IN THE UK COVID-19 PUBLIC INQUIRY

BEFORE BARONESS HEATHER HALLETT

IN THE MATTER OF:

THE PUBLIC INQUIRY TO EXAMINE THE COVID-19 PANDEMIC IN THE UK

MODULE FOUR OPENING SUBMISSIONS

COVID-19 BEREAVED FAMILIES FOR JUSTICE UK

These submissions should be read alongside those of NI CBFFJ, which we endorse.

Section 1: Introduction

1. Those who have lost so much – in particular the bereaved – have continually urged the Inquiry to recognise that the bridge between its fact-finding role and the making of recommendations to improve the future is accountability. This amounts to identifying what went wrong and holding those responsible to account. The corollary of that is to recognise achievements and best practice that worked, and mitigated the devastating effects of the pandemic.

2. Module 4 will involve both sides of that coin. It is clear from the disclosure that you will hear parts of the biomedical R&D sector reacted rapidly and had the expertise and drive to develop vaccines, and later therapeutics, which were effective and saved many lives. It is as important to identify why measures were effective as it is to identify why other things failed, because lessons are learned from both.

3. Were successes because pre-pandemic governments had grasped the importance of vaccines and therapeutics and ensured sufficient resourcing and planning, or were some successes chance, and others a measure of UK scientific excellence in certain relevant fields? That will be for you to determine, but the question directs us to the starting point of all of the issues in this inquiry: were we as well prepared as we could be for a Disease X pandemic? And the follow-on question: as of today, are we as prepared - now - as we can be for the next one?

4. Resilience with respect to M4 is not to be measured in the number of hospital beds or ICUs or nurses or doctors. However, the question is the same, just the metrics are

different. Did the UK have a sufficient scientific sector with relevant skills and resources to see a pandemic coming over the horizon, and which could immediately set about developing vaccines, anti-virals, therapeutics and other medical equipment and treatments to stop, slow or mitigate the effects of the virus? Did the UK and its constituent parts have a sufficient manufacturing sector, or hibernated or agile reserve sector to be able to put rapid learning into the arms of millions? Did the UK have a robust and versatile regulatory and development regime which could safely fast-track such measures? Were there any or sufficient processes to ensure public money was not thrown away in an emergency as appears to have occurred with the Vaccine Manufacturing and Innovation Centre Ltd (VMIC referred to below).

5. Beyond resilience, did the UK and its four public health and healthcare sectors have proper planning to ensure its capacity was used optimally, to ensure stockpiles, supply lines and surge supplies? Did it have proper planning to collaborate rapidly with international partners? Did it have proper planning to stand up rapid roll out networks, identify the most vulnerable, and deliver as urgently as was needed? Did those public healthcare systems have plans to counter historically well-known and obvious systemic issues such as structural and institutional racism, and other forms of structural discrimination relating to age, sex, and disability?

6. CBFFJ UK represents 7,000 bereaved family members from across the four nations and jurisdictions of the UK. Those family members are a cross section of society and its communities. The families urge that in considering the wide-ranging scientific, technical and governance issues in M4 their voices are not forgotten.

Section 2: The experience of the bereaved

7. In accordance with the Inquiry's commitment to considering the experience of bereaved families to inform its understanding, CBFFJ UK looks forward to the Inquiry's exploration of issues which have raised particular concern among its members within the scope of Module 4.

8. CBFFJ UK member Helena Jean Rossiter is due to provide the first oral evidence of the public hearings. She will tell the Inquiry about the loss of her son, Peter, to Covid-19 on 11 August 2021, and explain some of the questions she has been left with, together with a summary of some of the experiences and associated concerns of other families within the group. We submit that, as has been the case in Modules 1-3, Mrs Rossiter's evidence and that of other individuals who have been bereaved or deeply

affected in other ways, will play an invaluable role in focusing the Inquiry's attention on the real-world impact of the pandemic and decisions made in the response.

