much indeed.
7 **THE WITNESS:** Thank you.
8 **LADY HALLETT:** I shall break now and return at -- shall
9 I say 11.40 so that the team can have a chance to talk,
10 and then perhaps a break themselves. Twenty to.
11 **(11.21 am)**
12 (A short break)
13 **(11.40 pm)**
14 **LADY HALLETT:** Yes.
15 **MR MANSELL:** My Lady, the Inquiry calls Melanie Newdick,
16 please.
17 **MS MELANIE NEWDICK (affirmed)**
18 **Questions from COUNSEL TO THE INQUIRY**
19 **LADY HALLETT:** I hope we haven't kept you waiting for too
20 long.
21 **THE WITNESS:** That's fine.
22 **LADY HALLETT:** We totally understand this is going to be
23 really difficult for you and we're very grateful to you
24 for coming along.
25 **THE WITNESS:** Don't worry, it's 600 miles to come down,

1 so ...
2 **LADY HALLETT:** I didn't realise you'd come quite that far.
3 **THE WITNESS:** Yes, yeah.
4 **MR MANSELL:** Please could you give the Inquiry your full
5 name.
6 **A.** Yeah, my name is Melanie Newdick.
7 **Q.** Thank you very much for attending all that way to assist
8 the Inquiry today.
9 A few preliminary matters. I'm going to ask you to
10 keep your voice up, please don't speak too quickly, and
11 ask me to repeat anything if it's not clear. Okay?
12 **A.** Okay, yeah.
13 **Q.** You have kindly provided a witness statement to the
14 Inquiry on behalf of Scottish Covid Bereaved, or SCB,
15 and that is INQ000472173. Are the contents of that
16 statement true to the best of your knowledge and belief?
17 **A.** Yes.
18 **Q.** The Inquiry is, of course, familiar with Scottish Covid
19 Bereaved, and is grateful for the evidence it has
20 provided in earlier modules of the Inquiry. I will deal
21 very briefly with the background of the organisation.
22 It started out as passed of the group Covid Bereaved
23 Families for Justice UK, which was formed on Facebook in
24 June 2020.
25 **A.** Yes.

1 **Q.** Then in September 2022, SCB became a completely separate
2 group?
3 **A.** Yes, it did, yeah.
4 **Q.** You note the diversity of your membership, which
5 includes healthcare and other frontline and key workers?
6 **A.** Yes.
7 **Q.** And you note that some of those are suffering from
8 post-traumatic stress disorder and other impacts of the
9 trauma that they experienced during the pandemic?
10 **A.** Yes.
11 **Q.** You also have members who are either from an ethnic
12 minority group or who have a loved one who died who was
13 from an ethnic minority group?
14 **A.** We do, yes.
15 **Q.** And in that regard you highlight the Scottish Government
16 vaccine data which shows that the highest vaccine rates
17 were for white people with lower uptake among ethnic
18 minorities?
19 **A.** Yes.
20 **Q.** You also have members suffering from Long Covid?
21 **A.** Yes.
22 **Q.** Your aims, very briefly, are that you're a group of
23 bereaved individuals united in a common goal?
24 **A.** We are.
25 **Q.** And by sharing your experiences you want to assist this

1 and the Scottish Inquiry in establishing what happened
2 and making recommendations for the future.
3 **A.** Absolutely.
4 **Q.** Now your statement deals with a number of issues of
5 concern to SCB, and I want to start, please, with the
6 pace of delivery, vaccine delivery, in Scotland,
7 including vaccination of vulnerable hospital inpatients
8 and care home residents.
9 **A.** Yes.
10 **Q.** This is a topic that is of particular concern to SCB.
11 Could you tell us a little bit about the concerns you
12 have?
13 **A.** Yes. If we take ourselves back to when we very first
14 had vaccines, at the end of 2020, there was an initial
15 fast pace of delivery, but that slowed. So it was not
16 delivered across the -- at the same pace across the
17 whole of Scotland. So the part of Scotland where
18 I live, which is a very remote part of Scotland, the
19 delivery slowed because Christmas came. So some people
20 didn't get the vaccine as early as they could, which
21 could have had impacts for them as well. And we also
22 had the situation where people missed their opportunity
23 to get vaccinations because they were in hospital.
24 Which seems incredible, really, when you think about it.
25 **Q.** Another issue you raise is the question of whether

1 Scotland lagged behind England in terms of delivery; is
2 that something else that you're --
3 A. Yes, we would really appreciate some insight into that
4 from the Inquiry. And then, you know, when you look at
5 the -- particularly the difference between the different
6 parts of Scotland -- Scotland is pretty huge. It's
7 a third all the land in the UK. So -- and the bit I'm
8 in is a particularly remote part of Scotland as well.
9 So there's some real differences within the speed of
10 delivery within Scotland itself.
11 Q. You also highlight the fact that different health boards
12 in Scotland took different approaches to vaccination
13 delivery.
14 A. Yes.
15 Q. What are your concerns about that?
16 A. Well, I'm not sure whether the Inquiry is aware that now
17 in Scotland we have a completely different process for
18 vaccinations than you have here in England. So you are
19 able to go to your GPs to get vaccinations, we can't do
20 that any more in Scotland. April 2023, no GPs in
21 Scotland, or very few, have been able to give any sorts
22 of vaccinations, not Covid, not flu, not all the
23 childhood vaccinations. We have to go through
24 a completely different process. We have to go to
25 clinics arranged by the health board.

1 So our concerns are, now, whether -- if we put
2 ourselves back to when we had the Covid pandemic, if we
3 had another pandemic tomorrow, would our system be able
4 to deliver vaccines at the pace that we did previously?
5 And at the minute, the data seem to say that it can't.
6 We're seeing a lot of differences in vaccine uptake.
7 So, to give you a very quick example, we're having
8 a huge flu outbreak at the minute, as I'm sure you know.
9 The vaccine uptake in the Highlands is now half the rate
10 compared -- with the new system, compared to what it was
11 when GPs provided that service. So that's huge
12 implications for everything, but also for another
13 pandemic.
14 Q. You've mentioned the GP model. Was that particularly
15 important in Scotland for reaching rural communities?
16 A. It's really important. It's really important for
17 everybody. I mean, any vaccine system should be
18 designed to make it as easy as possible for as many
19 people as possible to get a vaccine, so now we have an
20 extra step, which doesn't just make it difficult for
21 everybody to get a vaccine; it makes it even more
22 difficult for those that we already talked about:
23 anybody in an ethnic group, anybody from a deprived
24 area, anybody who has any concerns about vaccines.
25 That's now an additional step and an additional barrier

1 that we have in our system that you don't have in
2 England.
3 LADY HALLETT: Sorry, can I just go back. So what is the
4 system? So I recently had the RSV infection jab.
5 I just go down to my GP and it's done. How would you do
6 that in Scotland?
7 A. Okay, so knowing that I was going to come down here and
8 you've got a lot of flu in London, I rang the
9 vaccination helpline and I could have gone to a clinic
10 today 20 miles away from home between 1 and 3 pm.
11 I could go to a clinic tomorrow, which is 220 miles away
12 from my home, which is the next one available. We have
13 to ring the health board or we have to go online and we
14 have to find a clinic to go for that vaccination. We
15 can't go to the GP for any vaccination, not a tetanus,
16 not a childhood vaccination not a flu, not a Covid,
17 nothing.
18 LADY HALLETT: Do they have hours that cater for people who
19 are working during a normal working day but isn't
20 a normal working day for everybody?
21 A. No, all the hours -- I had a look at the whole schedule
22 for January. Most of the hours are something like 10 to
23 12 or 1 to 3, 2 to 4. There's no evenings, there's no
24 weekend clinics either. So it makes it very difficult.
25 LADY HALLETT: I can imagine.

1 A. Yes, yeah.
2 MR MANSELL: We've touched upon barriers for vaccination for
3 people, and one of the issues raised in your statement
4 is the barriers faced by elderly or those vulnerable
5 person in shielding categories.
6 A. Mm.
7 Q. What are SCB's concerns in relation to that?
8 A. Well, we raise concerns about having to go to, to take
9 vulnerable people to vaccination clinics. That is now
10 the system. You have to go to either a specific day
11 where people are coming in, or you have to go to
12 a drop-in clinic to get your vaccinations. So our
13 concerns are, is this new system, is it making it easier
14 or is it making it more difficult for those people to
15 access vaccines?
16 Q. I think those are the major areas of concern that we've
17 touched upon. I just want to go through, at quite
18 a high level, some of the other issues raised in your
19 witness statement. One of these is communication about
20 vaccine development, and SCB's concern that the
21 development of the Covid-19 vaccines wasn't communicated
22 clearly enough to the public so as to alleviate any
23 concerns about it; is that right?
24 A. Yeah, and I think in the opening statement yesterday
25 Mr Keith set out what the process was, and instead of it

1 being a linear process with the steps following on from
2 each other, they ran concurrently. But I'm not sure
3 people knew that. And maybe, if that had been
4 communicated, it might have helped, and then it would
5 have stopped people thinking that the process had been
6 shortened and steps had been removed.
7 **Q.** Another issue you raise is the cancellation of the
8 Valneva contract, this was the UK Government's decision
9 to cancel the contract with the vaccine manufacturer
10 Valneva. The company was due to manufacture some of
11 those vaccines at a plant and in Scotland --
12 **A.** Yes.
13 **Q.** -- and you would like to know and your members would
14 like to know if the cancellation had an impact on the
15 overall vaccine programme in the UK or in Scotland in
16 particular?
17 **A.** We absolutely would, especially considering that Valneva
18 went on to get full European approval, and because the
19 type of vaccine would have been really -- it's
20 especially suitable for people with health conditions
21 that couldn't have other vaccines.
22 **Q.** That's right. It's a different modality --
23 **A.** Yes.
24 **Q.** -- to mRNA vaccines, for example?
25 **A.** Yes.

1 **Q.** Another issue you raise is the vaccination of key
2 workers, and you ask why certain key workers were
3 prioritised over others?
4 **A.** Yes. And I think, you know, we have questions about
5 again whether -- how those decisions were made. You
6 know, was it the role they were doing? The type of job?
7 How did those decisions come about? So a good example,
8 a quick example, when we had the initial vaccines for
9 care home residents, care home workers couldn't get the
10 vaccine at the same time. So in our local care homes
11 that's how Covid went into the care homes from
12 a community outbreak through the staff, and then 47
13 people died in my local town, just in care homes, from
14 that outbreak.
15 **Q.** In your statement you set out a number of lessons you
16 believe can be learned about vaccination and
17 therapeutics in Scotland and recommendations for the
18 future. One of the main issues of concern for SCB was
19 the distribution of the vaccine to those in vulnerable
20 categories; is that right?
21 **A.** Yes. We had some concerns about that, how that happened
22 for Covid-19. We have some concerns about how that
23 might happen under this new system, and would the same
24 people have the same problems or would it be more
25 accessible this time?

1 **Q.** You also highlight the fact that in future it may be
2 helpful to consider allowing individual health boards to
3 implement their own system for vaccine distribution in
4 the future, suited to their particular population. Is
5 that something you'd like to see?
6 **A.** Yeah, exactly. So the Highlands, where I live, it's
7 geographically the same size as Belgium. It's got 2.5%
8 of the population but we have to use the same
9 centralised system because that's what the Scottish
10 Government has told all the health boards in Scotland
11 they have to do. It doesn't work for a remote, rural
12 community. Who is going to drive 220 miles to get
13 a vaccine? I'm very keen on vaccines, but even I'm not
14 going to do that.
15 So we need a system that's actually going to work
16 for the population that it serves and not a central
17 one-size-fits-all policy.
18 **Q.** You would also like to see better communication in the
19 future with relatives in situations where therapeutics
20 are being offered, and you make the point that those who
21 are unwell and vulnerable may not be in a position to
22 make decisions alone.
23 **A.** Yes. I think we would like to see much better
24 communication around those. So again, what lessons
25 going forward, yes.

1 **Q.** And you also raise the issue of access to accurate
2 information, and we've touched upon this already in
3 discussing the development of the vaccines, but you are
4 concerned about people being able to make informed
5 decisions about vaccines, and therefore you would like
6 to see some stricter controls on social media and indeed
7 the mainstream media when it comes to misinformation.
8 **A.** Yes, I'm sure you're aware that one of the -- Facebook
9 has just decided it's going to get rid of all its
10 moderation and go for a community moderation. That's
11 potentially got a huge impact. I think an important
12 thing to remember about, or to think about for vaccine
13 hesitancy, is that the hesitancy is not usually about
14 the vaccine, it's usually -- it usually comes from
15 trauma, and the impact that that has on trusting anyone
16 in authority, whether that be a health board, police
17 officers, solicitors, maybe, I don't know. So that's
18 where it comes from. So it's about having, you know,
19 it's thinking about it in a trauma-informed way which
20 I know the Inquiry does.
21 Our system in Scotland currently has put an extra
22 barrier for those people. They can no longer have
23 a chat with their GP and they can no longer, when
24 they're in for something else, the GP can no longer say
25 to them, and take that opportune moment to say, "Okay,

1 let's get your vaccinations done." "Well, I've got some
2 questions about it". "Okay, let's deal with them now."
3 It doesn't work like that any more so we've made it
4 even harder for the people.
5 Just quickly, that system when it was designed, the
6 Scottish Government, they got in members of the public
7 to talk to them about redesigning the new system. They
8 deliberately excluded anybody that was vaccine hesitant,
9 saying that they felt they had nothing to add to the
10 process. You know, really, if we'd built this process,
11 this new process around these people, it would have
12 worked for everybody else as well and they would have
13 had more access to vaccines which are, after all, the
14 most successful public health intervention we have.
15 **MR MANSELL:** Ms Newdick, we have covered a huge amount of
16 ground. Thank you very much for that evidence.
17 My Lady, that concludes the evidence of this
18 witness, unless you have any questions.
19 **LADY HALLETT:** No, thank you, Mr Mansell.
20 We haven't dealt with your own bereavement,
21 Ms Newdick, but I know you've told the Scottish inquiry
22 about the death of your mother, and I appreciate it must
23 have been -- I've read it -- it must have been extremely
24 difficult for you, but at least you got her home.
25 **THE WITNESS:** Yes, we did, thank you. Thanks.

1 **LADY HALLETT:** And thank you so much for all the
2 constructive and helpful comments you've made. You're a
3 very good advocate for the cause.
4 **THE WITNESS:** No problem, thank you.
5 **LADY HALLETT:** And safe journey back.
6 **THE WITNESS:** Yes, yes, I'll be flying back tonight, thank
7 you.
8 **LADY HALLETT:** Do you follow us remotely?
9 **THE WITNESS:** Yes, absolutely.
10 (The witness withdrew)
11 **LADY HALLETT:** I understand, Ms Mitchell, if it's okay with
12 you, we'll carry on. Thank you.
13 Mr Mansell.
14 **MR MANSELL:** My Lady, the next witness, please, is
15 Fiona Clarke.
16 **MS FIONA CLARKE (sworn)**
17 **Questions from COUNSEL TO THE INQUIRY**
18 **LADY HALLETT:** I hope we haven't kept you waiting,
19 Ms Clarke.
20 **THE WITNESS:** That's okay. Thank you.
21 **MR MANSELL:** Can you give the Inquiry your full name,
22 please.
23 **A.** Fiona Louise Clarke.
24 **Q.** Thank you very much for attending today to assist the
25 Inquiry. I'm going to ask you to keep your voice up,

1 please.
2 **A.** Yes.
3 **Q.** Speak into the microphone, so that the stenographers can
4 make a note of what you're saying. Ask me to repeat
5 anything if it's not clear.
6 You've provided a witness statement to the Inquiry
7 on behalf of Northern Ireland Covid-19 Bereaved Families
8 for Justice, or NICBFFJ. That is INQ00047358. And are
9 the contents of that statement true to the best of your
10 knowledge and belief?
11 **A.** Yes, it is.
12 **Q.** The Inquiry is familiar with the group NICBFFJ and it
13 has benefited from the evidence it has given to the
14 Inquiry in earlier modules. The group started in
15 December 2021, and is a branch of the UK-wide Covid
16 Bereaved Families for Justice group; is that right?
17 **A.** Yes, that's correct.
18 **Q.** It was formed as both a support group and an action
19 group, and seeks to challenge decision makers to
20 highlight issues and safeguarding concerns, as well as
21 address the detrimental impact that visiting
22 restrictions were having upon patients and residents in
23 hospitals and care homes and their families?
24 **A.** Yes.
25 **Q.** Is that right?

