

Thursday, 16 January 2025

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2 (10.00 am)  
3 **LADY HALLETT:** Ms Stephenson.  
4 **MS STEPHENSON:** Good morning, my Lady. The first witness  
5 today is Dr Salman Waqar.  
6 **DR SALMAN WAQAR (sworn)**  
7 **Questions from COUNSEL TO THE INQUIRY**  
8 **MS STEPHENSON:** Good morning.  
9 Please can you say your full name.  
10 **A.** It's Salman Waqar.  
11 **Q.** Dr Waqar, thank you for attending today to assist the  
12 Inquiry. A few preliminary matters. Can I just ask you  
13 to speak up, keep your voice nice and loud and directed  
14 towards the microphones and speak slowly, please.  
15 You have made a witness statement on behalf of the  
16 Federation of Ethnic Minority Healthcare Organisations,  
17 dated 6 June 2024, INQ000485278. Can you confirm that  
18 you've read your statement recently.  
19 **A.** Yes.  
20 **Q.** And are its contents true?  
21 **A.** They are.  
22 **Q.** I just want to touch briefly on some background matters.  
23 You are a practising GP; is that right?  
24 **A.** That's right.  
25 **Q.** You hold a number of senior training roles and

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1 could speak up I'd be really --  
2 **A.** Sorry.  
3 **MS STEPHENSON:** If we can begin with one of the most  
4 fundamental of areas of concern that you raise within  
5 your statement, which is the issue of historic mistrust  
6 amongst ethnic minority communities.  
7 Your statement explains how those historic  
8 experiences have fed into mistrust of the healthcare  
9 system and of vaccines, as we're looking at obviously in  
10 this module in particular.  
11 Can you explain, please, how some of those past  
12 experiences contribute to lack of confidence in  
13 vaccination programmes.  
14 **A.** Certainly. So I think it's important to recognise, as  
15 the Inquiry has vitally heard in the past, that these  
16 are not new issues; these are historic. But they're not  
17 historic for us because they're lived realities as well.  
18 And we also have the skin in the game as well, if I may  
19 put it that way, in that we know that our relatives and  
20 ourselves experience disproportionate outcomes in many  
21 other areas. We know, for example, that if you're  
22 a black woman you're three to four more times likely to  
23 die during childbirth. So if you're carrying that into  
24 the pandemic, you're obviously going to be looking at  
25 this is and thinking: are the same things going to be

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1 fellowships and you're one of the founder members of  
2 FEMHO as I'm going to call the organisation?  
3 **A.** Correct.  
4 **Q.** FEMHO, briefly touching on the nature of the  
5 organisation, is a voluntary multi-disciplinary  
6 consortium, so it comprises of over 55,000 individual  
7 members, belonging to 45 organisations and networks, and  
8 brings together organisations on behalf of black, Asian  
9 and minority ethnic health and social care workers at  
10 all levels within health and social care; is that  
11 correct?  
12 **A.** That's correct.  
13 **Q.** Can you just set out for us what the aims of FEMHO are?  
14 **A.** So we are healthcare workers who have been working in  
15 our day jobs in the system but also a part of the  
16 communities that we hail from, so we recognise many of  
17 the issues that affect us. So we are trying to address  
18 some of those structural issues that impact us and to  
19 try to offer solutions in a workable way to the system.  
20 So we engage with the health policy individuals and  
21 organisations as well as back to our communities as  
22 well.  
23 **Q.** Thank you. And --  
24 **LADY HALLETT:** Dr Waqar, I'm terribly sorry, it's probably  
25 my age -- you'll be able to tell me as a GP -- if you

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1 happening to our communities as well?  
2 And I would say that there may be -- and this isn't  
3 an academic point, but I think there may be a difference  
4 between distrust and mistrust as well. I think you may  
5 have misgivings about a system but if you have more than  
6 misgivings, if you think the system is actively harming  
7 you, by evidence, by -- you can -- the evidence for that  
8 you can give through your lived experience, and through  
9 the fact that in the past, when it comes to vaccination,  
10 we have several examples such as the Tuskegee trial in  
11 America, such as -- in this country, in the UK, we had  
12 radioactive chapatis given to ladies in the sixties  
13 without their consent, these things filter through the  
14 generations. And so when we are exposed to the Covid-19  
15 Inquiry, as we set out in the evidence as well, I think  
16 those things are very much at the tip of people's  
17 thoughts, and they drive the behaviours that they --  
18 that we saw in many of these communities.  
19 **Q.** Thank you. Can I just ask you to slow down in your  
20 answers so that the stenographers can record your  
21 evidence in full.  
22 You cite as a factor in eroding trust the use or  
23 misuse of personal data of ethnic minority people as  
24 being an experience that's been reported to you. How  
25 does that feature in the issues that you've just talked

4

1 about?