9. In line with members' concerns, CBFFJ UK urges the Inquiry to examine carefully the utility, accuracy and timeliness of the guidance, advice and other communications provided to clinicians, patients and the general public in respect of vaccines and therapeutics during the pandemic, having regard to families' experiences of receiving conflicting and apparently flawed information and advice.

10. We welcome the Inquiry's intention to explore decision-making in respect of the vaccine rollout, including prioritisation, dosage intervals and availability and prioritisation of booster doses. Other important aspects of vaccine rollout which require examination include the practical arrangements made for vaccine delivery and how this was managed within the cohorts identified for prioritisation, including for vulnerable people such as care home residents and hospital inpatients.

11. Decision-making around access to therapeutics and prophylactics, including for children, must also be explored.

12. As explained further in Section 5, below, CBFFJ UK invites robust scrutiny of the role of structural and institutional racism as drivers of unequal vaccine access and uptake.

13. In our submission exploration of these issues, which flow from CBFFJ UK members' direct experience, is critical in order to assist not only the bereaved families we represent, but also the wider public in their understanding of the pandemic and the UK response as it touched on vaccines and therapeutics.

Section 3: Planning and preparedness

14. As CBFFJ UK has submitted in previous modules, examination of UK planning and preparedness going into the pandemic is critical to the Inquiry's twin tasks of establishing a narrative and learning lessons. It is necessary to reflect on the position the UK found itself in at the brink of Covid-19 in order to ensure that we can be better prepared for the future, noting the overwhelming likelihood of another pandemic in the near to medium term. We submit that the issue of preparedness is a fundamental aspect of Module 4, notwithstanding the UK's achievements in terms of vaccines.

15. The Inquiry will have well in mind its own Module 1 findings as to the overall state of preparedness in 2020, including the finding that there was a "damaging absence of

focus on the measures, interventions and infrastructure required in the event of a pandemic" (p3). The 'Technical Report on the COVID-19 pandemic in the UK', written by the UK CMOs, DCMOs, GCSA and NHS Medical Director and others, concluded that "unsurprisingly, the UK was relatively effective and rapid in areas in which we already had strengths and substantial capacity, including in biomedicine, which could be adapted and built on" [INQ000203933_019]. CBFFJ UK recognises the evidence about areas of excellence in the UK, including in research, but invites the Inquiry to carefully consider whether preparedness was lacking in other key areas, resulting in limitations in the UK's ability to respond and capitalise on those strengths.

16. The Inquiry noted in its Module 1 report that "proper preparation for a pandemic costs money." The same principle applies in respect of funding for the research and development which was central to the UK's ability to mount an effective pharmaceutical response to the pandemic. The Inquiry is invited to scrutinise the UK's preparedness in this regard. We note the evidence of Professor Wendy Barclay, who says in her statement that "the funding that supports research into new vaccines and delivery vehicles, that is essential to be carried out carefully in peace time, was and remains suboptimal and fragmented" [INQ000474315_007, §26]. Strikingly, Professor Dame Sarah Gilbert notes that even in the early months of 2020 securing funding for vaccine development was "difficult" until the Vaccine Taskforce was put into place. For the part of the process she is concerned with, at the very beginning, "the major obstacle is funding" [INQ000474278_017, §73; _018, §81].

17. In Module 1 the Inquiry heard evidence about the WHO Research and Development Blueprint initiative, which aims to reduce the time between declaration of a public health emergency and the availability of diagnostic tests, vaccines, antivirals and other treatments that can save lives and avert a public health crisis. Scientists from the UK took part in the review process in 2017 and 2018 when an urgent need for accelerated research and development for a range of diseases, including MERS, SARS and Disease X was identified [INQ000183447_0002 *disclosed in Module 1*]. CBFFJ welcome the fact that the Inquiry has included the extent to which the UK was prepared for rapid development of a 'Disease X' vaccine in early 2020 in its list of issues for this Module, and we submit that the same question should be asked in respect of the development of therapeutics.