1 **A.** Correct, yes.
2 **Q.** You explain in your statement that the group represents
3 and is made up of members who have lost loved ones to
4 Covid-19 in a variety of circumstances, including in
5 care homes, hospitals, and in the community?
6 **A.** Yes.
7 **Q.** And the aims of the group include applying pressure to
8 ensure that there is accountability for the past actions
9 of the UK and Northern Ireland governments, and
10 providing a collective voice for bereaved families and
11 a supportive space for them to connect?
12 **A.** Yeah.
13 **Q.** Now I'd like to ask you at the outset, please, to speak
14 a little bit your mother, Margaret Lusty. Your mother
15 sadly died in January 2021 at the age of 90.
16 **A.** Yes.
17 **Q.** She had been a shop owner --
18 **A.** Mm-hm.
19 **Q.** -- and proprietor earlier in her life?
20 **A.** Yes.
21 **Q.** You describe her as "a country woman from Cookstown",
22 and say "nothing would get her down"?
23 **A.** That's right.
24 **Q.** And despite her age and health difficulties with kidney
25 disease, she was still independent and still driving; is

1 that right?
2 **A.** Yes, that's right.
3 **Q.** Your mother was in the phase I priority group for
4 vaccination. She received a first dose on
5 7 January 2021. That was around five weeks after the
6 vaccine had first been approved?
7 **A.** Right.
8 **Q.** And her experience of being vaccinated was a positive
9 one?
10 **A.** Yes.
11 **Q.** Could you speak a little bit about that.
12 **A.** Yes. The vaccination -- we all wanted to be vaccinated
13 to protect her. We didn't want to bring Covid in to
14 her. She was also looking forward to getting her jabs
15 to protect herself.
16 Now, whenever she was vaccinated, I was in hospital
17 myself at that time, with Covid, so I really wasn't
18 aware, the process if you like, of her going through,
19 but she was happy enough. I remember her telling me it
20 was like a conveyor system and things were done very
21 safely and she was quite relieved to get the first
22 vaccine.
23 **Q.** I think she went with your brother; is that right?
24 **A.** Yes, my brother took her, yes.
25 **Q.** To be vaccinated at a local health centre in

1 Glengormley. And it is, as you've just alluded to,
2 a rolling system. She went in one door --
3 **A.** And out the other.
4 **Q.** -- and out the other.
5 **A.** Yes.
6 **Q.** Which was something that was thought to be very good
7 because she wasn't spending a lot of time with other
8 people in that setting?
9 **A.** That's correct. She said to me that it was -- she was
10 just in and straight in again. So ...
11 **LADY HALLETT:** Did she not do the -- I remember you had to
12 sit down for 15 minutes or something after; did she not
13 do that?
14 **A.** No.
15 **LADY HALLETT:** Oh.
16 **A.** No, she was straight out. She said straight out the
17 next door.
18 **MR MANSELL:** It may have been that that was introduced
19 slightly later in the process but we can --
20 **LADY HALLETT:** It may be, yes. I wasn't in the first
21 cohort.
22 **MR MANSELL:** Nevertheless, despite that positive experience
23 with the vaccination itself, your mother tested positive
24 for Covid-19 on 12 January 2021, and was admitted to
25 hospital on 16 January.

1 **A.** Yes, that's correct.
2 **Q.** You were at the same hospital, as you've explained,
3 because you had Covid-19 at the time?
4 **A.** Yes.
5 **Q.** You were allowed to see her in the hospital. You
6 explain in your statement that it was a bit of a battle
7 but you got to see her?
8 **A.** Yes.
9 **Q.** You sat with her all night and comforted her, and you
10 managed to see her again the next day, but is it right
11 that she died later that day, on 17 January 2021?
12 **A.** Yes, she died about a quarter to three that afternoon.
13 **Q.** You have set out in your statement in very moving terms
14 the sad and distressing experience that your mother had
15 while she was in hospital. One of the issues you raise
16 is whether your mother was provided access to
17 therapeutic treatment whilst she was in hospital?
18 **A.** Yes.
19 **Q.** Something that's of concern to you.
20 **A.** Yes.
21 **Q.** Your mother's story raises a broader issue about
22 vaccines, does it not, and that is about the pace of
23 vaccine development and approval and whether things
24 could have been done quicker?
25 **A.** Most certainly, yes.

1 **Q.** Is that something that is of concern more widely to
2 NICBFFJ members?
3 **A.** It's such a vast group, you know, we have different
4 opinions on this. My opinion at that time, because
5 I was living with my mother, was to protect her. And my
6 mother's opinion was she would take the vaccine to stop
7 her from getting Covid, or the symptoms from being as
8 severe as what we believed them to be. There's other
9 people within the group who don't believe in the
10 vaccines, who are -- believe that the vaccines have
11 maybe caused illnesses. That certainly is not mine.
12 **Q.** One thing you raise in your statement is that you would
13 have quite liked the option for your mother to have
14 received a vaccine --
15 **A.** Oh, yeah.
16 **Q.** -- before it had been through the authorisation process?
17 **A.** Yes, I would have.
18 **Q.** Is that something you think she would have been
19 interested in herself?
20 **A.** I know she would have been, yes.
21 **Q.** I'm going to move through some of the other issues that
22 you raise in your witness statement that are relevant to
23 this module of the Inquiry now, but thank you for
24 sharing that story about your mother.
25 One of the issues of concern to your group is

1 relatives contracting Covid-19 from staff who were
2 carrying out the vaccination programme.
3 **A.** Yes.
4 **Q.** Could you tell us a little bit about the concerns that
5 you have about that?
6 **A.** Well, people within care homes for instance, you know,
7 their family members who were vaccinated, they never got
8 to see their loved ones or got to be with their loved
9 ones. Maybe people within the care homes that were
10 working there hadn't been vaccinated. And it was so
11 hard to get my head round that. My sister at that time,
12 she was working in a care home. And it was also
13 haphazard at that stage. Do you know, there was no
14 uniformity. Some care homes, you were allowed to be
15 with your loved ones. Some, you weren't.
16 **Q.** Another issue you raise in your statement is access to
17 vaccine clinics and vaccination centres for housebound
18 and elderly patients.
19 **A.** That's right.
20 **Q.** That's something that is of concern to your members?
21 **A.** Yes, it is. There's parts of Northern Ireland that are
22 quite rural, and there are people, if you like, they're
23 immobile. They should have had like a mobile --
24 a doctor on call to go out and administer the
25 medication, administer the vaccines. It would have been

1 so much more helpful.
2 **Q.** You're concerned there were missed opportunities --
3 **A.** Absolutely. And again, it was just down to bureaucratic
4 rules, really.
5 **Q.** You've explained that within the group there are
6 different views on different aspects of vaccination.
7 **A.** Yeah.
8 **Q.** The issue of vaccination as a condition of deployment is
9 one that perhaps splits opinion within your group.
10 Could you give us an idea of what the views are?
11 **A.** Yes, certainly there's people that don't believe in the
12 vaccine, that believe that the vaccine could possibly
13 cause more harm than good, but my intentions at that
14 time, I can only really say my intentions, my intention
15 at that time was to protect my mother. I was going to
16 work, I was coming home, and I needed to protect her.
17 So I would have taken anything, regardless. You know,
18 I had no concerns if it was going to do me harm; it was
19 to protect her.
20 **Q.** You question why, in June 2021, when the government in
21 England indicated that vaccines would become compulsory
22 for care home staff, the government in Northern Ireland
23 did not take the same approach; is that something that
24 is of concern to your members?
25 **A.** Absolutely. It was just, as I've said before, it was so

1 haphazard. Nobody knew what the other one was doing.
2 **Q.** Another issue you raise is in relation to public
3 messaging and the clarity and adequacy of public
4 messaging on vaccines and vaccine delivery. And you say
5 that some of your members would like to know whether the
6 Northern Ireland Government's messaging about vaccine
7 efficacy was in terms of absolute or relative risk.
8 It's understanding how those figures were presented to
9 the public. Is that what you want to understand?
10 **A.** Yes.
11 **Q.** Vaccine safety is raised within your statement. You've
12 explained you had no concerns about vaccine safety?
13 **A.** That's correct.
14 **Q.** Some of your members do have concerns. And you wonder
15 whether there's a -- any perceived lack of openness
16 about the process for development contributed to vaccine
17 hesitancy amongst some people in Northern Ireland; is
18 that right?
19 **A.** Yes, absolutely.
20 **Q.** You also raise the issue of disparity in vaccine uptake,
21 in particular as between Health Service staff and staff
22 in care homes. Perhaps this goes back to the haphazard
23 point you were making before?
24 **A.** Yes.
25 **Q.** And you set out a series of recommendations that you

1 would like the Inquiry to consider. Is there anything
2 in particular you want to say today about lessons
3 learned or recommendations you'd like to see implemented
4 in the future, from your group's perspective?
5 **A.** I found that whenever I was in hospital, I can't
6 remember in the time that I was there that I had seen
7 the doctor. It was all nurses. Certain hospitals would
8 have been more willing, shall we say, to let people be
9 with their loved ones than others. I found it very
10 cruel. I found it a very inhumane way to treat people.
11 Again, I'm only talking about my own personal opinion.
12 **Q.** Is it right that you stress, and NICBFFJ stresses, that
13 a partnership approach between patients and patients'
14 families and healthcare providers is important in this
15 context so that there is communication and understanding
16 of these issues?
17 **A.** Yes, good communication skill, yes.
18 **Q.** You also explained that there should be proper
19 engagement by healthcare professionals with patients and
20 patients' families in order to advise and explain on the
21 available therapeutic options --
22 **A.** Absolutely.
23 **Q.** -- perhaps that you felt was missing in relation to your
24 mother?
25 **A.** Yes.

1 **Q.** You also stress the urgent need to develop and trial
2 therapeutics for treating Long Covid?
3 **A.** Yes, definitely, yes.
4 **Q.** And is there anything else you would like to tell the
5 Inquiry today that's relevant to vaccines and
6 therapeutics?
7 **A.** No, that's it.
8 **MR MANSELL:** Okay.
9 Well, my Lady, that concludes the witness.
10 **LADY HALLETT:** Thank you very much, Mr Mansell.
11 Thank you very much, Ms Clarke, for coming along.
12 It sounds as though your mother was a wonderful
13 character.
14 **THE WITNESS:** Yes, she was, yes.
15 **LADY HALLETT:** You must miss her enormously. And Covid has
16 obviously hit your family really hard, and it's hit you
17 particularly hard: you've been hospitalised with Covid
18 and you are still suffering from Long Covid.
19 **THE WITNESS:** Yes.
20 **LADY HALLETT:** So I can imagine how difficult it must have
21 been just for you just to travel here. So thank you for
22 making the effort. You have come from Northern Ireland,
23 have you?
24 **THE WITNESS:** Yes, I have, yes.
25 **LADY HALLETT:** Well, wishing you a very safe journey back

1 and thank you so much for all your help.
2 **THE WITNESS:** Thank you, my Lady. Thank you.
3 (The witness withdrew)
4 **MR KEITH:** The next witness is Anna Miller, please.
5 **MS ANNA MILLER (affirmed)**
6 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 4**
7 **MR KEITH:** Could you commence, please, by giving the Inquiry
8 your full name.
9 **A.** Yes, it's Anna Catherine Miller.
10 **Q.** Ms Miller, thank you very much for attending today, and
11 for assisting the Inquiry. Whilst you give evidence,
12 could I just remind you to try to keep your voice up,
13 and speak as clearly as you can into the microphone so
14 that it can be recorded by the stenographer as easily as
15 possible.
16 **A.** Yes.
17 **Q.** You very kindly provided a witness statement, dated
18 4 October 2024, on behalf of the group whom you
19 represent today, the Migrant Primary Care Access Group.
20 It's INQ000474407.
21 Was that a statement that was prepared jointly by
22 senior employees of the four organisations within the
23 group that you represent?
24 **A.** Yes, exactly.
25 **Q.** Let's just have a look for a moment, if we may, at what

1 those four organisations consist of. The first one
2 comprises Doctors of the World UK. Is that part of
3 Médecins du Monde?
4 **A.** Yes, it's part of the Médecins du Monde international
5 network.
6 **Q.** And what, in essence, is that group concerned with?
7 **A.** So we're an international -- it's the organisation that
8 I work for, and we're an international organisation that
9 provides medical care across the world. Sometimes it's
10 in emergency settings, but also sometimes it's looking
11 at unmet healthcare needs in countries that have fairly
12 well functioning healthcare systems and supporting
13 people who aren't able to access those healthcare
14 systems.
15 **Q.** And are you head of policy and advocacy in fact at that
16 organisation, Doctors of the World UK?
17 **A.** Yes. In the UK, yeah.
18 **Q.** In terms of its functions in the United Kingdom, does it
19 help support a number of individuals enabling them to
20 access NHS services better?
21 **A.** Yes, exactly. We see between 1,000 and 2,000 people
22 a year, and it's always people who are struggling to
23 access NHS services.
24 **Q.** The second organisation is the Joint Council for Welfare
25 of Immigrants. Is that a charitable organisation that

1 advocates for migrant justice?
2 **A.** Yes.
3 **Q.** And, very roughly, how many clients or people on an
4 annual basis does the joint council support? We don't
5 need the precise figure, Ms Miller, roughly will do.
6 **A.** My memory is that I think it's in the same kind of
7 region. I think it's a little bit less than Doctors of
8 the World, I think we're probably talking under
9 a thousand. I'm sorry, I don't know off the top of my
10 head.
11 **Q.** It's not a memory test. You said in your statement that
12 it's around about 200 clients that you help a year.
13 **A.** Right, okay.
14 **Q.** The third organisation is Kanlungan. What is that?
15 **A.** Kanlungan is a consortium of organisations that
16 represent Filipino and South East Asian organisations
17 across the UK.
18 **Q.** And lastly but not least, Medact. What organisation is
19 that?
20 **A.** So Medact is a membership organisation. Most of their
21 members are healthcare professionals, and as an
22 organisation, it works to address, I guess,
23 socioeconomic barriers and health inequalities more
24 generally.
25 **Q.** You're representing today a group which very credibly

1 assists migrant workers, members of the migrant
2 community in the United Kingdom. Could you give us some
3 idea, please, of the numbers. What proportion of the
4 UK population, for example, is made up of people born
5 abroad, foreign-born people?
6 **A.** So it's about 15% of the UK population.
7 **Q.** And just by way of an overview, what particular issues,
8 in terms of vulnerabilities and where they are subject
9 to inequalities and to lack of access to healthcare,
10 does that group of foreign-born people give rise to?
11 What areas and issues and concerns, in very general
12 terms, is your group concerned with on their behalf?
13 **A.** Well, I mean, of course, not all migrants in the UK face
14 adverse socioeconomic conditions and low socioeconomic
15 conditions, so to a certain extent I'm not speaking on
16 behalf of, you know, every single migrant in the UK, but
17 the people who access the services for the organisations
18 that I represent on the whole -- well, without
19 exception -- is people who face extremely adverse
20 socioeconomic circumstances. Most face extreme poverty
21 or even destitution.
22 Their -- the precarity of their situation is
23 exacerbated by insecure immigration status that often
24 prevents them from working legally, so they end up
25 working in dangerous and exploitative conditions.

1 Very, very limited access to housing and accommodation.
2 And also I think it's important to note the level of
3 discrimination, racism and vilification by media, by
4 press, that this -- that the people who we represent,
5 our patients, are also subject to.
6 **Q.** You identify in your statement a number of other
7 prevalent characteristics, that is to say aspects of
8 their life and employment in the United Kingdom, which
9 has given rise to concern generally. Just having
10 a quick look at those, do many of the people whose
11 interests you represent have, for example, chronic
12 mental health issues?
13 **A.** Yes.
14 **Q.** Is there a high degree of social isolation, in
15 particular digital exclusion?
16 **A.** Yes, absolutely.
17 **Q.** What is digital exclusion?
18 **A.** Well, when you look at this group, it's sort of like, in
19 a way a little bit of an unusual form of digital
20 exclusion. I'm generalising here but, like, on the
21 whole, because migrants tend to be younger and they also
22 by default are people who are separated from their
23 country of origin and often separated from family, it's
24 a population that's very reliant on digital
25 communication and actually it's a very -- on the whole,

1 a very digitally literate population. Where digital
2 exclusion comes in for this group, it's entirely linked
3 to poverty and lack of resources. It's not having
4 enough money to put data on your phone. It's being
5 relied on -- it's relying on public access open wi-fi
6 networks all the time, which of course, when the
7 pandemic happened closed, so the digital poverty that
8 existed in the first place was enormously exacerbated
9 once public spaces and public wi-fi closed down.
10 **Q.** Right. And also, does that cohort of people also
11 exhibit high levels of disability?
12 **A.** Yes, that's what the evidence shows.
13 **Q.** All right. Now, obviously one of the sectors that was
14 most -- or amongst the sectors most impacted by the
15 pandemic was those persons who work in hospitality,
16 transport, and the health and social care sectors. Are
17 those sectors in which the people whom you represent
18 are, in fact, overrepresented?
19 **A.** Yes, absolutely disproportionately represented across
20 all of those sectors and a lot of those are frontline
21 sectors.
22 **Q.** And therefore in the course of the pandemic, their
23 operation and the way in which they were affected by the
24 pandemic, not least because of the fact that many of
25 them kept working in those frontline sectors, were

1 issues which you were directly concerned?
2 **A.** Yeah, exactly.
3 **Q.** Let's look for a moment, please, at some of the areas in
4 which you've expressed -- about which you've expressed
5 the greatest concern. Is it fair to say that in
6 a general sense, your statement is quite critical of the
7 United Kingdom Government for failing, as you see it, to
8 implement sufficient measures in good time for the
9 protection of the persons whom you represent?
10 **A.** Yes. Our experience on the whole was that we as
11 organisations, it was left to us to identify and raise
12 issues that the people we represented faced accessing
13 a range of Covid services and just ability to protect
14 themselves from the virus and then, when we did, that
15 that was not -- the issues we raised were not properly
16 considered. We either got no response, often there was
17 no action. We were often left to identify what the
18 solutions would be as well, and even when we proposed
19 solutions, that led to no action, or -- and I think
20 we'll come on to this, sometimes when there was an
21 attempt to act on the information we were providing, the
22 information we were providing, the attempts to do that
23 ultimately were completely undermined and hamstrung by
24 a set of policies that were in place and remained in
25 place throughout the pandemic.