2 **A.** So you can't fix what you can't see, and we saw during  
3 the pandemic that poor data around ethnicity and many  
4 other factors drove some of the awareness and some of  
5 the responses that the system gave to the affected  
6 communities.

7 If you don't trust the fact that you record your  
8 ethnicity on a system or your religion or any other  
9 characteristics of yours in your GP records, in your  
10 hospital records, in any other official records that  
11 exist, because of what you have not only seen yourself  
12 but you have heard other people telling you, or you just  
13 have a view that this is what happens to your records,  
14 those data won't be visible on the system. So we were  
15 going into this somewhat blinded in terms of not knowing  
16 the full extent of the issues that we had.

17 **Q.** I'm just going to pause you there because we're going to  
18 come on to the adequacy of data recording and of ethnic  
19 minority group identifying information. But in terms of  
20 issues of trust and confidence, was it the case, as you  
21 set out in your statement, that in the past there have  
22 been issues such as use of the Home Office, in  
23 communication between the NHS and the Home Office, which  
24 has affect the trust of some ethnic minority community  
25 members in healthcare services, and vaccination

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1 **A.** Correct, yes.

2 **Q.** That brings us on to, then, the issue of clinical trials  
3 and diversity in trials. It's a concern that you  
4 highlight within your statement that there has been  
5 a historic issue of underrepresentation in clinical  
6 trials. Can you expand on why that was a significant  
7 issue for the communities that you speak for in terms of  
8 Covid vaccines?

9 **A.** So when you are communicating to people about any sort  
10 of therapy, you want to reassure them that this is the  
11 right therapy for them and any risks are outweighed by  
12 the benefits that they will have, and often people will  
13 ask questions around safety, as you've alluded to, and  
14 people want to know, is this right for me and people  
15 like me, given all these things that we just discussed  
16 about around the inequalities that they experience.

17 If we're not able to say to them that these  
18 medicines, these therapies have been tested upon people  
19 like you -- and that isn't just purely a genetic thing,  
20 it's also about people who are in a similar lifestyle  
21 situation as them, for example, their social situations,  
22 their economic situations, how they interact with one  
23 another. We know, for example, in Covid there is  
24 a serious risk of transmission, so if you are from  
25 a community which socialises a not more, socialises in

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1 programmes?

2 **A.** Sorry, yes, that's correct, yes.

3 **Q.** You also refer to the rapid development of vaccines, as  
4 many of your members saw it, as a factor affecting trust  
5 and confidence in the Covid vaccines. Can you explain  
6 how the speed of development fed into issues of trust?

7 **A.** On the one hand it was phenomenal that we managed to do  
8 that, as a nation, as humanity, that we were able to put  
9 those vaccines to market. But when you're dealing with  
10 a community which has got these issues around where are  
11 you going with this? What is the ultimate goal of this?  
12 When you have other people out there that are taking  
13 advantage of that, which I know you'll talk about in  
14 a moment, around communications, it just means that if  
15 that's not appropriately communicated, that just  
16 enhances that divide that people have in terms of  
17 understanding what those -- why has it come about so  
18 quickly, and have we made some shortcuts here and could  
19 that potentially harm our communities more, given the  
20 fact that -- what we know about the historic issues that  
21 affect them.

22 **Q.** So really it's about communities being satisfied that  
23 all the proper safety procedures have been followed, and  
24 that this has followed a thorough course of trials and  
25 regulatory approval?

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1 certain ways, then the way that those data will present  
2 themselves in real life will be potentially quite  
3 different from what they are in other communities.

4 And we know that ethnic minority communities have  
5 got inequalities, as I mentioned earlier, and these  
6 social determinants of health don't necessarily come  
7 forth in the way the data are presented, and so when we  
8 put that to communities, it's important that we're able  
9 to say that these medicines, these vaccines, have been  
10 tested on people like yourself, and that's why you can  
11 have more confidence in the data that they show around  
12 the safety and effectiveness.

13 **Q.** So would it be fair to say it's not just about ensuring  
14 that the trials include a representative group from  
15 society, but also that healthcare professionals who are  
16 giving people information about the vaccines are well  
17 informed enough to be able to tell them that people, to  
18 borrow your words, who are like them, have been included  
19 in trials?

20 **A.** Correct.

21 **Q.** I want to move on now, please, to the effectiveness of  
22 the post-marketing surveillance systems for the  
23 vaccines. So starting with the Yellow Card system. How  
24 would you describe the level of awareness and  
25 understanding of the system amongst the communities that

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1 you represent?

2 **A.** Not particularly good. I would go as far as to say I  
3 don't think many people are aware of the Yellow Card  
4 Scheme even now, and this isn't just amongst ethnic  
5 minority health workers or patients, I think amongst the  
6 general healthcare workforce the Yellow Card Scheme is  
7 perhaps not particularly well understood.