18. In this regard we note the evidence of Sir Jeremy Farrar, now Chief Scientist at the WHO, that between February 2018 and early 2020 "there was very little attention paid to the concept of "Disease X" globally including in the UK" [INQ000496107_001; _004]. Dame Kate Bingham's view was that "there was no apparent Government plan for the

vaccine response to 'Disease X' [INQ000474406_011, §7.3]. Professor Sir Andrew Pollard's view is that "in early 2020 we were not well-prepared to make vaccines for disease X or even a coronavirus" albeit that we were better prepared than we would have been five years earlier [INQ000474399_010, §23]. Professor Wendy Barclay observes that "preparedness to find therapeutics for Disease X or COVID was at an even lower status in January 2020 than for vaccines" and that for coronaviruses we were "starting from scratch" [INQ000474315_007, §28].

19. Professor Barclay also observes that the UK is not, and by inference was not in 2020, independent in its ability to respond to a new outbreak and develop a new vaccine to Disease X, citing limitations in the UK's capacity in relation to secure labs with long term investment, production and testing small lots of novel vaccines for experimental medicine studies and small trials that are essential for triage in the development process, together with the lack of any onshore DNA synthesis capability to generate basic molecular biological reagents [INQ000474315_007, §27]. Other witnesses make similar points, including Professor Gilbert, who notes that the UK has "no national capability in vaccine manufacturing" [INQ000474278_013, §57] and Professor Pollard, who observes that investment in a manufacturing facility "would mitigate some of the difficulties in 2020 in vaccine development" [INQ000474399_010, §27]. The question of manufacturing capability is addressed further below.

20. While the running of clinical trials is considered to be a key strength in the UK, the evidence so far indicates that there were (and are) limitations in respect of preparation for phase 1 and 2 trials: see Technical Report [INQ000203933_314] and the evidence of Sir Jeremy Farrar [INQ000496107_005, §4]. Professor Sir Martin Landray notes the UK's advantages in terms of clinical trials but also points to areas where the UK was "much less prepared" including in relation to access to data, even with patient consent [INQ*474660_004, §16].

21. The Inquiry will also no doubt wish to consider the state of readiness of the UK Government to work with academia and industry to meet the (foreseeable) challenge of facilitating the development, procurement and deployment of vaccines and therapeutics in response to a pandemic. In her written evidence, Dame Kate Bingham expresses the view that "by 2020 the DHSC's expertise and plans in the vaccine field were narrow and constrained" and based too much on influenza models. She notes the failure of successive governments to build or maintain relationships with innovators and key figures in the vaccine field, concluding that "[t]he resultant lack of any real planning, industry relationships and skills were why the VTF had to be established at such short notice" [INQ000474406_011, §§7.3-7.4].

22. CBFFJ UK submits that in order to discharge its investigative role the Inquiry must ask whether the UK's response on vaccines and therapeutics was limited by these or any other shortcomings in preparedness.

Section 4: Beyond the headlines – evaluating the UK response

23. In our submission the Inquiry must also consider whether the UK's ability to respond was constrained by any other factors during the pandemic itself, including the efficacy of cross-departmental working, the ability of the relevant bodies and mechanisms to follow through on the policy objectives that had been identified, and any failure to capitalise on existing strengths.

24. In this regard CBFFJ UK looks forward to the Inquiry's scrutiny of the role of leading government departments, including HMT, DHSC, No 10 and the Cabinet Office and BEIS and the effectiveness of their work and working relationships on vaccines and therapeutics. This must include consideration of whether it should have been necessary to establish new structures such as the VTF and TTF and their surrounding governance arrangements in the height of the pandemic and the extent to which the success of those structures must be attributed to the ability of figures such as the GCSA and DCMO to mobilise their personal networks and the willingness of external professionals and academics to lend their time and expertise at short notice.

25. As to the government departments themselves, we urge by way of example careful examination of the approach adopted by HMT in respect of funding for this vital element of the pandemic response. While recognising the importance of HMT's role in protecting the public purse, the evidence so far indicates that there are legitimate questions to be asked about the appropriateness of HMT's approach to funding decisions in this context, particularly having regard to the policy priorities outlined by the government.