1 **Q.** Let's look at what those policies are. Obviously, when
2 dealing with the government, many of the persons whom
3 you represent came up against the operation of the
4 various policies and procedures and processes that the
5 government had put in place for dealing with
6 foreign-born people. So in essence, immigration
7 policies.
8 Has there been a very significant issue about how
9 immigration policies rub up against public health
10 policies that the government was trying to put into
11 place at the time?
12 **A.** Yes, and I think the key policy to consider and look at
13 here is the NHS, what we call the NHS charging policy,
14 it's the policy to charge people, it's complicated, but
15 people from overseas for NHS treatment. It's extremely
16 complex and extremely uncertain for anybody to know if
17 they're going to end up getting charged, but it is
18 applied to migrants living in the UK. It's complicated,
19 and it depends on what your immigration status is, but
20 it's applied to migrants who are living in the UK.
21 They're not overseas visitors, they're people who are
22 resident in the UK. I won't go into the details of it,
23 but I think the keys things, takeaway things to
24 understand about this policy is that its main impact is
25 deterrents. It keeps people who worry they might -- it

1 might be applied to them from going anywhere near
2 healthcare services and it is partially -- it's
3 partially because the risks associated with the policy
4 are high. It's not just that you're going to get
5 a large bill, if the NHS trust decides they're going to
6 charge you, you get a large bill, and also a 50% fine
7 for accessing that service; it's also that it carries
8 the risk of being reported to the Home Office and for
9 those who don't, you know, for those who aren't migrants
10 and might not understand, being reported to the
11 Home Office runs the risk that you will be put into
12 immigration detention and for some people it runs the
13 risk that you'll be returned to a country that you fear
14 for your own safety in.
15 So this is why what we end up seeing as deterrents,
16 is the risk is too high for a lot of people to go
17 anywhere near healthcare services.
18 And then the second point I'd raise is because it's
19 such a complex policy for individuals, it's nigh on
20 impossible, before you enter a service, to know if you
21 are going to end up being charged or not, because
22 charges apply to some services, they don't apply to
23 others, they don't apply to public health services.
24 But -- this isn't a comment about migrant patients but
25 all patients, they're generally -- people don't

1 understand what type of service they're accessing in the
2 first place, and clinicians always say patients present
3 with symptoms without diagnoses, you might have a good
4 idea of -- you know, you might be fairly confident that
5 what you've got is an infectious disease and therefore
6 you are not going to be charged, but you might not be
7 right about that. It still carries a risk.
8 **Q.** Thank you very much.
9 I'm just going to ask you to just slow down a little
10 bit. We're going quite rapidly through it and it's
11 quite hard for the stenographer to record it all.
12 The bottom line here is that it obviously differs
13 between nation and it differs in terms of particular
14 cohorts, but if you're not ordinarily resident in the
15 United Kingdom, if you don't have "settled" status or
16 citizenship, then you're liable to be charged by the NHS
17 for what are known as secondary or tertiary NHS
18 services; is that right?
19 **A.** Yeah.
20 **Q.** But as a general rule, that liability to being charged
21 for health services doesn't apply to primary care, so
22 for example, treatment in an A&E department, or for
23 infectious diseases; is that right?
24 **A.** Um --
25 **Q.** If they're on a list of prescribed diseases?

1 **A.** Yes; primary care is GP -- and yes, A&E and infectious
2 disease are both also exempt, yes.
3 **Q.** All right. So with Covid, the testing for Covid and the
4 initial treatment for Covid was exempt from the charging
5 regime by and large because it formed part of a primary
6 care service for which migrants would not be liable to
7 pay the NHS. But the problem you've identified is,
8 people don't generally understand that, and therefore,
9 there was a terrible fear that if they went anywhere
10 near the NHS they would end up being reported to the
11 Home Office or the NHS might ask about them about their
12 liability to pay and that would expose them to the
13 attention of the Home Office, is that the nub of it?
14 **A.** Yes, that's -- exactly, yes.
15 **Q.** So there are two issues here. One is the complexity of
16 the system by which people may become liable to pay the
17 NHS; and secondly, the link between the NHS and the
18 Home Office?
19 **A.** Exactly, yes.
20 **Q.** All right. Did the government take steps, as far as you
21 understand, to try to explain that nobody would be
22 liable to pay the NHS for primary care treatment, for
23 testing or treatment, or is it your position and the
24 position of your group that those steps didn't go far
25 enough?

1 **A.** I would go as far as saying essentially no steps were
2 taken. There was -- before the pandemic, there was
3 already an exemption for the testing, treatment of,
4 and -- of infectious disease and vaccinations, and
5 essentially, that was in place before the pandemic,
6 because it applied to other infectious disease. And
7 that was the situation that remained throughout,
8 throughout the pandemic. I would say the one thing that
9 did happen is that a period, I think it was about
10 a month after -- I think it was April -- about a month
11 after the lockdown, the government translated that
12 information about exemptions for public health and
13 specified that Covid was included in that. They
14 translated it into number of languages and hosted it on
15 couple of websites that is not a patient accessible
16 website.
17 That was the extent of what the government did.
18 **Q.** It was a public health website?
19 **A.** It is a public website. It was what was then called the
20 Public Health England Migrant Health Guide which is
21 a guide for clinicians around best practice with migrant
22 patients.
23 **Q.** And the position of your group is that whatever steps
24 the government took to publicise the fact that migrant
25 people were not liable to pay the NHS simply didn't go

1 far enough?
2 **A.** Yes. Eventually, when there was, I suppose, an attempt
3 to, like, actually get it out into the public more, that
4 was not until February 2021. So it was only once really
5 the vaccine rollout programme came in that there was any
6 serious attempt that actually people needed to receive
7 this information, even though, you know, we'd had the
8 best part of a year of people being at risk and needing
9 to know about the exemption.
10 So it wasn't until then, and at that point the
11 government briefed the Daily Mail, and then a little bit
12 later the BBC, and that was pretty much the extent
13 of it. Those are not places that -- you know, that's
14 not a well thought through attempt to reach migrant
15 communities. Those are not places where migrants in the
16 UK tend to get their information from. So that was the
17 extent of it.
18 **Q.** Did your group carry out research to try to understand
19 the extent to which migrant people avoided even getting
20 healthcare or treatment or testing for Covid as a result
21 of either ignorance as to what the position was
22 concerning liability for payment, or because of a fear
23 that if they engaged with the NHS their details would be
24 passed on to the Home Office?
25 **A.** Yes.

1 **Q.** What level of lack of understanding or fear was there in
2 terms of a willingness to seek healthcare?
3 **A.** Yes. Right at the beginning of the pandemic we did
4 a rapid needs assessment, which included migrant
5 communities with it, and that identified the fear around
6 the NHS and the fear of charges as a key barrier to
7 coming forward. And then later on in the pandemic, both
8 the Medact and the Joint Council for the Welfare of
9 Immigrants, they both carried out separate pieces of
10 research but they were both essentially surveys of
11 healthcare staff and also of migrants themselves, and
12 they both found -- one slightly above, one slightly
13 below -- 50% of respondents said that migrants wouldn't
14 go forward to the NHS because of fear of charging and
15 also data sharing.
16 **Q.** On the subject of data sharing, in very general terms,
17 the way in which the system worked then was if a migrant
18 sought healthcare from the NHS, for something that --
19 for healthcare that they were obliged to pay for, so
20 secondary, or tertiary treatment, and they didn't pay
21 the amount that was owing, was it then open to the NHS
22 service to seek details from the Home Office as to their
23 liability for payment, their immigration status, and
24 essentially start the ball rolling in terms of trying to
25 find out why they hadn't paid what was owing? Is that

1 the nub of it?
2 **A.** It's slightly different.
3 **Q.** Please?
4 **A.** So the information flow actually goes the other way. So
5 once an NHS trust has applied charges to somebody and if
6 they're over £500 and their bill isn't cleared --
7 **Q.** Slow down, please, if you can.
8 **A.** If the bill isn't cleared within two months, the
9 NHS trust is then obliged, through Department of Health
10 guidance, to report the details of this debt and the
11 person who holds the debt to the Home Office. The
12 Home Office then uses that information, it's able --
13 it's a primary grounds to refuse certain types of
14 immigration application, so it means, for some
15 individuals, having incurred an NHS debt ends up meaning
16 your chances in the future of regularising your
17 status --
18 **Q.** Are reduced?
19 **A.** Are reduced.
20 **Q.** But the first step is taken by the NHS. Because it's
21 the NHS who are owed the money, they will take the first
22 step to contact the Home Office to find out what the
23 position is?
24 **A.** Yes. First of all, yes.
25 **Q.** Did the government, during the pandemic, announce or say

1 to NHS trusts in England, or across the United Kingdom:
2 if persons without settled status or citizenship have
3 sought treatment for Covid or testing for Covid, they
4 will incur no debt, and therefore you have no need to
5 contact the Home Office to find out what the position is
6 with their immigration status because there is no debt
7 owing, there is no money due to be paid?
8 **A.** That is essentially what Department of Health was
9 relying on. They were relying on and hoping that
10 invoices wouldn't be raised because it's meant -- Covid
11 services or certain Covid services were meant to be
12 free, and therefore they wouldn't -- because an invoice
13 wasn't raised, there would be no debt to pass on to the
14 Home Office. That's what they -- that's what they were
15 relying upon.
16 The extent to which they communicated that to
17 hospitals, I mean, I don't know everything, but
18 everything that I saw that went to NHS trusts was just
19 around reminding them that Covid -- you know, certain
20 Covid services were exempt and there would be no need to
21 raise bills.
22 I never saw any direct communication to NHS trusts
23 that reiterated the point about not sharing data or
24 taking particular care not to share data.
25 **Q.** But if no money was owed to the NHS, if there was no

1 debt, then there would be nothing for the NHS trust or
2 the primary service to speak to the Home Office about,
3 because there would have been nothing to engage them?
4 **A.** Yes, exactly. But could I just outline --
5 **Q.** Please.
6 **A.** -- what the problem with that was?
7 **Q.** Yes.
8 **A.** Okay, so the NHS charging programme, the way it's
9 applied, errors are really commonplace. We run
10 a specific service supporting people who have been
11 charged for NHS services, and 20% of our cases are just
12 purely that the NHS trust has charged for a service that
13 should have been free. And one of the reasons, it's --
14 mistakes are partially because this is -- it's
15 an immensely -- it's immensely complicated for
16 NHS trusts to apply somebody's immigration status over
17 the service, so sometimes it's due to the complexity,
18 but it's also partially due to the fact it's the heavily
19 automated system. Once one NHS trust has flagged on
20 your record that you've got some type of insecure
21 immigration status, that stays on your record, and any
22 other NHS trust will see it.
23 And the way that it usually operates is that a role
24 within the finance team will see when somebody has
25 a hospital episode, and it's been flagged that they

1 might have insecure immigration status, they will start
2 the ball rolling on issuing letters and generating
3 invoices.
4 So this is not clinicians and public health doctors
5 sitting around and carefully thinking: oh, well, that's
6 a public health service, so don't charge for that. It's
7 how -- the default is you get -- if you've got one of
8 these flags on your record, the default is you get
9 charged for stuff, and the onus is on you then to
10 demonstrate why the service shouldn't have been charged
11 for or why you, as an individual, should have been
12 exempt from it. So --
13 **Q.** And you've referred just now to 20% of your cases --
14 **A.** Yeah.
15 **Q.** -- being instances in which migrant people were charged
16 for NHS treatment --
17 **A.** Yeah.
18 **Q.** -- for which they shouldn't have been charged.
19 Can you tell us how many of those cases related to
20 migrant people being charged for Covid-19-related
21 testing or treatment for which they shouldn't have been
22 charged? Because obviously we're concerned with the
23 vaccination, therapeutic and provision of medicine to
24 migrant people in the course of the pandemic.
25 **A.** I can't say within that, and also within that cohort of

1 people, I would say few to none, just because of the
2 timeframe for that. That is a report that we published
3 in 2020, so fairly early on the pandemic. There might
4 have been one or two Covid cases in that cohort. So
5 I can't honestly say about that. But since then, we
6 have seen patients charged for Covid services, charged
7 for services --
8 **Q.** Do you mean for long-term health conditions, for
9 example?
10 **A.** Long-term health --
11 **Q.** Long Covid or chronic conditions which have resulted
12 from Covid --
13 **A.** Yes --
14 **Q.** -- as opposed to initial treatment in A&E?
15 **A.** Well, sometimes --
16 **LADY HALLETT:** I think I've got the point on this issue,
17 Mr Keith. I think we need to move on.
18 **MR KEITH:** All right.
19 **A.** Sorry, the answer is yes, I've even seen an NHS trust
20 pursue charges for a vaccine. So yes.
21 **Q.** In your statement you say that one of the things that
22 you've campaigned for is for the government to put into
23 place a firewall between the NHS and the Home Office.
24 So it's not enough just to rely upon the government to
25 tell the NHS what to do. Is that an issue which you've

1 raised with the government and you've sought their
2 response as to whether or not such a firewall should be
3 implemented?
4 **A.** Yes, multiple times, and the Health and Social Care
5 Select Committee carried out an inquiry into this
6 in 2018.
7 **Q.** All right.
8 The next issue, broad area, raised in your statement
9 concerns the GP registration system. By and large, in
10 the vaccination process, in order to book a vaccination,
11 patients would have to provide an NHS number. And is it
12 the position that many of the people whose interests you
13 represent do not have or have to no access to getting an
14 NHS registration number? Is that the problem?
15 **A.** Yes, our patients are routinely refused GP registration,
16 even though they're entitled to it. The vast majority
17 of our work is actually supporting people to get
18 registered with a GP once they've come to us for initial
19 medical care.
20 **Q.** Again, was this an issue which was pursued by your group
21 during the course of the pandemic when it became
22 apparent that there were migrant people who weren't
23 being offered vaccination or if they wanted vaccination,
24 couldn't get it because they had no NHS registration
25 number?

1 **A.** Yes. Right from the beginning of the pandemic, we
2 raised it as a sort of access to healthcare issue that,
3 you know, people need a GP and needed access to a GP,
4 but once it became clear to us that the way the vaccine
5 model -- the way access to the vaccine was being
6 organised and that it was going to be dependent on the
7 national booking system, at that point we then began to
8 flag the issue about if you don't -- so it's important
9 to note, with migrants the only way you're issued an NHS
10 number is by registering with a GP. If you're born in
11 the UK you get it at birth but if you're born outside
12 the UK you have to register with a GP. That's what
13 generates an NHS number for you. And so then we were
14 aware that our patients are largely not -- or people
15 just before they're our patients, are not registered
16 with a GP and so therefore they wouldn't have an NHS
17 number. So once we realised the vaccine -- the main way
18 people were going to access to the vaccine was through
19 the national booking system, and that you had to have an
20 NHS number to be able to use the national booking
21 system, we were -- we became aware that our patients
22 were going to be completely excluded from the vaccine
23 rollout.
24 **Q.** In very general terms, what steps did the government
25 take to make it known that you could get a vaccine

1 without an NHS number for which you'd have had to have
2 been registered with a GP? Was there any kind of
3 announcement made or any publicity given to a solution
4 to this problem?
5 **A.** Yes. So in February 2021, I referred to the fact that
6 the government briefed the Daily Mail and the Daily Mail
7 then ran a front page story the next day saying,
8 "Vaccine amnesty for migrants". So that was -- yes,
9 that was the first step. But at that stage, all of the
10 messaging was, it was about an amnesty, which was quite
11 confusing because we usually associate that with an
12 immigration amnesty, but also it didn't deal with -- it
13 essentially was just saying to people, "Go along, just
14 go along, get the vaccine", and, you know, eventually
15 when the messaging refined slightly because we raised
16 issues about the data sharing issue, the messaging was
17 refined slightly to say: there will be no immigration
18 checks.
19 And this goes to the core issue about the fact that
20 the government had -- the Department of Health had made
21 the decision not to put in place a firewall, actually
22 just to not -- to stop sharing information with the
23 Home Office, which meant that, and we raised this a
24 number of times, it meant that they were never able to
25 say, "There is a guarantee that your information won't

1 be shared". They just said, "No checks will be carried
2 out at vaccine centres."
3 So that's quite different situations --
4 **Q.** Just pausing there. Are you aware of communications
5 sent by the government, probably the DHSC, or in
6 England, Public Health England, to vaccination centres,
7 pharmacies, GPs, NHS commissioning trusts, and in the
8 other -- and in devolved administrations, to their own
9 NHS boards, saying: it is possible to, and you should be
10 able to offer, vaccination without the production of an
11 NHS number?
12 **A.** Yes, NHS England did that, but my point is that didn't
13 reflect what the reality was, is that they were putting
14 out that, they were just putting out sentences saying,
15 "No NHS number needed", but until June 2021 there were
16 eligibility criteria for the vaccine associated with
17 age, and the way that was then managed was that you
18 would go online and book it through the national booking
19 system. That was always the process to make sure that
20 people within the right age cohorts were able to access
21 the vaccine. But people without an NHS number couldn't
22 do that. So essentially the whole, just like, "No NHS
23 number needed", what that basically meant was wait until
24 June until it becomes completely open access, and
25 then --

1 **Q.** So what you're saying is, in terms of the minutiae, the
2 detail in which the prioritisation system was operated,
3 difficulties arose in terms of a lack of an NHS number
4 because in order to be able to get priority status to
5 which they were entitled, they needed that number?
6 **A.** Yes.
7 **Q.** All right. The next topic which you raise in your
8 statement, again on the subject of prioritisation, is
9 that, did you raise with the government your concern
10 that migrants were not given priority status in that
11 first priority 1 group -- that first phase group? So,
12 for example, there were a number of categories, not just
13 stratified by age, but by, for example, work in the
14 health and social care sector, who were given priority
15 status. Did you advocate for migrant people to be given
16 priority status?
17 **A.** It was never our position that all migrants should be
18 given priority status. That was never our position.
19 There was one more specific point which was in relation
20 to people who are in the asylum system and are in
21 accommodation provided by the Home Office on account of
22 the fact that they would otherwise be destitute, and
23 that is often hotels, during the pandemic, the
24 government started using military sites, barracks, 26
25 people in a room, sleeping in -- well, in a barracks

1 together. It was that setting where -- and it wasn't
2 just us. JCVI and NHS England both put out direction
3 and guidance to local health teams that they could and
4 should be considering asylum accommodation, destitution
5 settings like that, within their local area, when they
6 were carrying out the vaccine rollout, and there was
7 guidance from JCVI that homeless accommodation should be
8 considered as part of cohort 6.
9 **Q.** Right.
10 **A.** So our point was that asylum accommodation should have
11 been considered as part of cohort 6.
12 **Q.** So in essence, there was a particular vulnerability in
13 the context of asylum accommodation --
14 **A.** Yes.
15 **Q.** -- that merited priority being given in cohort 6, which
16 was one of the priority phases --
17 **A.** Yes.
18 **Q.** -- obviously number 6.
19 The last area I want to ask you about is this,
20 please: much of your statement is concerned with the
21 issue of whether or not there are systemic inequalities
22 and pre-existing barriers in the way of migrant people
23 preventing them from getting access to healthcare
24 services and, in particular, Covid. Is this a topic
25 which has long been the concern of your group and which

1 has been raised with the government on a multitude of
2 occasions, to this effect: that as a matter of policy,
3 the government needs to do more to try to reduce
4 barriers and prevent discrimination and inequality by
5 focusing more on the specific needs of the people whom
6 you represent? Is that the nub of it?
7 **A.** Yes, yes.
8 **Q.** And is that something which you continue to engage the
9 government with?
10 **A.** Yes, yeah, absolutely. And I was -- it's not just about
11 doing more, it's about highlighting and properly
12 considering the impact of a number of policies that the
13 Department of Health run that deter and prevent people
14 from being able to access NHS services.
15 And also, the thing that was unique and really
16 brought to focus during the pandemic was how much these
17 policies presented a public health risk -- policies I'm
18 talking about are NHS charging and the data sharing --
19 how much these policies present a public health risk and
20 put the whole population at risk.
21 Public Health England had continually advised
22 government that these types of policies were a public
23 health risk, but that advice was overlooked before the
24 pandemic and it was overlooked during the pandemic.
25 And I think, if I may, a final point I'd like to

1 just point out is how extraordinary these policies are.
2 The Médecins du Monde network runs clinics like ours all
3 across Europe, and I have a very good idea of healthcare
4 entitlement policy across Europe. The UK is an outlier
5 in terms of the extent to which people are charged and
6 punished for accessing NHS services and this very
7 interconnected way in which health data is used to
8 support immigration enforcement.
9 It's really important to not view that as an
10 immigration policy, and also not to view that as an
11 essential or even a normal part of a healthcare system.
12 **MR KEITH:** Ms Miller, thank you very much. I'm going to
13 have to ask you to leave it there. Obviously the widest
14 provision of NHS services is outside the scope of this
15 Inquiry. We are concerned with vaccination and
16 therapeutics. But that's very helpful, thank you very
17 much indeed.
18 **LADY HALLETT:** Thank you very much indeed, Ms Miller. Thank
19 you for your help.
20 **THE WITNESS:** Thank you.
21 (The witness withdrew)
22 **LADY HALLETT:** Very well, we shall break now for lunch.
23 I shall return at 1.50.
24 **(12.50 pm)**
25 **(The Short Adjournment)**

1 **(1.50 pm)**
2 **LADY HALLETT:** Mr Keith.
3 **MR KEITH:** My Lady, the first witness this afternoon is
4 Sam Smith-Higgins, please, who will be attending online.
5 Thank you.
6 **MS SAM SMITH-HIGGINS (affirmed)**
7 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 4**
8 **LADY HALLETT:** We've met before, Sam Smith-Higgins, so thank
9 you very much indeed for joining us this afternoon.
10 **THE WITNESS:** Can I please apologise for not being there in
11 person, I find it really disrespectful when people don't
12 appear in person but my husband is going through cancer
13 treatment, daily cancer treatment, and obviously I have
14 to drive him and what have you, so it was just
15 impossible this time but I do apologise and thank you
16 for letting me appear remotely.
17 **LADY HALLETT:** No apology necessary, I don't consider it any
18 kind of disrespect, and I do hope the treatment works.
19 **THE WITNESS:** Thank you. Me too.
20 **MR KEITH:** Ms Smith-Higgins, could I start, please, with
21 some of the formalities. Could you give the Inquiry
22 your full name, please.
23 **A.** Sam Smith-Higgins.
24 **Q.** Thank you very much.
25 You've kindly provided a witness statement dated

1 7 February 2024, which you've signed. It contains, as
2 is absolutely usual, a statement of truth declaring to
3 the truth of the facts in your statement. And the
4 reason why you've provided that statement and why you're
5 giving evidence today is that you were one of the
6 co-leaders of Covid-19 Bereaved Families for
7 Justice Cymru?
8 **A.** That's correct.
9 **Q.** Together with Anna-Louise Marsh-Rees, whom we had the
10 pleasure of hearing in, I think, modules 1 and 2 and 3.
11 **A.** That's correct.
12 **Q.** Your group, Mrs Smith-Higgins, Covid-19 Bereaved
13 Families for Justice Cymru, originated I think as an
14 autonomous group. It separated from the UK group in
15 July 2021, and it's dedicated itself to campaigning for,
16 and giving a voice to, those bereaved by Covid-19 in
17 Wales; is that right?
18 **A.** That's right.
19 **Q.** I think you're the most prominent organisation in Wales
20 involved in the discourse, as you describe it,
21 surrounding the Covid-19 pandemic?
22 **A.** We certainly are.
23 **Q.** And could you just say something briefly, please, about
24 your primary aims. You've referred in your witness
25 statement to the fact that there is an urgent and

1 burning and utterly understandable need to understand
2 why decisions were made as they were, and for errors to
3 be acknowledged, recognised, and learnt from. Is that
4 a fair summary of the primary aim of your group?
5 **A.** It is. It is. And also to get change. You know, at
6 the moment Covid, flu, are still rampant throughout
7 healthcare settings in Wales. We desperately need
8 change there. We have changed for -- made change for
9 bereavement services in Wales already, so yeah, we've
10 got many aims.
11 **Q.** You, sadly, have been bereaved, and may I ask you,
12 please, about your farther.
13 **A.** Sure.
14 **Q.** He was 73, was he not, when he was admitted into
15 hospital in January 2021 for cancer-related reasons.
16 Had he been vaccinated when he went into hospital?
17 **A.** No. So my dad, Phil Smith, was diagnosed just as
18 lockdowns came in with prostate cancer. Two consultants
19 wrote on his notes that he had prostate cancer but he
20 wasn't told for six months, by which time the cancer had
21 spread. In January, it was fairly routine for him to be
22 admitted on 5 January for treatment to reduce oedema,
23 and I knew he would be in by -- for up to two weeks.
24 And when he was admitted I asked there and then if he
25 could have the vaccine, and I was told no. I asked if

1 he could have HEPA filters. No, he couldn't that have
2 any of that. And so I kind of knew that he was going to
3 catch Covid within the next two weeks. It was, you
4 know, undoubted.
5 **Q.** It was rife, of course, at that stage.
6 **A.** It really was. And the vaccinations had started coming
7 out on 8 December, and I'd -- you know, I was a carer
8 for an 85-year old, my mother, as well, and so
9 I expected her to be, sort of, vaccinated relatively
10 soon, but as December went through, I was tweeting like
11 mad everybody, MPs, MSs, head of NHS, saying: What is
12 going on? Why hasn't my mother been vaccinated? And it
13 soon became apparent that actually, in Wales, they were
14 focusing on the healthcare workers and not the -- you
15 know, the aged or the most vulnerable.
16 By 11 January, Cardiff and Vale health board tweeted
17 that up to date, up to 11 January, they had vaccinated
18 12,300 people, of which 69 were in care homes and only
19 75 were over 80. The rest were all healthcare workers.
20 So, you know, I'm watching the TV, getting angry
21 because I'm seeing people on the TV being vaccinated,
22 healthcare workers, they don't even live in my health
23 board area, having vaccinations just simply because they
24 work for that particular health board.
25 **Q.** And of course you are father, who was then 73, wasn't

1 a care home resident, he wasn't over 80, and therefore
2 he wasn't in the first two priority lists for
3 vaccination but he was vulnerable because he was in
4 a hospital where Covid was rampant?
5 A. And this is the point. He was under the Velindre cancer
6 hospital, which is the -- *the* cancer trust in Wales, and
7 they didn't introduce testing for their patients until
8 I think they sent out -- started sending out invitations
9 mid-January. It was all too late. For those seven
10 weeks from when vaccinations were introduced, it was --
11 its focus was on keeping healthcare workers working. It
12 wasn't about saving lives or saving people like my dad,
13 who were going into what was and still is the most
14 likely place you'll catch Covid, which is a hospital in
15 Wales.
16 Q. And Mrs Smith-Higgins, he sadly died on 26 January. Did
17 you, terribly, in fact, receive a letter following his
18 death inviting him to attend for vaccination?
19 A. That's correct. It was all bittersweet. As I say, we
20 knew he was going to catch Covid while he was in there.
21 It was hot, unventilated; it was rife in there, and we
22 just knew he was going to get it.
23 Q. So is one of the main issues which you've sought to
24 raise on the part of your members and of your group, and
25 perhaps the main issue, judging by your statement, the

1 issue of the pace of vaccine delivery in Wales?
2 So it has a number of aspects. One of them you've
3 touched upon already, is whether or not there was
4 a decision or policy such that allowed health and
5 careworkers to be vaccinated in advance of vulnerable or
6 elderly people, and, secondly, whether or not the
7 programme for vaccination in Wales delivered vaccination
8 as speedily as was reasonably possible at that time?
9 A. Absolutely. It was their -- a policy for keeping people
10 in work or keeping people alive. Because, you know,
11 vulnerable person weren't being vaccinated, fit and
12 healthy careworkers were being vaccinated. So, you
13 know, what was it? Saving lives or keeping them in
14 work?
15 Q. You refer also in your statement to another related
16 issue, which is that in January 2021 the Welsh
17 Government sought to stagger the rollout at one stage in
18 order to ensure that the persons who helped with the
19 process for vaccination, such as vaccinators, weren't
20 left with nothing to do. They were concerned about the
21 prospect of delivering so many first doses that they ran
22 out of vaccines to deliver. Is that an issue which your
23 group is concerned about?
24 A. Well, it is, you know, the fact that they apparently
25 only had two places in Wales where they could store

1 these vaccinations is a huge concern. I don't know what
2 else to say about that, really, it just makes no sense,
3 does it? You know.
4 Q. Another area, and you've touched upon prioritisation
5 already, is that a number of your members have expressed
6 concern, have they not, about people they know being
7 missed off the prioritisation list as a sector, as
8 a cohort, or members -- you also have concerns about
9 members who were on the list, they should have had their
10 vaccination prioritised but they weren't invited to
11 attend for vaccination?
12 A. Yeah, well --
13 Q. Are there a number of people in that category in your
14 group?
15 A. Absolutely. As you'll have come to learn by now through
16 all the modules, data in Wales is appalling. We have
17 a serious issue here with data, stats. At the last
18 module they were trying to identify people by the -- the
19 flavour of their surname as to whether -- we've a real
20 issue with data in Wales.
21 Q. And would your group be assisted by hearing evidence on
22 the subject of those persons who suffered from severe
23 asthma and whether or not they were prioritised over
24 those with moderate asthma, whereas in fact anybody
25 suffering from asthma should have been classified as

1 clinically vulnerable, and in a particular group for
2 vaccination?
3 A. It's a particular concern for me because I am asthmatic
4 and I do use two steroid inhalers per day, but I wasn't
5 classed as having a sufficient respiratory problem to be
6 classed as vulnerable. So yeah, for me, if I'd caught
7 Covid, then I would have been in serious trouble, I'm
8 sure.
9 Q. A particularly contentious issue you know is VCOD,
10 vaccination as a condition of deployment, and you'll be
11 aware, I know, that the English Government introduced
12 a policy of mandatory vaccination for key workers in
13 resident care homes in CGQ registered homes, but the
14 other four nations, the other home nations didn't in
15 fact introduce a policy of vaccination as a condition of
16 deployment. Where do your members stand on this issue?
17 Do they regard the non-implementation of such a policy
18 in Wales as a failure or was the decision not to follow
19 the English lead in having such a policy the right
20 course, do you think?
21 A. There's mixed views from our families, and basically
22 what they want is clarification on how our government,
23 having received the exact the same information as
24 Westminster government, took a different decision. You
25 know, in Wales private care homes were implementing VCOD

1 anyway, so for us it's clarification on what was the
2 process, what were the thoughts?
3 Q. In Wales during the pandemic were you conscious of
4 community pharmacies being properly utilised for the
5 purposes of delivering and rolling out vaccines?
6 A. No. Again, not at all. As I say, pharmacists had to
7 apply to give out vaccines. It wasn't an automatic
8 thing. There were barriers put in there. And to date,
9 I, you know, you still don't go through community
10 pharmacies for such things here.
11 Q. Were there problems, as far as you could tell, with the
12 rollout of vaccines in deprived areas in Wales, and also
13 rural areas where obviously there were a great deal
14 more, there's a great deal more difficulty in terms of
15 the barriers there to getting to a vaccination centre or
16 perhaps getting to a GP, or to a community pharmacy?
17 A. Absolutely. I live in Cwmbran and one of the mass
18 vaccination centres was actually here in our town. It
19 was the one that Boris Johnson visited actually, and
20 even for us, under Aneurin Bevan Health Board, the
21 health board area is huge, and so for example, somebody
22 travelling from Ebbw Vale would have to travel in the
23 calculator for 40 minutes to get to that vaccination
24 centre in Cwmbran. Somebody travelling by bus would
25 have to catch numerous buses and it would probably take

1 them an hour-and-a-half.
2 Now, for people who have been, you know, shielding
3 for months and months and months, to suddenly have to
4 take an hour-and-a-half journey within the same health
5 board to then stand outside for an hour-and-a-half
6 queuing to get into a sports centre, it wasn't the best
7 thought out, to be honest.
8 Q. Your statement also refers to a number of other groups
9 of people who had difficulties in terms of being able to
10 be offered vaccination or to take up the offer of
11 vaccination. Are two such groups about whom particular
12 concern has been expressed to you those suffering from
13 disabilities, disabled people, and also a particular
14 cohort of unpaid carers? Are they two groups of people
15 whose constituent members have often raised their
16 worries to you?
17 A. Yeah, again, you've hit the jackpot here, because I'm
18 also an unpaid carer. There is no registry of unpaid
19 carers in Wales, no -- there's no register of care
20 homes, actually, either. But there's no register of
21 unpaid carers. It's really difficult to prove that
22 you're an unpaid carer. I had to fill in a power of
23 attorney to get my GP to believe me, that I was actually
24 an unpaid carer. I escorted my mother to get her
25 vaccination. I should have been vaccinated at the same

1 point, really, I believe. There were so many of us
2 unpaid carers there with older people, taking them in,
3 it just seemed nonsense at the time.
4 Q. Your statement also refers to concerns expressed by your
5 members about the extent of disinformation and
6 misinformation that was prevalent in Wales. Is that
7 a subject matter or a concern that's widely held in your
8 group, or is that something on the outer margins of
9 their core concerns?
10 A. Well, the misinformation, you know, for our families,
11 the vast majority of us are -- were sort of, you know,
12 if you've watched somebody die of Covid, you will take
13 a vaccination to prevent that. We were all of the same
14 sort of thought: get it in our veins. We weren't
15 hesitant in any degree. But, that said, in Wales, there
16 is hesitancy, and the approach taken by Welsh Government
17 clearly wasn't good enough because Muslim Doctors Cymru
18 had to take it upon themselves to go out there and start
19 trying to educate themselves, you know, their own
20 communities, with videos and what have you. So there's
21 definitely work to be done there.
22 Q. Would you like to see the systems for reducing barriers
23 and increasing confidence in vaccines improved in the
24 future?
25 A. Yeah, absolutely. You know, as I say, the data is