26. From the perspective of the VTF, Dame Kate Bingham notes that at an early stage the Treasury's "rigid Whitehall calculation methodology" was not fit for purpose in the context in which they were operating, considered that approval of the VTF budget was too slow, and identified an "aversion" among some Treasury representatives to "any spending that wasn't immediately critical to a short-term UK Government response" [INQ000474406_018, §14.3-14.5]. Similar concerns are raised by Sir Sajid Javid, a former Chancellor of the Exchequer who observes that in the circumstances it is not helpful for HMT to adopt an overly risk averse approach. He explains in his statement

that he struggled to get relevant financing within required timescales in connection with the approval of antivirals in late 2021 and that in September HMT had to be "dragged through this process" which took far longer than it should have. [INQ*474381_009, §§23-24; 071 §247ff].

27. As Chair of the ATF during this period, Eddie Gray is at pains to acknowledge the challenging economic position but nevertheless refers to debate within budget review as "little more than mischief-making by the Treasury" [INQ000474342_025 §60]. He describes the impact of an unwieldy process together with an unequal and flawed balance of power between HMT and other departments, which in the case of the ATF led to "a slow journey away from [DHSC] advocating what it felt was the appropriate public health response towards a position of finding a proposal that 'the Treasury would accept'." His view was that the ultimate result of this path, if pursued, would have been that the balancing decision between public health and affordability would, in effect, have been made inappropriately by relatively junior civil servants. In December 2021 Mr Gray became concerned that process issues meant that the rationale and arguments for ATF's proposal were being "lost or obfuscated" and at times he was required to approach both the Secretary of State and the PM directly to seek a resolution [INQ000474342_027 §§72-73].

28. A key indicator for the Inquiry to consider in its evaluation of the UK response is the extent to which the stated objectives of the VTF were fulfilled. CBFFJ UK note that the objectives were broad in compass, comprising not only securing vaccines for the UK but also seeking to promote equitable distribution of vaccines around the world and to promote long-term resilience for the UK in dealing with a future pandemic. The Inquiry will hear a wealth of evidence about the achievement of the first of these goals, and it is right that this should be properly recognised given the enormous impact on individual lives and society as a whole.

29. However, the evidence before the Inquiry is that the wider goals were not met. Dame Kate Bingham characterises the progress made in securing equitable access to vaccines across the world as "modest", expressing the view that the UK "donated too few vaccines to countries overseas" [INQ000474406_0059, §47.9] The Inquiry should consider the impact of this in terms of the UK's relative contribution to global vaccine access and its long-term role in international pandemic preparedness efforts.

30. Dame Kate Bingham expresses similar views in respect of the third goal, concluding that the VTF "did not succeed in building permanent pandemic capabilities in the UK". In particular, she raises concerns about the failure to build a bulk antibody

manufacturing capability in the UK, the failure to get VMIC on a secure footing and the failure to maintain positive and collaborative working relationships between government and industry [INQ000474406_0059-60, §§47.9-47.12].

31. CBFFJ UK welcomes scrutiny by the Inquiry of government actions and decision-making in respect of VMIC given its significance to the government's overall vaccine strategy and its importance in terms of future preparedness. Professor Gilbert notes that "the UK has no national capability in vaccine manufacturing, which VMIC would have provided" [INQ000474278_013, §57]. Professor Pollard observes that plans for VMIC were "shelved" and expresses the view that "VMIC could have filled some of [the] gap in capability for small to medium scale production and allowed more rapid innovation in vaccines in the UK post-pandemic" [INQ000474399_012 §28]. Dame Kate Bingham notes that the sale of the VMIC "has reduced our resilience and capability to be prepared for a future pandemic" and "could have been used to help with the innovation side of vaccine development and bulk manufacturing" [INQ000474406_060, §§47.11].