1 really bad in Wales. You know, in England you'll have
2 an NHS App with all your information on there, your
3 vaccine history and what have you. We haven't got that
4 here. We've got, you can see the last medications you
5 ordered and possibly, with a bit of luck, book an
6 appointment in four months' time for a GP. So, you
7 know, our data, we are streets behind where you are in
8 Wales [sic], and that is a barrier. You know, you
9 couldn't do anything electronically to rebook your
10 appointment, for example. You had to call and go
11 through all that process, and, you know, it wasn't made
12 easy to have a vaccination in Wales.
13 Q. All right. Finally, and certainly not least, a vital
14 part of the pandemic story is of course the provision of
15 existing and new therapeutics for those who couldn't
16 take vaccines, the immunocompromised, for example, or
17 those for whom vaccines would not bring a substantial
18 benefit. Have a significant number of members of your
19 group asked about whether or not the systems for
20 developing and researching, manufacturing, and making
21 available new and existing therapeutics were properly
22 operated; that everything was done, in essence, that
23 could be done in order to make therapeutics available?
24 A. Yeah, hundred per cent. And two points to make on that.
25 The timeframe for vulnerable people to get their

1 therapeutics, their antivirals was five days. You had
2 to allow two days to get the test sent off and get your
3 results back, which left a three-day window for most
4 people. That was really tight trying to arrange to get
5 to the place where they would do it.
6 And secondly, my dad was transferred to a Covid ward
7 on 21 January. Before he went onto that ward, I said,
8 "Great, are you going to pump him up with antivirals,
9 steroids? Are you going to get him the fittest you
10 can?" "Oh, we'll see."
11 He didn't have anything until the day before he
12 died, and that's when they gave him dexamethasone.
13 So, you know, for a lot of our families they didn't
14 receive anything. They were lucky to get oxygen. So
15 yes. Work needs to be done.
16 **MR KEITH:** Thank you very much for your assistance.
17 **LADY HALLETT:** Thank you very much indeed,
18 Mrs Smith-Higgins. Given all that you've been through
19 and you're going through, I'm particularly grateful to
20 you for giving us your help. I hope that now you've
21 given this help -- we might be hearing from you again in
22 the future, I don't know -- but please just focus on
23 trying to get your husband through the treatment and
24 we'll keep everything crossed for you.
25 **THE WITNESS:** Thank you very much, and again, my apologies,

1 you know I would have been there if I could.
2 **LADY HALLETT:** I know. Thank you.
3 (The witness withdrew)
4 **MR KEITH:** My Lady, the next witness is Ruth O'Rafferty,
5 please.
6 (Off the recorded administrative discussion).
7 **MS RUTH O'RAFFERTY (affirmed)**
8 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 4**
9 **LADY HALLETT:** I hope you haven't been waiting too long,
10 Ms O'Rafferty.
11 **THE WITNESS:** Not at all.
12 **MR KEITH:** Can we start, please, with the formality of
13 inviting you to give your full name.
14 **A.** Yes, my name is Ruth O'Rafferty.
15 **Q.** Thank you very much.
16 Thank you for attending today, Mrs O'Rafferty, and
17 for assisting the Inquiry. You've kindly provided what
18 can only be described as very lengthy witness
19 statements, two witness statements, in fact. The first
20 one dated August 2024 and then much more recently, quite
21 late in the day, a very lengthy, I think a 271-page
22 additional statement. But a great deal of care and time
23 and trouble has obviously gone into the preparation of
24 those documents. Thank you very much for those. You've
25 signed both of them.

1 I'd like to start your evidence, please,
2 Mrs O'Rafferty, by asking you to tell us something about
3 the Scottish Vaccine Injury Group, whom you represent
4 today. We understand that it was initially formed to
5 apply for Core Participant status in the Scottish
6 Inquiry, not the UK Inquiry but the Scottish Inquiry,
7 but, perhaps more importantly, to provide tailored
8 support for Scottish people who had suffered an adverse
9 reaction to any of the Covid-19 vaccines; is that right?
10 **A.** That's correct.
11 **Q.** Within your group do we presume, therefore, that there
12 are people who suffered injury as well as those who,
13 worse, suffered bereavement following vaccination?
14 **A.** Yes, we have both. The majority suffered vaccine
15 injury.
16 **Q.** Can you give, please, the Inquiry some idea of the size
17 of the Scottish Vaccine Injury Group? How many
18 interests or how many people are you representing and
19 how many people are you looking after their interests
20 for?
21 **A.** Currently just approaching 750 people. We have
22 about 680, I believe, in the Facebook group and then we
23 have a number of individuals who have joined us for the
24 Inquiry, so we just message each other and keep in touch
25 by email.

1 **Q.** You have set out in your witness statement -- we might
2 have it up on the screen, please, it's INQ000497102 --
3 at paragraph 3, the extremely worthy aims of your
4 group's. I would just like to ask you about some of
5 them?
6 You refer in paragraph 3(a) to the aim of preparing
7 for the Scottish and United Kingdom public inquiries,
8 that's self-evident, and you refer in (b) to the support
9 and encouragement, to which you've referred, for those
10 who have suffered adverse reactions, and you refer to
11 the Facebook group in (c).
12 At (d) you refer to the sharing of up-to-date
13 information on treatments and therapies. Presumably
14 that's a matter of great importance to the members of
15 your group, because you'll be privy, no doubt,
16 necessarily, over the passage of time, to much more
17 information and detail on treatments and therapies which
18 you've come across which you can disseminate to their
19 great assistance.
20 **A.** Exactly. And there is a lot of treatments which would
21 be viewed, I suppose, as alternative treatments, like
22 infrared, near-red light panels, hyperbaric oxygen
23 therapy, things that wouldn't necessarily be recommended
24 on the NHS, and we're part of a global coalition of
25 vaccine injury groups, so we share things with each

1 other globally, which is very useful.
2 Q. At (e) you seek to refer to the aim of raising awareness
3 of vaccine injury to the public media, political arena
4 and healthcare system.
5 I referred in my opening, as you probably know, to
6 the public interest in trying to reduce the
7 stigmatisation, of which you speak in your witness
8 statements, surrounding those who believe themselves to
9 have been injured by a vaccine. Is this aim to raise
10 awareness of vaccine injury there because are many
11 people who doubt whether in fact the vaccines cause
12 injury? And of course it's a very strongly held view on
13 the part of your members that they have to a large
14 extent been ignored?
15 A. Yes.
16 Q. Is that the nub of this?
17 A. Yes. There's been a lot of censorship. In fact,
18 Mark Zuckerman's *(sic)* in fact openly talked about how
19 Facebook removed anything related to vaccine injury. So
20 we -- what we experience when we go into medical
21 appointments are medical professionals who have not seen
22 evidence of vaccine injury in social media or the
23 mainstream media, so we're actually met often with quite
24 a lot of disbelief. And actually we did a survey in our
25 group to find out how doctors seem to feel about vaccine

1 injury, and 46% of them said -- or 46% of the
2 respondents said that even though doctors said to them
3 "Yes, we think this was the vaccine that caused this",
4 they didn't write it in their medical notes. There's an
5 element of fear there that if you speak out against the
6 vaccines you're going against societal or cultural
7 expectations that the vaccines are wonderful.
8 Q. All right. Is it in part because your members feel that
9 they're not being heard, they're not being listened to,
10 and also that there is a degree of ignorance or
11 suspicion, perhaps, about the injuries that they've
12 suffered, that you have, as you set out at (g), also
13 sought to campaign for specialist funded research and
14 specialist centres so your members can receive the
15 treatment for the injuries which they believe they've
16 suffered from vaccines?
17 A. Yes.
18 Q. Right.
19 A. In fact, in Germany there are specific units that
20 research vaccine injury and Long Covid, both, because
21 there is an overlap in symptoms. And we feel that
22 because these were novel technologies that were used for
23 the vaccines, there will be side effects that maybe will
24 be unexpected, and we're very surprised, actually, that
25 nobody has come to us and said: well, look, you are this

1 wonderful research opportunity that we have to find out
2 what's happening as a result of the vaccines.
3 Q. Am I right in saying that this was the first occasion on
4 which a representative from your group has given
5 evidence to a -- obviously a public inquiry --
6 A. Yes.
7 Q. -- but also the public by way of a select committee or
8 some sort of organisation?
9 A. As far as I know, yes. I believe UK CV Family may have
10 spoken to some parliamentary members but we haven't.
11 Q. Then the last two subparagraphs, (f) and (h), similarly
12 identify that the aims of the group include trying to
13 signpost people towards help, and also setting up the
14 charitable and administrative systems to fund particular
15 treatments that aren't available on the NHS?
16 A. Yes.
17 Q. So that gives us some idea of the aims.
18 Now, in your statements you have, I should say --
19 and this will come as no surprise to you, I know --
20 raised a vast number of points and issues spanning the
21 technology of vaccines, the scientific foundations for
22 them, their authorisation, their research and
23 development, their delivery, in fact almost every aspect
24 of vaccination and vaccines.
25 Today I'd like you, however, to try to help us with

1 expanding on those issues and those concerns that your
2 members hold with a particular focus on the list of
3 issues, the scope of this Inquiry, and this module.
4 There are obviously all number of points and areas and
5 issues that fall wildly outside the scope of this
6 Inquiry and I don't want to take time looking at those.
7 So in no particular order, but it's a topic that you
8 referred to repeatedly in the course of your statements,
9 you identify that one of the main concerns held by your
10 members is, of course, the integrity of the regulatory
11 system in the United Kingdom, the degree of scrutiny
12 that was brought to bear on the authorisation of
13 vaccines, and whether or not the safety processes were
14 properly operated, and in particular, whether they were
15 designed and operated in a way that would bring
16 safety-related concerns, side effects, to light. Is
17 that a fair summary of that particular topic?
18 A. Yes.
19 Q. Do your members have particular concerns about the
20 administrative or legal routes by which the vaccines
21 were authorised? You've referred in the statements to
22 the authorisation process under Regulation 174 of the
23 regulations to which I referred yesterday. What is the
24 concern on the part of your members as to whether it was
25 regulation A or regulation B or some other legal route

1 that was operated?
2 A. I think -- I will try to answer that question, I don't
3 think I'm knowledgeable enough to answer it in great
4 deal, but from our perspective the MHRA and the
5 government faced a very significant challenge, and they
6 put in place some updated regulations to allow them to
7 authorise vaccines under very fast processes -- and I'm
8 not really quite sure if I understand exactly what your
9 question is, to be honest.
10 Q. Are they concerned about the particular legal route or
11 administrative route that was deployed? So are they
12 worried that there was this legal process under
13 Regulation 174 that was used or are they worried about
14 the way in which in detail, and in practice, the MHRA
15 went about deciding whether to authorise vaccines?
16 A. I think the latter. And shall I expand on that just --
17 Q. Yes, please do.
18 A. Okay. So one of the main things that we were concerned
19 about is that in 2005 there was a parliamentary review
20 into the influence of the pharmaceutical industry on the
21 regulatory process in the United Kingdom. And they made
22 lots of recommendations all those years ago which still
23 have not been implemented.
24 Q. All right. We're in danger of veering off on --
25 A. Okay, so that provides some context for what I'm just

1 about to say.
2 Q. All right. Please continue.
3 A. Mm-hm. So a normal process when a new medication is
4 brought out is that they'll make a mock-up of
5 a medication or a vaccine for a clinical trial and then,
6 once it's been authorised, they will then upscale and
7 produce a product that can be mass produced, because you
8 can't -- the way something is made for a clinical trial,
9 you can't mass produce it. These particular vaccines
10 are biologics and there was a research study that
11 says --
12 Q. I'm so sorry, I'm going to have to interrupt you there,
13 we don't have the time or the wherewithal to be able to
14 go into some of these areas in this sort of detail.
15 A. Okay.
16 Q. Can I put it another way to you: is the core concern of
17 your members that -- does it revolve around the system
18 by which, in reality and in practice, the MHRA
19 authorised the vaccines, including whether they properly
20 scrutinised the manufacturing and process systems for
21 the production of those vaccines, whether or not the
22 safety trials were properly conducted, whether or not
23 the clinical process was subject to the same degree of
24 scrutiny as the rollout process? Are those the sorts of
25 issues that they're worried about?

1 **LADY HALLETT:** Shall I put it another way?
2 **THE WITNESS:** Yes, please.
3 **LADY HALLETT:** Did your fellow members feel that they
4 sacrificed safety to gain the speed?
5 A. Yes. Thank you.
6 **LADY HALLETT:** Right.
7 **MR KEITH:** So it's the rolling review issue, it's the
8 overall speed by which authorisation was granted and the
9 degree to which they examined it?
10 A. No, we understand the ruling review allowed them to see
11 things a lot sooner so they were able to scrutinise
12 things much more quickly than they would normally and we
13 don't have a problem with that. What we have a problem
14 with is the upscaled product. Because these are
15 biologics, and because the process defines a product, if
16 you change any little thing in the manufacture of
17 a biologic, the temperature, the ingredients, where it's
18 made, you can get a different product. And there was
19 concerns raised whether the upscaled product was
20 comparable to the clinical trial product.
21 Q. As I've said, the two processes: the one --
22 A. That's right.
23 Q. -- that underpinned the clinical research and the one
24 that underpinned the at-scale manufacturing?
25 A. Correct.

1 Q. Right. I think we're clear. From your statement it
2 appears that there are wider issues raised also by your
3 members about the degree to which the data, the trials,
4 the studies and the statistics were properly
5 scrutinised, whether they were accurate, and whether or
6 not the MHRA had before it all the necessary information
7 they needed to properly make a decision on
8 authorisation?
9 A. Yes.
10 Q. Yes? All right. There's quite a strong scientific
11 edge. There are a lot of scientific issues raised in
12 your statements. A great many paragraphs devote
13 themselves to concerns by your group on the technology
14 underlying vaccines, so for example, vector-based
15 vaccines, the mRNA technology, the use of lipid
16 nanoparticles. I could go on. Is the scientific
17 technological basis of the vaccines a matter of concern
18 for your members, or are they concerned about the
19 administrative impact, that is to say the decision to
20 authorise?
21 A. All of the above.
22 Q. All the above?
23 A. Yes.
24 Q. All right.
25 A. These -- these are -- mRNA vaccines have never before

1 been authorised for use in the public, and because they
2 were brought out in such a massive scale, our concerns
3 are that there wasn't enough vigilance, you know, that
4 doctors were not aware -- for example, we had somebody
5 who ended up in hospital paralysed for months, and we
6 discovered that she had the same diagnosis as
7 a condition that appeared in the AstraZeneca trial. Had
8 her doctors known that that had happened during the
9 AstraZeneca trial, the trial was actually paused --
10 Q. Right, there's a number of -- and I perfectly understand
11 that you hold those beliefs but there's a number of
12 assertions or observations made in the course of that
13 answer which we haven't got time to unpick now. The
14 overarching view though is, or the overarching position,
15 is you are worried about the scientific superstructure
16 or underpinning of vaccines and whether or not it was
17 properly understood when it came to authorising their
18 use in the United Kingdom? Is that the heart of it?
19 A. Yes, whether the doctors actually understood this is
20 a brand new technology, if they had understood the
21 conditions that had arisen during the clinical trials or
22 not. Because had they known, they may have been better
23 preparing to diagnosis more quickly, and then those
24 conditions wouldn't have advanced to the stage they did,
25 where there's irreparable damage because --

1 Q. Or they would have been treated perhaps in a different
2 way?
3 A. Yes.
4 Q. Right.
5 Much of your statement is concerned with the
6 separate but no less important issue of public
7 messaging.
8 A. Mm-hm.
9 Q. That is to say informing the public about vaccines,
10 about their benefits, about their risks, and about the
11 specific emerging knowledge about the very rare risks
12 that vaccines might give rise to in a number of
13 different ways. So were you and are you concerned about
14 the whole patient information leaflet process, whether
15 or not it gave the public enough information, whether or
16 not they were updated in sufficient time when new data
17 and new understanding came to light, whether or not
18 people, when they received their vaccines, understood
19 that there was a patient information leaflet available
20 which might or might not have the right degree of data?
21 Is that the broad area?
22 A. That's correct. A lot of our members were not given
23 a leaflet until after they'd received their vaccination
24 which means they didn't really have informed consent.
25 They didn't know what they were consenting to and the

1 leaflets really -- we now know the level of damage and
2 the level and breadth of injury that can result --
3 Q. Well --
4 A. -- and these are not listed in the leaflet.
5 Q. Right, so your general position is that you believe
6 there was more injury, more damage, more harm done, than
7 was being indicated by the patient and public-facing
8 leaflets and information? Both from the MHRA, from the
9 government, and from these public information documents?
10 A. Yes.
11 Q. Right.
12 A. And doctors rely on the Green Book, for example, and
13 that only mentions myocarditis, thrombosis and
14 Guillain-Barré syndrome, really. And we have so many
15 more other undoubted vaccine reactions.
16 Q. The -- another topic, another important issue, is -- and
17 raised by your members -- is whether or not, despite
18 there not being a formal vaccine as condition of
19 deployment policy in Scotland, Wales and Northern
20 Ireland, they feel that there's a perception or that
21 they perceive that people were nevertheless coerced,
22 publicly or privately, into taking vaccines.
23 A. Mm-hm.
24 Q. So is the heart of the concern expressed on this topic
25 whether or not the state, the government, were fair and

1 open in describing the benefits and the risks so that
2 people could make a decision individually for themselves
3 without feeling they were under a degree of coercion?
4 A. Well, we had language, even in --
5 Q. I don't want to go into the detail of specific cases --
6 A. Okay.
7 Q. -- because we can't do anything about specific cases,
8 but is that a proper summary, if you like, of the
9 overarching --
10 A. Well, the published message was: you would take the
11 vaccine to save everyone else, that you were selfish not
12 to, you were irresponsible not to, and we have lots of
13 people in our group who are in the medical profession,
14 who were coerced. We even had somebody who had emails
15 distributed around their workplace naming and shaming
16 people who hadn't yet had their vaccine.
17 Q. All right. You understand of course, that we can't
18 delve into individual cases.
19 A. No, no.
20 Q. But the overarching point is you're concerned about why
21 it was that some people felt they were being coerced or
22 they were under pressure, and whether or not they were
23 given the right information to be able to make
24 a decision free from coercion?
25 A. Yes.