32. In light of this evidence, and that of Professor Sir John Bell to the effect that "failures of Government largely led to the collapse of this concept" the Inquiry must consider why VMIC failed, whether Professor Bell is correct in his understanding that the full amount of capital has been recovered by government (and whether this extends to the full amount of public funding which appears to be over £200 million [INQ000474557_033, §118), and whether adequate measures are in place to address the apparent deficit in support for life sciences and gap in preparedness which has resulted from the collapse of the project [INQ000499442_17, §54-55].

33. Similarly, the Inquiry should examine the decision by government to abandon the 'portfolio approach' to vaccine strategy and focus solely on building capacity for manufacture of mRNA. The evidence so far reveals that the criticisms levelled at this change of approach by Dame Kate Bingham and Dr Clive Dix are consistent with the findings of an independent report commissioned by the VTF onshoring directorate from McKinsey and Company, which found that "resilience requires multiple vaccines and biotherapeutics candidates in as many modalities as possible and the ability to develop, produce and distribute quickly and at scale" [INQ000474338_052, §215]. They also chime with the written evidence of Professor Pollard, who speaks positively of the mRNA manufacturing facility which will be provided by the partnership between the government and Moderna, but notes that "there is no big pharma manufacturing available in the UK using other vaccine platforms (except for the live attenuated

influenza vaccines) and so we do not have capability if mRNA turns out to be the wrong platform for a particular disease" [INQ000474399_013, §30].

34. Overall, the Inquiry must examine whether, as a result of these factors or otherwise, Dr Clive Dix is correct in his view that the UK is now in a weaker position than it was prior to the Covid-19 pandemic and has "rolled the dice on Moderna being our solution" this being "totally at odds to any strategy to build resilience and preparedness for the future" [INQ000474423_015, §6.2]. As far as vaccines are concerned, Professor Gilbert's statement is clear: "The UK is not well prepared to produce vaccines for the next pandemic, There is no co-ordination and no plan. There is no national capability." [INQ000474278_018, §82].

35. In parallel with its consideration of the wider vaccine response, CBFFJ submit that the Inquiry must also examine with care the strategy adopted with regard to therapeutics and antivirals, which were of key importance in the pandemic because of their role in protecting vulnerable people who could not receive vaccines or for whom vaccines were not effective: see for example the written evidence of Professor Landray as to their significance to a robust pandemic response [INQ000474660_077, §305]. As recognised by witnesses including Sir Jeremy Farrar and Lord Bethell, there was no guarantee of success in respect of vaccines when Covid-19 first emerged, and there would be no such guarantee in a future pandemic. Notwithstanding their great success, it is right to note that vaccines have not been able to prevent the spread of Covid-19 and do not fully protect against Long Covid, reinforcing the importance of therapeutics and antivirals.

36. The Inquiry is urged to evaluate the evidence to date which indicates that therapeutics and antivirals were not sufficiently prioritised. In his written evidence Sir Jeremy Farrar observes that "we do not have the balance right at present" between investment in and development of therapeutics on the one hand and vaccines on the other [INQ000496107_007]. Dame Kate Bingham expresses concern about the respective approaches to vaccine and therapeutics and antivirals within the UK's pandemic response, [INQ000474406_043, §38.15]. The evidence referred to above about funding decisions in respect of antivirals is also relevant to this assessment, as is the perception of Charlotte Taylor of the ATTF that there was "limited enthusiasm for prophylactic use across the system", a view that the GCSA considered to be misguided, telling Ms Taylor there was a "clear place for them" which just needed to be defined [INQ000066712_002].