1 **Q.** That's the heart of it.
2 **A.** Yes.
3 **Q.** The Yellow Card reporting scheme is obviously a vital
4 part of the safety structures in the United Kingdom. Is
5 that a general topic about which your members expressed
6 a great deal of concern, in essence, whether or not it
7 properly allowed people to record, to register with the
8 government, and the authorities, adverse effects which
9 they believed they'd encountered, and also whether or
10 not, going the other route, the Yellow Card Scheme and
11 the MHRA kept people properly informed about the
12 position? Is that the heart of the concern?
13 **A.** A lot of people had never heard of the Yellow Card when
14 they joined the group, to be honest. And then we had
15 people who felt -- who hadn't been able to access the
16 Yellow Card again, they can't find it. The Yellow Card
17 Scheme is a passive reporting scheme, as you know, so
18 it's reliant on people knowing about it, and the
19 government does, by their own admission, say that
20 between 1 and 10% of people actually report to the
21 Yellow Card.
22 **Q.** And it's obviously a scheme whereby members of the
23 public and medics --
24 **A.** Yes.
25 **Q.** -- can report and so your position is that people

1 weren't made properly aware of the availability --
2 **A.** No.
3 **Q.** -- of the Yellow Card Scheme to allow them to report?
4 **A.** Yes, although it does say about the Yellow Card in the
5 leaflets. But our experience is that doctors were not
6 reporting to the Yellow Card, even though they said to
7 us that they felt that the vaccine was responsible. And
8 in fact, the Green Book says that all doctors should,
9 even if they're not sure, they should report it to
10 Yellow Card, and then MHRA will make the decision
11 whether or not there was a causation there or not.
12 So yes, we feel that the Yellow Card is not fit for
13 purpose. I know that I asked for a copy of my Yellow
14 Card, and they put that a lot of my symptoms had been
15 resolved when they haven't. So I don't know where they
16 got that information from.
17 **Q.** And finally another scheme, no less important, but it's
18 one that appears to be of huge concern, and worry to
19 members in your group and other groups, I should say, is
20 the Vaccine Damage Payment Scheme.
21 **A.** Yes.
22 **Q.** Has it been the experience of your members that where
23 they have made applications under the scheme, that
24 they've simply not been dealt with sufficiently speedily
25 or at all, or got a positive response, and no doubt you

1 would argue that the actual terms of the scheme, the
2 preconditions for an award -- and it's not
3 a compensatory award, but for an award -- are overly
4 onerous and impossible in practice to meet?
5 **A.** Yes. I mean, how can you prove you're 60% disabled when
6 your condition fluctuates from day to day? It's
7 actually -- the response that I get from group members,
8 overwhelming response, is that it's a very traumatic
9 experience to go through, because a lot of them --
10 I mean, I'm having quite -- I'm losing my words here,
11 but a lot of us are neurologically impacted so we find
12 it difficult to communicate. And we have some people
13 who are so badly injured that they can't actually write.
14 So they're trying to get medical records from here,
15 there and everywhere, collate it all, and they have to
16 prove causation. I mean, how can a normal layperson do
17 that? It's very traumatic.
18 And then, when the -- when the results come back,
19 and a lot of them -- most of them come back the first
20 time round as rejected, and some of the reasons are
21 utterly ridiculous, to be honest. Somebody was
22 accused --
23 **Q.** Well, we can't talk about individual cases.
24 **A.** Oh, sorry, yes. No individual members, okay.
25 **MR KEITH:** Thank you very much, Mrs O'Rafferty. If I may

1 say so, you have been a very fine advocate, despite your
2 own words, in the interests of your members, but that
3 gives us a very helpful understanding of where the main
4 points of concern are and the scope of them.
5 **LADY HALLETT:** I was about to say something similar. You
6 say that people very often have problems communicating
7 but thank goodness today you were obviously feeling on
8 top form for communication, although I appreciate your
9 condition may change on different days.
10 **THE WITNESS:** Thank you.
11 **LADY HALLETT:** The thing I was particularly interested in
12 was you talked about the research in Germany about both
13 vaccine injury and Long Covid, and I've been going
14 through your statement and, don't worry, I will go
15 through it all in some detail before I reach any
16 findings. Again, I have been through it, but I will go
17 through it again. But I was interested because a lot of
18 the concerns that your members have echo the concerns
19 that Long Covid sufferers have: recognition, of course,
20 being one of the primary ones, and then the kind of
21 support and treatment that you need. So I was quite
22 interested to hear you talk about that research.
23 Thank you very much indeed for your help, I'm really
24 grateful to you, I hope it hasn't been too difficult
25 getting here and getting home.

1 **THE WITNESS:** Not at all. Thank you.
2 (The witness withdrew)
3 **LADY HALLETT:** Ms Morris, I understand that you and your
4 team represent this witness and the next one, so would
5 it help if I took the afternoon break now?
6 Okay, it's a bit earlier than we'd normally do but
7 just so that Ms Morris and the team can talk to you
8 before you go, and I shall come back -- if I said
9 20 minutes, Ms Morris, would that help, so you have a
10 chance to talk properly?
11 Very well, 20 minutes, whatever that is from now.
12 (2.38 pm)
13 (A short break)
14 **(2.59 pm)**
15 **LADY HALLETT:** Mr Mansell (inaudible).
16 **MR MANSELL:** My Lady, the next witness is Kate Scott,
17 please.
18 **MS KATE SCOTT (sworn)**
19 **Questions from COUNSEL TO THE INQUIRY**
20 **LADY HALLETT:** Are you okay, Ms Scott?
21 **THE WITNESS:** Yes, thank you.
22 **MR MANSELL:** Ms Scott, could you give your full name to the
23 Inquiry, please.
24 **A.** Yes, Mrs Kate Scott.
25 **Q.** Thank you very much for attending the Inquiry today and

1 assisting with the evidence that you're going to give.
2 A few preliminary matters, if I may.
3 **A.** Yes.
4 **Q.** I'm going to ask you to keep your voice up, don't speak
5 too quickly, speak into the microphone so that the
6 stenographers can make a record of everything you're
7 saying. And if I ask a question that isn't clear,
8 please don't hesitate to ask me to repeat it.
9 **A.** Okay.
10 **Q.** You have provided a witness statement on behalf of
11 Vaccine Injured Bereaved UK, or VIB UK, and that is
12 INQ000474371. Are the contents of that statement true
13 to the best of your knowledge and belief?
14 **A.** They are, yes.
15 **Q.** Now, I'd like to start, please, by asking you some
16 questions about VIB UK, its aims and membership. You
17 explain in your statement that VIB UK is a UK-wide
18 campaign and support group consisting of individuals and
19 families who have either been severely injured for
20 bereaved as a result of receiving a Covid-19 vaccine; is
21 that right?
22 **A.** Yeah, that's correct. Everyone in our group has medical
23 confirmation that their injuries or the death of their
24 loved one was caused by the vaccine.
25 **Q.** It's fair to say, is it, that one of VIB UK's central

1 aims is to achieve reform of the Vaccine Damage Payment
2 Scheme or VDPS?
3 **A.** Yes, that's correct. The scheme is inadequate and
4 inefficient, it offers too little, too late, to too few.
5 **Q.** And that is something we will come back to in the course
6 of your evidence.
7 **A.** Yes.
8 **Q.** You note in your statement that your organisation did
9 not exist before the pandemic, and you had to create it.
10 And you say this is a symptom of poor planning on the
11 part of the government, which in your view overlooked
12 the potential for vaccine injury and bereavement?
13 **A.** Yeah, we feel like an uncomfortable truth and we were
14 made to feel like you were the only ones or you were the
15 unlucky ones, and just to get on with it, and that's
16 impossible when you're grieving a loved one or your
17 husband is in intensive care in a coma for four weeks
18 and five days, and there was no one to speak and to
19 there was no one to help us, so we've had to, in the
20 worst circumstances, come together and try to navigate
21 this as group.
22 **Q.** I think you may be alluding there to your own personal
23 experience, and again, that is something we will come
24 back to and explore with you in more detail, but just
25 staying for the moment, please, with the group itself

1 and its aims.
2 You express your gratitude to the Chair in your
3 statement for giving VIB UK Core Participant status in
4 this module of the Inquiry, and I want to emphasise
5 that, in making that decision, the Inquiry acknowledges
6 the experiences of those who have suffered adverse
7 effects following vaccination, and is of the view that
8 this will help to counter the stigmatisation which you
9 speak about in your statement.
10 **A.** Yeah, hopefully.
11 **Q.** You stress that VIB UK is "not anti-vaccination but
12 rather pro-fairness".
13 **A.** Yes.
14 **Q.** Could you expand on that, please.
15 **A.** Yes, how can we be anti-vaccination when everyone in our
16 group stepped forward and took a vaccine that the
17 government told us was safe and effective? Everybody in
18 our group is either injured or bereaved as a result of
19 doing so. So by -- you know, you cannot be
20 anti-vaccination if you're injured from a vaccine that
21 you took.
22 **Q.** You make the point that if there is not a proper system
23 of redress for those who have suffered injury and
24 bereavement, it will fuel vaccine hesitancy in the
25 future --

1 A. Yes, I think --
2 Q. -- something you want to avoid?
3 A. Yeah, a hundred per cent.
4 So I think Mr Keith stated yesterday that it is
5 accepted that vaccines -- or no medicine is a hundred
6 per cent safe and effective, therefore there should be
7 a fair compensation scheme and the government should
8 have planned for that, knowing that if nothing is
9 a hundred per cent safe and effective and it's being
10 rolled out to so many people, there would be injuries
11 and there would be deaths, and we should have got the
12 help and support and the financial compensation to be
13 able to continue to live our lives.
14 Q. Staying with VIB UK and the support that it provides, is
15 it right that it's created its own support group for
16 those who have been injured and bereaved by the
17 vaccines? And if so, what sort of support does it
18 provide?
19 A. Yes, so mainly we're a campaign group, kind of
20 campaigning for VDPS reform, but we soon realised that
21 we had no one to talk to who had the shared experience
22 of almost being pushed into the shadows during the
23 pandemic. We're an uncomfortable truth but we are
24 a truth, and the truth is, for everybody in our group,
25 the vaccine caused serious harm and death. So we

1 just -- it's not a formal thing, we have a group
2 WhatsApp, it's -- people talk about it on it daily, you
3 can ask to speak to people individually, and just a safe
4 place to share your grief or your concerns or your
5 challenges. Because there wasn't anywhere, there still
6 isn't anywhere, other than that.
7 Q. Alongside the group chat you've spoken about and the
8 safe space for people, you talk in your statement about
9 hosting a video call every six weeks to offer support
10 and enabling members to work together on campaigning for
11 change?
12 A. Yes. And just to catch up, and we send monthly updates
13 on the work we've been doing. Because it's so difficult
14 and emotionally draining -- we're four years in now with
15 very little change having been happened and very little
16 of power voices having been listened to -- some people
17 have to dip in and out, because we're also trying to
18 navigate life with a disability or life without a loved
19 one.
20 Q. Could we please have on the screen page 4, paragraph 10
21 of Mrs Scott's statement. And here you set out VIB UK's
22 hopes in relation to its participation in the Inquiry.
23 We just look at these, please.
24 A. Yes.
25 Q. You ask that it result in three key outcomes. First, to

1 highlight the fact of vaccine injury and bereavement;
2 second, to remove the stigma suffered by those who are
3 vaccine injured or bereaved; and third, to compel the
4 government and pharmaceutical companies to look again at
5 how to deal with the inconvenient fact of vaccine injury
6 and bereavement and the effect it's had on those who
7 have been affected. Is that right?
8 A. Yeah.
9 Q. That can come down from the screen. Thank you.
10 We've dealt with the group, its aims, the support
11 that it offers, its membership. You are, of course,
12 a member of that group, and the reason you're a member
13 of the group is because of the experience that your
14 husband Jamie had following vaccination.
15 A. Yes.
16 Q. Could you tell us, please, about the impact on Jamie as
17 well as the impact on you and your family?
18 A. I can, yeah. Just one last thing about VIB UK, though,
19 is that the primary causes of the injuries in our group
20 are vaccine-induced thrombotic thrombocytopenia, VITT,
21 Guillain-Barré syndrome, vasculitis, and more. They are
22 all confirmed conditions, so there is a range of
23 conditions.
24 My husband Jamie had VITT, vaccine-induced
25 thrombotic thrombocytopenia. He is a walking miracle.

1 Every day I'm filled with gratitude that he's still
2 alive, but his brain injury is the size of a credit
3 card. His relationship with me and, mostly, his
4 relationship with our children will never be the same
5 again. And I have this constant conflict of that
6 gratitude with the grief that goes with how different
7 life is, and then the guilt for the others in our group
8 who I know would just want five more minutes with their
9 loved one.
10 Jamie is amazing. He was in a coma for four weeks
11 and five days. He's had significant brain surgery, and
12 he was in rehab for 124, in total. When he came home,
13 he was able to watch our son's nativity, but in a very
14 different way. He is blind in both of his eyes in his
15 upper right quadrant, he'll never drive, he'll never
16 live totally independently, he can't look after our
17 children for long periods of time independently, he
18 can't split and divide his attention, he has no high
19 functioning ability, he has short-term memory loss, he
20 has processing information challenges, he has auditory
21 challenges, he has chronic fatigue, he has severe
22 headaches, he has had over three hundred medical
23 appointments since we've been home, and they're ongoing,
24 and just everything, everything is different from how he
25 responds to situations to how he shows his emotions, to

1 how he interacts with our children.
2 Q. I take it from what you've said that he is unable to
3 work?
4 A. Yeah, he'll never be able to work again. He had
5 a really high-functioning, high-stressful,
6 multi-international job that he loved and he was just as
7 cool as a cucumber. He balanced me out and now he's got
8 all these new feelings, and he often describes that he
9 can see this video playing in his head and how he should
10 respond and how things should come out but the bit in
11 between is it all gets muddled. So he's got aphasia,
12 which means that sometimes he can't find or think of the
13 right word, which might mean he calls our children the
14 wrong name, or he will go upstairs to get something and
15 come down with something completely different. Or he'll
16 go to the shop with some support and he'll forget what
17 he's gone to get and come out with different things that
18 don't make up a shopping list, that you can't cook
19 anything with, but every day he tries it's tiring and
20 we're grateful that he's alive but at the moment he
21 doesn't feel like he is living and he was full of so
22 much life.
23 Q. Given the impact, is it right that your family and Jamie
24 have made a claim to the Vaccine Damage Payment Scheme?
25 A. We have, yes and it was successful, which is an awful

1 thing to have a phone call to say, "Congratulations, we
2 have confirmed that your injury has been caused by the
3 vaccine and that your husband is 60% or more disabled."
4 That's not the case for everyone in our group.
5 People are rejected on such different disability
6 percentages, which I know we're going to cover, but for
7 Jamie -- I think the national average salary is £30,000.
8 He will never work again. He was on much more than
9 that. Our house is based on that. Our lifestyle was
10 based on that. I'm no longer working. I also had
11 a career job but caring for our children, making sure
12 they get to school safely is my responsibility, taking
13 Jamie to his appointments is my responsibility, looking
14 after him in those appointments because he can't process
15 medical information, being his advocate everywhere I go,
16 making sure he is safe, stops me from being able to work
17 full time and that puts a real stress.
18 I don't think that doing the things that the state
19 asks you to do should put us at risk of losing our house
20 or people in our group having to use a food bank, having
21 to move house because they can no longer afford it.
22 That's just extra trauma to what we're already
23 struggling through.
24 Q. Thank you for sharing your account of vaccine injury and
25 telling us about what happened to Jamie and you and your

1 family.
2 A. Thank you.
3 Q. I'd like to move now to talk about some of the broader
4 issues that you have personal experience of and which
5 your members are deeply concerned about, and we will
6 start with the Vaccine Damage Payment Scheme.
7 A. Okay.
8 Q. You say, and you have said already today that it is not
9 fit for purpose, in your view, and has systemic
10 inadequacies and inefficiencies, and it's some of those
11 concerns that you have about the scheme that I'd like to
12 turn to now. The first is the time it takes to process
13 claims. And in your witness statement you set out some
14 figures you obtained as a result of a Freedom of
15 Information Act request, which show that as of the
16 3 October 2023, there had been 7,544 claims related to
17 Covid-19 vaccines, and only 3,519 claimants had been
18 notified of an outcome. 361 claims had been awaiting
19 a decision for more than 12 months. Of those,
20 150 claims had been awaiting a decision for more than
21 18 months.
22 A. Yes, and awfully, the data has changed and those numbers
23 are worse, so as of 30 November 2024, there's 17,519
24 claims to the VDPS. Only 194 of those have been
25 notified that they're entitled to the payment.

1 416 people have been told that they are unsuccessful
2 because although causation is met, they are not,
3 inverted commas, "disabled enough". And of that,
4 there's 1,027 people still waiting 12 months later.
5 Within that, 438, 18 months, and 126 are still waiting
6 nearly three years later for the outcome of their claim.
7 Q. What sort of impact is this having on your members, the
8 amount of time they're having to wait for these claims
9 to be processed?
10 A. Well, most of them have lost their jobs. So paying
11 mortgages, paying rent, feeding your children, feeding
12 your family. Some people, they're -- Dr Stephen Wright,
13 he died from VITT, one of the first within our group.
14 His wife has lost his income. She looked after the
15 family and bought a beautiful household that's now
16 without a daddy and without fair income.
17 Q. Another issue you raise about the VDPS is the
18 application form and problems encountered by your
19 members when completing the application form. What are
20 those problems?
21 A. So, Jamie's came back and they reviewed over 3,000 pages
22 of medical data. So I understand that that takes time.
23 Originally you had to print out the form and you could
24 only handwrite the answer. When people first applied
25 there wasn't even a box to tick that some one had died,

1 so you had to write that yourself and write your own
2 tick box to mark that the person you were claiming for
3 had passed away.
4 **Q.** You say that the paper application system and questions
5 are antiquated and inept.
6 **A.** Yes.
7 **Q.** Would you like to see reform of the process for making
8 the application?
9 **A.** Yes, along with the whole scheme. I believe they've
10 made a couple of changes so there is now a kind tick box
11 to say your loved one has died and you can fill it out
12 online, but it's not a nice -- if anyone has ever had to
13 fill out any of these forms, it's pages long, it's
14 brutal, and if you're grieving or not used to using
15 computers or having all of that information or having
16 the support of someone, you're just again left to do it
17 on your own. And you can see from how much the numbers
18 have grown that people are still only finding out that
19 there is even this scheme available.
20 **Q.** Another aspect of the scheme is the 60% disablement
21 criteria in order to qualify for a payment under the
22 scheme. Could you explain to us the problems that that
23 has posed for your members?
24 **A.** A percentage disablement is also somewhat offensive
25 I feel, but regardless of if it's 10% or 59% or Jamie,

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1 way over 60%, or dead -- I guess that's 100% disabled --
2 there's no compensation if you fall below that. We only
3 saw yesterday in the video the consequence of being told
4 "Sorry, you're only 55% disabled". It's awful, it's
5 devastating, and then there's no one to help. Someone
6 in our group was told they were only 20% disabled; it
7 took another year to do the mandatory reversal, and then
8 they were told, "Oh, actually, you're 90% disabled,
9 congratulations, here you go."
10 There's other people who are 59% disabled in our
11 group and only if you've got the strength and will to
12 carry on can you fight that system that is so set
13 against us.
14 **Q.** Would you like to see the threshold lowered or some
15 other reform? Have you got any ideas for how it could
16 change?
17 **A.** There's many other schemes across the world, I don't
18 think I'm expert in that other than saying if you did
19 something that the state has told you was safe and
20 effective and that wasn't the case, then there should be
21 fair and adequate compensation, that's on a sliding
22 scale of the impact. Like Jamie will never work again,
23 so that's £120,000. If the national average salary of
24 £30,000, it's gone very, very quickly in a very
25 expensive world.

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1 **Q.** That is the next thing, in fact, that I was going to
2 come on to, which is the fact that the payment under the
3 scheme is limited to £120,000. What would you like to
4 see change about that?
5 **A.** Again, well, it's nothing compared to what would be seen
6 through civil or through the courts, and we're always
7 told that it is not a compensation scheme, and yet legal
8 action is costful, stressful, complex and for -- many
9 are unable to get legal representation even though
10 causation has been confirmed.
11 So again it comes back to this acceptable safety
12 profile. Mainstream media, the government,
13 pharmaceutical companies, tell us that we fall within
14 this acceptable safety profile. How many are
15 acceptable? One life? Should that not have been enough
16 to pause and just have a look, because there were other
17 options? Or 441 people had VITT, 81 of those died. Not
18 everyone has got access to legal support, and we
19 shouldn't have to do it. There should be a compensation
20 scheme that supports those people who are injured and
21 bereaved.
22 **Q.** This is a point that I know it's important for you to
23 make, that -- it's about what is an acceptable safety
24 profile and what does that mean in terms of the people
25 who are vaccine injured and bereaved, and what sort of

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1 scheme should be in place for them. Is that right?
2 That if there is going to be a recognition, not --
3 **A.** I think it damages future trust in vaccines that if you
4 are this unlucky number or this rare number -- but
5 bearing in mind for our group it's not rare. Statistics
6 are interesting, aren't they? Within our group, one
7 hundred per cent of the people in it, it was not safe
8 and effective. That is the fact within our group. And
9 we have always had the truth on our side, and the truth
10 is, for everyone in our group and the others who don't
11 even know about our group yet: the vaccine was not safe
12 and effective.
13 And this was mostly people who were fit and healthy.
14 Jamie didn't take a medicine in his life. He surfed, he
15 ran, we played rugby and football with the children, all
16 things he's now unable to do and will never be able to
17 do again. We were known as being the couple -- or the
18 last two on the dance floor, and this birthday I danced
19 on my own because he's not able to be in that loud noisy
20 environment.
21 **LADY HALLETT:** Sorry to interrupt, I really am, but I think
22 I'm going to have to stop you because it's really
23 difficult for me venturing into the area of where we're
24 talking about scientific evidence and acceptable safety
25 levels. That's something we'll discuss with the

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1 experts. And I'm really sorry, but it's more of
2 a scientific evidence-based as opposed to just the
3 individual circumstances.
4 **THE WITNESS:** No, that's what we're asking. We want you to
5 look at that. And no one has told us what that is. And
6 if it is acceptable, why is there not a fair
7 compensation scheme? I'm not a scientist. But
8 Boris Johnson wrote to me and told me we are not
9 a statistic, we would not be ignored. And all the time
10 all we're told is we're very rare and we are
11 a statistic. And I'm here to say that, no, we're not,
12 our lives are destroyed. And everyone in the audience
13 today who's to support us, so are theirs. It's not just
14 my story, there's many others who have had their voices
15 silenced and told that we are an acceptable safety
16 profile and "Get on with your life."
17 **LADY HALLETT:** That point I totally understand, I was just
18 trying to avoid going down the path of analysing at this
19 stage --
20 **A.** Yeah, no, I wasn't trying to do that. Thank you.
21 **MR MANSELL:** You deal with a number of points in your
22 statement, and we won't have time to go through all of
23 them in great detail now, but I just want to identify
24 some of the other concerns in headline form that you
25 have identified.

1 **A.** Yeah.
2 **Q.** One of them is around communication about safety issues,
3 and you raise the point that, in your view, there should
4 have been clearer communication about the risks
5 associated with the vaccines, and that they should have
6 been communicated to healthcare professionals and the
7 public so that people could be on the lookout for the
8 types of symptoms that could arise; is that right?
9 **A.** Yes, earlier action and clearer risk communication, we
10 think, could have saved lives. People within our group
11 called ambulances three times to be told it was
12 a migraine, it was only on the fourth, when they were
13 seizing in bed, that they were taken to hospital, and
14 that was because the risk and framework had not been
15 communicated to everyone. Or you were not even allowed
16 to suggest that vaccines caused injury and bereavement.
17 Posts were removed online of death certificates saying
18 it was misinformation, accounts were closed. I mean,
19 there was no one to say: hang on a minute, we -- if we
20 know it's going to be accepted that there's risk, there
21 should be a safety process of emotionally and medically
22 supporting these people and helping them afterwards.
23 **Q.** Another area of concern for your members is the
24 post-marketing surveillance system in the UK, including
25 the Yellow Card Scheme, and people being aware of that

1 scheme, and reporting properly through the scheme.
2 You'd like to see that examined as part of the Inquiry;
3 is that right?
4 **A.** Yeah, as far as we can see nothing happens after you
5 input that data. So Jamie had a Yellow Card, many in
6 our group have got Yellow Cards, no one has ever
7 contacted me about it, no one has followed up, people's
8 got lost, people's weren't registered. Sheila Ward's
9 husband -- Stephen Ward, who died, she had to contact
10 them to say, "Oh, just to let you know he's passed away.
11 He died from his condition because no one followed up."
12 And, again, in other countries, after only one
13 instance of this particular condition -- and there are
14 more confirmed conditions, but for VITT, for example,
15 one instance of it meant that they could pause it and
16 they reviewed it to say: what's happening here? Other
17 countries changed much quicker on what age range was
18 being offered that particular vaccine.
19 **Q.** So this is the speed of the regulatory response in the
20 UK to the blood clot safety issue, that's something you
21 want the Inquiry to examine; is that right?
22 **A.** Yes, because they have acted -- the same for
23 Guillain-Barré syndrome, my understanding is the quicker
24 you're helped, the better the outcomes are. So VITT is
25 my expertise area because that's what happened to Jamie,

1 but there are other conditions that are the same, people
2 were not listened to when they said, "I think this is
3 because of the vaccine", and if they had been, and if
4 medical people were able to get the right pathways in,
5 then people's outcomes could have been better.
6 **Q.** You also question whether the Yellow Card Scheme is
7 adequate in that it is a voluntary reporting scheme.
8 Would you like to see some assessment on the part of the
9 Inquiry as to whether it is useful to have a mandatory
10 reporting scheme?
11 **A.** Yeah, again, I'm not an expert but I think it should be
12 mandatory. If I turned up to A&E, they ask mandatory
13 questions of you, about things, and that should have
14 been one of them, you know, "Have you had a vaccine",
15 which is a foreign thing within your body within
16 a certain amount of time, because especially for certain
17 conditions like Jamie's there's a timeframe that is
18 crucial that it only happens in, and if you catch it
19 quickly, outcomes might have been better. Many people,
20 there's Zion, Lisa Shaw(?) might still be with us.
21 We'll never know that, but had it been communicated,
22 properly then they might have got the right help and
23 support they needed quicker.
24 **Q.** Mrs Scott, we have gone over a large number of concerns
25 in the course of your evidence, and I want to thank you

1 for the clarity of your answers and for sharing your
2 personal experiences with us.
3 **MR MANSELL:** Can I just ask one last quick thing, when you
4 speak to all the other experts, the scientists, the
5 pharmaceuticals, and the government, is just remember
6 that we are people, so they can easily omit or not
7 include or not discuss vaccine injury. We know for
8 a fact, I am the fact, these people over here are the
9 fact, it did happen, and they cannot continue to ignore
10 it. Sorry is a strong word and helping us would make
11 a difference.
12 **LADY HALLETT:** Thank you very much indeed, I am truly sorry
13 to hear about your husband's condition.
14 **A.** Thank you.
15 **LADY HALLETT:** It must be extraordinarily difficult --
16 (overspeaking) -- children.
17 **A.** Thank you.
18 **LADY HALLETT:** I do understand your concerns. I may have
19 intervened about one aspect but that's only because
20 I think that's for expert witnesses, but I do understand
21 your concerns, and certainly the point you make about
22 you're human beings, of course you are.
23 **A.** Yes.
24 **LADY HALLETT:** And I shall be examining the issues that you
25 have raised very carefully.

1 **A.** Thank you, because there's children without daddies and
2 children with disabled daddies and just remember that
3 when they try and pretend we're not important. We are
4 important and we are part of this pandemic story.
5 **LADY HALLETT:** I do understand.
6 **A.** Thank you.
7 **LADY HALLETT:** Thank you very much.
8 (The witness withdrew)
9 **LADY HALLETT:** Ms Stephenson.
10 **MS STEPHENSON:** My Lady, the next witness is Kamran Mallick.
11 **MR KAMRAN MALLICK (called)**
12 **LADY HALLETT:** Can we just pause -- I'm sorry, when the oath
13 is being taken I can't have people moving around. I'm
14 very sorry. The oath is very important.
15 Sorry, can we start again, please.
16 **MR KAMRAN MALLICK (sworn)**
17 **LADY HALLETT:** I hope you were warned you will be the last
18 witness of the day. I'm sorry if it's taken a long time
19 to get to you.
20 **THE WITNESS:** Not at all.
21 **Questions from COUNSEL TO THE INQUIRY**
22 **MS STEPHENSON:** Please can you say your full name.
23 **A.** It's Kamran Mallick.
24 **Q.** Mr Mallick, thank you for attending today to assist the
25 Inquiry. Just a few preliminary matters. You've heard

1 it said before, but please speak up into the microphone
2 and take it slowly.
3 You have kindly produced two witness statements for
4 Module 4 of the Inquiry. The first is dated
5 18 July 2024, and it is INQ000474256, a statement on
6 behalf of The Disabled People's Organisations. And
7 a supplementary statement dated 19 November 2024,
8 INQ000474610.
9 Can you confirm that you have read both of those
10 statements recently and that you're satisfied their
11 contents are true?
12 **A.** Yes, I am.
13 **Q.** Thank you. I am going to start with a few background
14 matters about your organisation. Is it right that both
15 of those statements have been prepared in cooperation
16 between four disabled people's organisations?
17 **A.** Yes, that's correct.
18 **Q.** And those are Disability Rights UK, Inclusion Scotland,
19 Disability Action Northern Ireland, and Disability
20 Wales?
21 **A.** That's correct, yes.
22 **Q.** You are the chief executive officer of Disability Rights
23 UK; is that correct?
24 **A.** I am.
25 **Q.** I'll be using shorthand DPO throughout your evidence to

1 refer to disabled people's organisations. In terms of
2 who makes up your membership, you explain in your
3 statement that the DPO used the term "disabled people"
4 to mean people facing disabling social barriers due to
5 their impairments or conditions regardless of their age,
6 and this includes physical impairments, mental health
7 conditions, hearing difficulties, deafness, visual
8 impairments, learning difficulties, and neurodiversity.
9 Is that an accurate representation of the people that
10 you're representing?
11 **A.** Yes, that's correct, we represent all disabled people,
12 yes.
13 **Q.** Can you give the Inquiry an idea of the number of
14 disabled people that there are in the UK who may be
15 affected by the issues that we're going to discuss in
16 your evidence?
17 **A.** So in total the UK population, 22/23% of the UK
18 population would be seen as disabled people. So we're
19 talking about 14 million individuals.
20 **Q.** And between all four DPO, you have a substantial reach
21 across all four nations, a network of partner
22 organisations, and individual members; is that right?
23 **A.** That's correct, yes.
24 **Q.** What kind of services do DPO offer? Could you explain
25 that in overview?

1 **A.** Sure. So the four national organisations that I am
2 representing today and that are part of this group, we
3 would see ourselves as kind of like the second-tier
4 organisations, and we often will have lots of local and
5 regional disabled people's organisations that are
6 members of our organisations, but all of us also have
7 direct contact with individual disabled people as well.
8 And we act as their voice on a national basis, really.
9 In terms of services, it can vary from direct
10 services such as in Northern Ireland there's a transport
11 service that's delivered by Disability Action Northern
12 Ireland. Disability Rights UK delivers help lines. So
13 a disabled student helpline, independent living
14 helpline, which are those direct services, but outside
15 of that it's a lot of advocacy and representation work
16 that we do.
17 **Q.** Does that include engagement with governments,
18 government departments on key issues, raising awareness
19 and campaigning in that way?
20 **A.** Yes. I mean, a lot of our advocacy naturally engages
21 with government and governmental bodies.
22 **Q.** I'm going to turn now to the key issues affecting your
23 members within what we're looking at in Module 4. At
24 first, dealing with the inclusion of disabled people in
25 the development and trials of vaccines and therapeutics.