37. Issues also arise for consideration in relation to clinical trials, notably Sir Jeremy Farrar's evidence that in January-May 2020 "time was lost in frustrating discussions, dysfunctional planning and execution in setting up a component of the Therapeutics Taskforce for triage of earlier stage assessment of potential therapeutics in Phase I, IIa and IIb Clinical Trials before such interventions were appropriate for assessment in the RECOVERY Trial". The Inquiry will need to consider this, together with his assessment that in future this should be established from day one, and also his observation that it took almost two years for the PANORAMIC community-based trial to get started [INQ000496107_005]. Professor Anthony Gordon also notes that "[t]he phase 2 trial space, evaluating more novel interventions earlier in the development process was less effective" [INQ000474416_019, §58] reflecting the conclusion of the Technical Report. Professor Tom Wilkinson reflects on the need for pre-existing plans for trial set up and delivery and an established plan to coordinate delivery of studies of all phases effectively, noting that "[t]his was lacking at the beginning of the pandemic" and could be addressed by establishing an extant capability [INQ000474619_029, §91.

38. The Inquiry must also carefully examine observations of those involved in clinical trials in respect of preparedness and resilience for future pandemics, including Professor Khoo's argument for publicly-funded trials platforms (noting that a model whereby early-phase drug development is industry's responsibility does not work for pandemic preparedness) [INQ000474449_016, §58]. This resonates with observations from others including Professor Christopher Butler, who notes problems with traditional funding models, which are not appropriate for platform trials. His application for funding to keep the PANORAMIC trial open as part of the UK's pandemic preparedness was met with the response that they did not fund infrastructure but only specific study hypotheses [INQ000474479_009, §42].

39. The Inquiry will no doubt be keen to do what it can to assist in avoiding a repeat of the missed opportunities identified by Professor Khoo, including the shelving of development for antivirals and the monoclonal antibody sotrovimab after the resolution of the SARS outbreak in 2001-2004 [INQ000474449_016, §58].

Section 5 - Structural and institutional discrimination

Vaccine uptake among ethnic minority and migrant groups

40. The UK entered the pandemic with increasing health inequalities and health among the poorest people in a state of decline. It was known from previous pandemics and research into lower respiratory tract infections that people of lower socioeconomic

status, people living in areas or regions with higher rates of deprivation, people from minority ethnic groups and disabled people are much more likely to be severely impacted by a respiratory pandemic. Pre-pandemic government policies failed to have adequate regard to pre-existing health inequalities, which impacted how the Covid 19 vaccine was rolled out, [INQ000195843_0077].

41. It was anticipated that the medium-term response to a novel virus would be managed through a vaccination programme and that its successful implementation would be dependent on uptake, which would differ among different ethnic and socioeconomic groups. Although it was known from national pre-pandemic vaccine programmes that vaccine uptake was lower among people from ethnic minority backgrounds and migrant groups this was not adequately addressed in pre pandemic planning, Covid 19 vaccine development and trials, Covid 19 vaccine prioritisation and/or vaccine roll out.

42. The Inquiry will have in mind the barriers to vaccine uptake among ethnic minority groups identified by the SAGE ethnicity subgroup prior to the vaccine roll out. They included: perception of risk, low confidence in the vaccine, distrust, access barriers, inconvenience, socio demographic context and lack of endorsement, lack of vaccine offer or lack of communication from trusted providers and community leaders [INQ000250215_0001]. Some of these barriers have been echoed through the lived experiences of FEMHO's members which include a lack of distrust in institutional powers, historic under representation and lack of diversity in clinical trial and lack of research and development of tailored treatment plans for diverse communities, [INQ000485278].

43. The SAGE ethnicity subgroup also forewarned that the failure to overcome barriers to vaccine uptake created a significant risk of lower Covid 19 vaccine uptake among people from ethnic minority backgrounds and advised on measures to overcome these barriers – including multilingual non stigmatising communication, increasing awareness, understanding and addressing different religious and cultural concerns and community engagement from trusted sources, [INQ000250215_0001].

44. The imperative to address barriers to Covid 19 vaccine uptake in ethnic minority communities emerged quite early in the pandemic: people from many BAME backgrounds were at risk of contracting Covid 19 with worse outcomes than their white counterparts; 34% of the people admitted in ICU in April 2020 were from BAME background, ONS data published in May 2020 showed that people from BAME backgrounds were experiencing the effects of Covid 19 more severely, and often with

poorer outcomes than their white counterparts; the first 10 doctors who died from covid 19 were from BAME backgrounds and 63% of healthcare workers who had died from Covid 19 in June 2020 were from BAME backgrounds [INQ000468639_0007].

45. It was also known that people from migrant communities were at greater risk of exposure to and harm from Covid 19 infection due to poverty. They continued to undertake front line work, often on zero hour contracts or cash in hand jobs and lived in poor and overcrowded housing. UK migrants had 22% higher odds of infection during the second wave of the pandemic compared to the UK-born population and overcrowding accounted for 32% of these increased odds. [INQ000474407_0013]. Vaccine uptake among migrant communities was affected by hostile environment laws and policies designed to deter and prevent migrant access to health care, chronically low levels of GP registration (including refusals by GP practices to register migrants and refugees and patients), socio economic barriers to uptake (including poverty and destitution, lack of transportation and language barriers, digital exclusion particularly among undocumented migrants), restriction on access to vaccines for those in asylum accommodation or detention and poor communication strategies [INQ000474407_0017].

46. The Inquiry will be mindful of this background in its assessment of the barriers to vaccine uptake faced by migrant communities, whether and the extent to which they were contemplated and addressed in the vaccine planning and roll out and the consequence of this.

47. The families consider that the government's failure to engage with and address known and pre-existing barriers to vaccine uptake among ethnic minority and migrant groups in its pre- planning, development and roll out of Covid 19 vaccine is consistent with structural and institutional racism [Nazroo §80 – 83 INQ000280057] and invite the Inquiry to examine the causal link. In particular the families urge the Inquiry to consider this a systemic issue rather than blaming marginalised people themselves, which is itself a manifestation of structural discrimination.

Prioritising Vaccines

The vaccine roll out was largely age-based cascading from the oldest age groups - with those 70 years and older, residents in care homes for older adults and their carers, frontline health and social care workers and the clinically extremely vulnerable being among the first cohort. This approach to vaccine priority resulted in significant numbers of the population from ethnic minorities and migrant backgrounds being excluded from early vaccine priority. The Inquiry is invited to assess whether factors such as poverty,

pre-existing inequalities, increased exposure to Covid 19 among people from ethnic minority background, the role of workplace inequalities in the differential impact of the pandemic on ethnic minorities and pre-existing barriers to vaccine uptake among ethnic minority and migrant groups should have been considered in prioritising early vaccine eligibility. The inquiry will have in mind the expert evidence received in Modules 1 and 2 on structural and institutional racism in its assessment of the approach to vaccine prioritisation among ethnic minorities and migrant groups.

48. The Inquiry is also invited to assess whether the prioritisation process may have exacerbated inequalities for ethnic minority and migrant groups. The inquiry will have in mind the UK government's apparent failure to consider the pre-existing barriers to vaccine uptake among ethnic minority and migrant groups and the SAGE ethnicity subgroup's report which cautioned that the failure to understand the views, needs and barriers to vaccine uptake risked exacerbating pre-existing inequalities [INQ000250215_0003].

49. Given the known barriers to vaccine uptake among ethnic minority groups the Inquiry is invited to assess whether the low vaccine uptake among these communities was foreseeable.

50. Several bereaved families of Black and Asian ethnicity are concerned that the government's response to the low uptake to the Covid 19 vaccine among ethnic minorities, migrant communities and regions with higher rates of deprivation was reactive following its failure to proactively engage with and prioritise people from these groups for vaccination. The families consider that this reactive approach which lumped vaccine hesitancy with low vaccine uptake under the headings "*confidence*" "convenience" and "*complacency*" failed to address the real barriers to vaccine uptake by ethnic minority, minority and deprived communities.

51. There is also strong feeling among our bereaved families from Black and Asian background that the term "*vaccine hesitancy*" to describe vaccine uptake among ethnic minority and migrant groups is to be rejected as it fails have due regard to the barriers to vaccine uptake among people from ethnic minority backgrounds. The terms *vaccine scepticism* or *vaccine non-confident or lack of confidence* (suggested by FEMHO) are preferred [INQ000485278_16- 17].