1 You identify in your statement concerns about gaps in
2 engagement with governments which, if I might put it
3 this way, left disabled people out of the conversation
4 in terms of trials and development. Can you tell the
5 Inquiry about those concerns?
6 **A.** Sure. So I think it's really important to recognise
7 where disabled people are in our society. We're often
8 unseen, unheard, we don't have access to power, we often
9 don't have representation in government, in places where
10 decisions are made, where legislation is written, where
11 guidance is designed. And therefore, those spaces have
12 a complete absence of our lived experience of what it's
13 actually like to live as a disabled person in our
14 country. And so, without that knowledge and
15 information, decisions get made, and we often refer to
16 it as "ableist" thinking. So it's designed by people
17 who don't experience the lives that we do and therefore
18 design those things as they would see them. They don't
19 walk in our shoes, they don't travel in my wheels, as it
20 were, so they don't experience the barriers that we do.
21 So hence we, as organisations, we feel it's really
22 imperative that the government has robust engagement
23 systems and mechanisms in place that are ongoing, that
24 don't just -- they don't just try to create them as and
25 when needed, but are ongoing and long-term as required,

1 actually, to the UK Government by the UNCRPD of which we
2 are a signatory to that treaty.
3 **Q.** Just bring that to apply directly to the trials and
4 development of vaccines and therapeutics.
5 **A.** Yes.
6 **Q.** Was it a concern of your organisation that without
7 inclusion in that process, disabled people may have
8 doubts or difficult questions about the safety of
9 vaccines and therapeutics for your members?
10 **A.** Well, absolutely. So there's an inherent level --
11 levels of uncertainty and mistrust within health systems
12 from a lot of disabled people, just because of the
13 experience that we've had of the system ongoing in our
14 lives. We're often done to, we're often told that
15 others know best for what's best for us, that we're not
16 experts in our own lives and our own conditions that we
17 live with day in, day out. So our concern was that when
18 in this pandemic so much emphasis was being put on that
19 the vaccine was our way out of it, that there was no
20 central voice of disabled people in our organisations in
21 the whole complete planning system, from the point of
22 kind of testing to deployment to, kind of, the whole
23 range of things, really.
24 **Q.** If we could move on, then, to prioritisation decisions
25 for vaccines, part of that deployment system that you

1 talk about which affected disabled people and the
2 clarity of communication, you point out in terms of
3 representation, advice on prioritisation was issued by
4 the Joint Committee on Vaccination and Immunisation, the
5 JCVI, and you had concerns about the representation of
6 disabled people, their voices within the JCVI and its
7 subcommittees when making prioritisation decisions.
8 What were your concerns there?
9 **A.** Well, our concerns was when they were creating the
10 prioritisation list of how -- so they were making
11 decisions based on their medical understanding but they
12 were taking no account of how someone who had a medical
13 condition, an underlying health condition, how they
14 structured their lives, that actually would put them at
15 risk of catching the virus and potential worse outcomes,
16 and so therefore a lot of disabled people weren't
17 included in, for example, the clinically extremely
18 vulnerable list, who actually would still have had
19 particularly poor outcomes had they have caught the
20 virus.
21 The fact that over 65s were prioritised, and so
22 therefore all the adult population of disabled people
23 who would potentially be at risk of adverse outcomes
24 were not included in the initial rollout and
25 prioritisation lists. So where people were placed

1 within those prioritisation was a concern to us.
2 Q. Perhaps if we can move on to look more closely at that
3 concern now, about where people were placed and how
4 their placement was communicated to the disabled
5 community.
6 You point specifically to the membership of cohorts,
7 priority cohorts 4 and 6, within your statement. You
8 make the point that there was no specific priority
9 cohort for disabled people?
10 A. No.
11 Q. That disabled people had to fit in or qualify within
12 other groups. Initially, as you've just explained,
13 high-risk adults under 65 years of age were in
14 category 6. That was the at September 2020 provisional
15 advice published by the JCVI. You point out that that's
16 captured a lot of disabled people because many were
17 clinically extremely vulnerable, and that made them high
18 risk. But the position changed, didn't it: that
19 clinically extremely vulnerable people were then moved
20 to category 4 at the end of December 2020, whilst others
21 with specific underlying conditions remained in
22 category 6.
23 So I'm taking us through it, with some simplifying,
24 the changes that happened. What was your concern about
25 those changes that I've described and the ease of

1 understanding for disabled people about which category
2 they fell into?
3 A. Sure. So the first thing to say is the CEV list wasn't
4 perfect and it certainly wasn't complete, because it was
5 expanded later on, but, irrespective of that, if I look
6 at myself, I was not included in that list, in any list,
7 so I didn't have my first call up for a vaccine until
8 April 2021, and yet my own medical professional people
9 told me that I was at high risk because of my lung
10 capacity, and so if I'd have caught it ...
11 So I think it is really important to remember that
12 millions of people weren't included in the CEV list even
13 though that was then prioritised.
14 Outside of that, the communication systems that then
15 told people where they fitted in, what lists they were
16 in, when their prioritisation -- when they would be
17 called up, was not accessible in itself. The whole
18 communication output from government lacked
19 accessibility on so many levels.
20 And if we just take, for example, the NHS standard
21 on accessible information which has been in -- kind of
22 in law since 2017, wasn't applied. People were
23 receiving letters that were not in Easy Read or
24 accessible information. People who, you know, blind
25 people were receiving letters that were telling them

1 something but they had no access how to read it. And
2 particularly at a time when we were during a lockdown,
3 when the current -- kind of the support systems that
4 people would have relied on suddenly weren't available
5 to them. So people with learning disabilities, for
6 example, if they were receiving notification by post,
7 and it's not in Easy Read, they can't then interpret
8 what that tells them.
9 Q. Was it also the case that your own organisation was
10 giving advice to some of those you represent, that they
11 would need to go to the GP themselves and between them
12 and the GP work out what category they might fall into
13 and whether they were entitled to a vaccine?
14 A. So -- absolutely. So part of our -- or what we took on
15 upon ourselves, both as a national organisation and our
16 member organisation, was that kind of role to try to
17 help interpret what was being sent to people and what
18 they should do.
19 Q. I want now to ask you about prioritisation decisions
20 affecting people with learning disabilities. To put
21 this into context, you explain in your statement that
22 the JCVI prioritisation advice at the beginning of
23 December 2020 included people with severe and profound
24 learning disability within priority group 6, and that
25 then changed and expanded at the end of February 2021 to

1 include all of those on the GP learning disability
2 register in addition to some other named conditions. So
3 in other words, initially, only people with severe and
4 profound learning disability were included in priority
5 cohort 6, and then that definition was expanded.
6 Please can you explain the concerns that you have
7 about that decision making.
8 A. Okay, so I think the first thing to say is that people
9 with learning disability don't self-label themselves
10 like that. And so people -- individuals don't think:
11 oh, well, I'm profound and mild --
12 Q. Severe and profound --
13 A. Severe and profound, sorry, and mild moderate. Because
14 people are not identifying as that, they wouldn't know
15 which category they fitted into in the first place.
16 I think there are also issues that there are no
17 registers in places like Scotland for people with
18 learning disabilities. So that wouldn't work.
19 And it kind of speaks to what I said earlier about
20 why the JCVI actually chose to go down -- categorising
21 in that way when there is existing data and known
22 knowledge that people with learning disabilities and
23 those -- have higher rates of death through
24 health-related issues, and so there's pre-existing data
25 on that, on the kind of mortality rates of people with

1 learning disability, and yet that didn't seem to come
2 into the decision here and these, kind of, split groups.
3 And the other thing to say is, while the JCVI
4 expanded the definition, that was only after, you know,
5 people like our organisations writing to them, but also
6 there was the -- Jo Whiley, radio presenter, who was
7 high profile, was able to raise the concern that she had
8 about a family member.
9 So those kind of things started to push them. But
10 that's not what it should take.
11 Q. When you refer to some of the statistics, I think you
12 point out in your statement that your understanding from
13 studies is that individuals with learning disabilities
14 were 3.6 times more likely to die from Covid but that
15 that statistic didn't separate people into those
16 categories of how --
17 A. No, that's right.
18 Q. -- severe their disability might be, it was for all
19 people who were within that group?
20 A. That's correct.
21 Q. You have also expressed concern in your statement about
22 prioritisation of people with Down's syndrome
23 specifically. Could you just tell us what your concerns
24 were there?
25 A. So, again, it was similar concerns as we had with people

1 with learning disabilities, that those individuals, the
2 risk they had to worse outcomes from catching the virus
3 were, again, well known. And again, those individuals
4 were not prioritised.
5 And again, this all comes back to a lack of, kind
6 of, input from our kind of organisations into the
7 decision-making process.
8 Q. I'm going to move on now to the issue of unpaid carers,
9 and how they were prioritised for vaccination. This is
10 a subject you focused on in your supplementary
11 statement.
12 The timeline here is a relatively complex one,
13 Mr Mallick, we may not have the space to do it justice
14 here, but if I might summarise for context from your
15 statement, was the position this: that the early,
16 sometimes termed "provisional", JCVI advice of
17 September 2020 made no reference to unpaid carers? And
18 then there were two versions of advice issued in
19 December, at the beginning and then at the end of
20 December 2020, where unpaid carers weren't specifically
21 mentioned in the main text, but they were referred to as
22 a footnote, literally a footnote, in the document. In
23 the first instance referring the reader to the
24 Green Book, which contained a list of conditions under
25 which some types of unpaid carers fell, and then,

1 secondly, as a footnote within the guidance.
2 What were your concerns about the clarity of the
3 JCVI advice which was implemented for unpaid carers,
4 and, more than that, what effect did that have on
5 disabled people and their carers?
6 A. The first thing I would just say is there was a total
7 lack of clarity. In order to put out a prioritisation
8 list that then required you to look in footnotes and
9 open other documents such as Green Books, I don't know
10 how many members of the general public would even be
11 aware that there is such a thing as a Green Book, and
12 then to go and try to read something that's written in
13 a language that speaks to a particular type of
14 individual, those kind of scientists, professionals, but
15 not to the general public, a layperson who might be
16 trying to find out where they fit in within the
17 prioritisation. To expect members of the public to do
18 that, unpaid carers to be doing that, is just not
19 acceptable.
20 The other thing is it comes back again to not
21 understanding how disabled people structure -- how we
22 structure our lives, and that a lot of us, much more
23 than most kind of data will tell you, rely on the kind
24 of unpaid support of family or friends, of other systems
25 that we put in place, to provide us with, kind of, the

1 day-to-day support we need to live our lives, and --
2 because that knowledge was not understood, unpaid carers
3 were not part of the -- the -- kind of the
4 prioritisation, and again required our organisations to
5 be kind of advocating on that point that they should be.
6 The impact for disabled people is that if you
7 yourself are at risk of worse outcomes of catching Covid
8 and you are isolating and you are relying on those
9 unpaid carers, who are then not eligible for or not able
10 to get the vaccine, you are at greater risk, because
11 those carers don't necessarily live with you but they
12 will be coming into your space. And so if those
13 individuals are not vaccinated, then you're at risk as
14 well. So it creates a real strain on that individual
15 and their relationship with one another.
16 Q. Were there also some concerns about the definition
17 itself of unpaid carer in its revised form, that it was
18 a person who was the sole or primary carer of an elderly
19 or disabled person at increased risk of Covid-19
20 mortality, and therefore clinically vulnerable? Did you
21 have views on whether that properly served the disabled
22 community?
23 A. Well, again, I think the risk is this idea that it might
24 be a sole or only person that looks after you or
25 supports you or gives you some support. You may have

multiple people that provide you support through a week.
The other kind of confusions around this was -- there was an expectation that unpaid carers would apply for Carer's Allowance. That's even if they knew about it, because there was certainly no information going out to people to say who is and who isn't able to claim that particular benefit, and also the time lag between knowing about it, applying for it and a decision being made would have meant that months would have gone by before you'd be eligible.

Q. Mr Mallick, we perhaps don't have time to go into the issue as it stood in every nation, but you point out in your statement that disabled people across the four nations experienced differences in the definitions of unpaid carers or the practical ways that they were applied and identified. Was that also the case?

A. Yes, that's right.

Q. I'm going to move on now to the issue of accessibility, but both in terms of communications about vaccines and therapeutics and also the accessibility of attending for vaccination.
You have already mentioned in your evidence, and you report in your statement, instances of disabled people receiving letters regarding vaccination in non-accessible formats. Can you tell us about those

issues and those problems that they caused?

A. Yes. So if you imagine receiving a letter that has a language that you don't fully understand, it's an official letter that you've received, it's got "NHS" written at the top and you can't really quite work out what it's about, the anxiety and stress that that might cause you, because you don't know how serious it is, if you're supposed to do something or go somewhere or call someone -- so if you can't understand a letter that's officially been sent to you during a very difficult period in the country, or through a pandemic, that's kind of creating extreme anxiety and stress for those individuals.
It also means that that person may then not act on anything, may not know what to do with it, particularly if you've got someone with a learning disability and the letter is in kind of standard English or complex English, not in an Easy Read version or plain English formats. If you're blind and you receive a letter. Also, you know, deaf people, English is not their first language. BSL is often the first language.
So if you don't have access to those alternative formats, you won't get the messing, that's coming at you.

Q. Presumably the same goes for booking systems, which need

to be accessible in the ways that you've described in terms of plain English, adjusted font, digital and non-digital routes?

A. Yes. So all of those rules apply, irrespective of the medium that you're choosing to use, remembering we have a digital divide in the country of those who do and don't have access to Internet, web, those kind of technologies, and that is particularly pronounced in disabled people's communities.

Q. And you -- perhaps this falls into one of the things that you would recommend or ask the Inquiry to consider, is that it's really important for the health services responsible for contacting disabled people to have a record of their communication preferences and in a pandemic scenario, for there to be easy access to communication preferences and for those to be used in vaccine booking systems?

A. Should be the absolute basic. Once you've told the NHS what your preferred communication method is, it should be registered and everything going out should be in that format.

Q. Not forgetting, then, finally on this point, the physical accessibility of going to get a vaccine for disabled people. Can you explain some of the challenges which were experienced and reported to your organisation

in attending vaccination centres?

A. So I think I've, you know, put a particular case in my witness statement around Dr Rupy Kaur, who is someone with 24 hours support, and has cerebral palsy and is an electric wheelchair user, was, when looking for vaccination for herself and her carers, was sent to a football stadium in Manchester, the Etihad stadium, and on arrival her carers found that there was no access for wheelchair users. And yet, when looking at the website that wasn't clearly evident. So that information just isn't front and centre about as a -- when you're picking what your access requirements are, the system should be designed to then identify the centres that actually have that accessibility for you so you're not sent trying to find the right place to go to.
And then, when trying to kind of tackle that, through 111 and the GP, was kind of then accused that you're trying to jump the system, the queue, to try to get priority elsewhere. So, kind of, accessibility starts at the point being informed on the web booking and having alternative methods but then when you get there, the location of centres, and then the whole kind of accessibility route of arrival, how near it is to you, if you can drive there, is there parking for wheelchair users or Blue Badge holders? Are there

1 drop-off points? Are you waiting outside in the rain as
2 a wheelchair user? When I went to get my vaccination,
3 I live in North London, but for some reason I was sent
4 to St Thomas' in Central London. Now, I'm fortunate
5 I drive, so I drove there on that occasion, but found it
6 difficult to park anywhere and then had to wait outside
7 in a huge queue in the rain, in the cold, and so all of
8 these things are just not taken into account.
9 And I think, just what I would like to say, what's
10 frustrating for our organisations is we tell the
11 government this all the time. This is not something
12 new. Disabled people have always been around and we've
13 been engaging with governments for years, saying the
14 same things over and over again.
15 **Q.** Thank you for sharing those experiences.
16 I just want to touch briefly on the point of
17 monitoring and uptake. Is it right that you have
18 concerns about the sufficiency of the type of data
19 captured about disabled people and the ability of such
20 data to reflect any disparities in vaccine uptake? And
21 you point in your statement to the fact that the
22 UK Government at times relied on ONS data, which wasn't
23 up to date, it didn't separate types of disability, for
24 example. Would you consider it also one of the key
25 things to come out of your statement, that governments

1 need to have data which distinguishes between types of
2 disability which is up to date, captured in as realtime
3 as possible, in an emergency scenario, so that groups
4 that might have lower uptake can be accurately tracked
5 and action can be taken to help them?
6 **A.** Yeah, I would absolutely say that. And it's been
7 systemically an issue that we don't collect that level
8 of data in that, kind of, in that way. And relying on
9 20 -- I think it was the 2011 census, data that didn't
10 disaggregate the data in that way based on impairments
11 and disability. So you can't monitor, and if you can't
12 monitor it you can't then take action on the areas that
13 you need to be doing.
14 **Q.** Finally, then, the subject of therapeutics and the steps
15 taken to enable their use including of prophylactics and
16 new drugs amongst disabled people. What were your
17 concerns, please, about that?
18 **A.** So I think looking at it, the priority was solely based
19 on the vaccine programme. A huge amount of investment
20 went into that and not looking at other therapeutics,
21 and particularly when we've got in our nation
22 1.2 million immunocompromised individuals who -- for
23 whom the vaccine was not a possibility, and they were
24 not able to take that, but that when there was evidence
25 of other therapeutics available that were available in

1 other countries and were showing good rates of success
2 that we didn't have access to those. And I think our
3 question was, really, is why was -- why were they not
4 prioritised? Was it because there was other evidence
5 that the government had access to about them not being
6 effective or was it purely a financial decision?
7 **Q.** Would it be right to characterise the DPO's view on the
8 cancellation of the Evusheld contract as one of
9 particular disappointment for you?
10 **A.** Yes, again, because of the success rates that it was
11 showing in other places, absolutely. And what it's --
12 the impact is that those individuals who can't have the
13 vaccine have to continue shielding. They, while the
14 rest of the country got out and went back to a level of
15 normality, those individuals' lives couldn't change.
16 They had to continue to isolate but without any of the
17 support systems that may have been available to them
18 during the height of the pandemic.
19 **MS STEPHENSON:** Mr Mallick, thank you very much. Those are
20 all my questions for you.
21 My Lady, do you have any questions?
22 **LADY HALLETT:** Thank you very much, Mr Mallick. I find it
23 astonishing that the government can ignore an advocate
24 as eloquent as you. I think I might have described your
25 advocacy as eloquent last time you helped me. You've

1 now helped me twice and I've got a feeling you're going
2 to be helping me in the future, so thank you very much
3 indeed. You've made some very important points and I'm
4 really grateful to you.
5 **THE WITNESS:** Thank you.
6 (The witness withdrew)
7 **LADY HALLETT:** Right, we shall finish now and start again
8 at 10.00 tomorrow.
9 **(3.57 pm)**
10 **(The hearing adjourned until 10.00 am the following day)**
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