52. The Inquiry will bear in mind the lived experiences of ethnic minority, migrant groups and those from deprived communities in its assessment of the effectiveness of the government's response to low vaccine uptake among these groups. We commend to

the Inquiry's attention the experiences of FEMHO members [INQ000485278] and MPCAG [INQ000474407]. detailed in their respective witness statements.

53. In assessing the government's response to low vaccine uptake among migrant and ethnic minority communities, the inquiry will also have in mind the expert evidence received in Modules 1 and 2 on structural and institutional racism.

UK's overall vaccination compared to the rest of Europe

54. During the first half of 2021 vaccination rates and coverage in the UK grew faster than among its closest European neighbours. However, although two thirds of the population was vaccinated by the end of September 2021 ethnic minority and migrant groups accounted for a significant number of unvaccinated people in the UK.[1] This deficit in vaccination among ethnic minority and migrant group was not addressed and the figures suggest that the UK's population vaccination coverage was surpassed by other western European countries such Spain and Portugal. The Inquiry is invited to assess whether and the extent to which its overall vaccine coverage was impacted by low rates of vaccination of people from migrant and ethnic minority groups.

Vaccine as a condition of deployment (VCOD)

55. The Inquiry will have in mind the barriers to vaccine uptake among ethnic minority groups and the government's response, including its adequacy in its assessment of the introduction of the VCOD scheme among health care workers.

Section 6: Conclusions and the next pandemic

56. The families campaigned for this Inquiry, making it clear that they wanted it to deliver conclusions and recommendations as quickly as possible. However, as with other modules, the Inquiry has a difficult task in M4 having listed it for just 11 days of evidence. This is particularly so, given the devolved nature of public health and health and social care sectors.

57. We urge the Inquiry to lead uncontroversial evidence and to cut through self-congratulatory and self-serving material from politicians and senior officials. On the other hand, we urge the Inquiry not to rush evidence of lived experience, and evidence

[1] Not by choice – the unequal impact of the covid -19 pandemic https://raceequalityfoundation.org.uk/health-and-care/not-by-choice-the-unequal-impact-of-the-covid-19-pandemic/

relating to deep-rooted and repeat issues such as structural and institutional discrimination. Mere recognition and handwringing over these issues will mean that the same problems will recur in the future. It is essential that this Inquiry makes recommendations which demand attention and does not pass up a historic opportunity to prompt Government and all institutions to take action.

58. In similar vein we reiterate our earlier submissions that issues of resourcing are central to issues covered by the terms of reference. A public inquiry is not constrained by the limitations of public law litigation which separates legality from democratic choices concerning where the resources of society should be allocated: quite the opposite. Where the insufficiency of resourcing is relevant to the issues under consideration by a public inquiry it does not have a choice, it is compelled to address them, or it will fail to discharge its terms of reference. This Inquiry should address resourcing in two key ways. Firstly, it must not shy away from robust findings of facts as to the reality of where resourcing plainly adversely affected preparedness for the pandemic, both resilience and planning. Secondly, issues of resourcing are vital to recommendations for the future. The corollary is that a public inquiry does not seek to determine issues of liability, and recommendations are just that. Recommendations must be fully considered, and the Inquiry must call for them to be acted upon swiftly, or rejected, partially or in full, only with open and transparent reasoning. A failure to be forthright and bold in the making of recommendations from an Inquiry as historic as this, means that little is likely to change. Experience from many previous inquiries, suggests that a failure to ensure recommendations are acted upon means that they are likely to be ignored.

Pete Weatherby KC
Allison Munroe KC
Kate Stone
Thalia Maragh
Lily Lewis
Hamish McCallum
Counsel for CBFFJ UK

Elkan Abrahamson
Nicola Brook
Emily Driver
Broudie Jackson Canter Solicitors
Solicitors for CBFFJ UK

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