8 As I've outlined in my statement, and just to  
9 briefly summarise, it's currently still only available  
10 in English. If you go today on the MHRA website, it  
11 asks you to use Google Translate to translate the Yellow  
12 Card Scheme if you wish to report it online. And there  
13 are many other factors that I've mentioned, again in my  
14 statement, around the fact that the way it's distributed  
15 is still very much you have to go out of your way to  
16 report it rather than asking communities to report about  
17 it. And I think it circles back into this issue of  
18 trust.

19 If people want -- if people are concerned about the  
20 side effects and safety of the vaccines, as we've set  
21 out, there should be mechanisms in place that allow them  
22 to express those, in confidence, and then to have the  
23 transparency around what are they actually seeing,  
24 insofar as how it's affecting their communities so that  
25 they will have more confidence in taking the vaccine and

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1 examples of how the Yellow Card could be improved.

2 **Q.** You touched already on communication and accessibility  
3 of communications and that's the next topic I would like  
4 to come to. The words that you use in your statement  
5 are "inexcusable paucity of accessible communications"  
6 when it comes to information about the vaccines and how  
7 to access them.

8 Could you expand on that, please. What were the  
9 difficulties encountered?

10 **A.** I think this -- this, for me, I think brings everything  
11 together. So when you have got the situation where we  
12 are in, where there is -- where there are existing  
13 historic inequalities you've got the issue around  
14 distrust and mistrust in the system, you've got systems  
15 that may not necessarily be set up well to pick up some  
16 of these signals, all the issues that we've identified.  
17 I think it then is incumbent upon us to try to identify  
18 effective mechanisms to proactively address those. And  
19 so I think because the visibility wasn't there, we  
20 weren't able to see effective communications come forth.

21 And I would say that, you know, if I may, my Lady,  
22 use a phrase, there is this idea that if someone says  
23 the moon is made of cheese, for example, you have to  
24 exert an order of magnitude greater of effort to try to  
25 debunk that, because it's very easy to come up with

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1 other therapies in the future.

2 Could we look, then, at having identified the  
3 problems that you have with the Yellow Card system.  
4 What are some improvements that you might suggest to  
5 make it more inclusive?

6 **A.** So, as I mention, I think the translation element is  
7 certainly one that warrants further exploration. I'd  
8 like to come on later about some of the limitations of  
9 translation later in my evidence, if I may. But I think  
10 it is important for communities to know that this is  
11 available to them, but the way that those -- the Yellow  
12 Card is available, for example, if you go to your  
13 pharmacy and you wanted to report something to your  
14 community pharmacists, are there mechanisms in place  
15 there where those trust relationships do exist,  
16 particularly in communities where community pharmacies  
17 are particularly well anchored into those localities for  
18 people to be able to express their concerns about the  
19 medicines that they're taking.

20 But also, the card itself doesn't collect  
21 demographic data. It doesn't collect ethnicity, I just  
22 looked at it the other day, it still doesn't collect  
23 data around ethnicity -- and also occupation, speaking  
24 as a healthcare worker, as well, if there was any  
25 occupational impact of that. So those are just some

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1 something that is completely nonsensical.

2 So this BS principle, if I may call it that, is  
3 something we saw a lot of. And I say that because for  
4 our communities to actually exert that extra effort was  
5 an order even greater than what someone else would have  
6 to do because we're dealing with so much more issues in  
7 our communities to tackle.

8 **Q.** Are you referring here to misinformation, or misleading  
9 or false information about the vaccines that might take  
10 hold and the difficulties in counterbalancing that? Is  
11 that what you're referring to?

12 **A.** Yes, but also the fact that much of the misinformation  
13 had in it kernels of truth, and how do you disentangle  
14 the truth from the misinformation is what became a real  
15 challenge for us, given the fact that we didn't  
16 necessarily have the resources to be able to do that  
17 because, as we set out in our statement, that it became  
18 incumbent upon us to go out into communities and to do  
19 that work on behalf of Public Health England and other  
20 agencies.

21 **LADY HALLETT:** Sorry to interrupt, Ms Stephenson. What  
22 resources would have helped you? It's really difficult,  
23 once misinformation gets out there on social media. So  
24 how could anybody have assisted you in stopping the  
25 spread of misinformation and correcting the position?

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1 **A.** At the time, one of the social media companies,  
2 Facebook, actually gave two of our member organisations  
3 about half a million dollars in ad credit to go out  
4 there and to continue doing the good work that they were  
5 doing. We didn't get that in kind from our existing  
6 government agencies, for example, to be invited to sit  
7 on tables, to have those conversations so we are able to  
8 take that information back to our communities in ways  
9 that are meaningful.

10 So, for example, if a community, an ethnic minority  
11 community, assembles in places of worship or there are  
12 certain cultural practices, they want to know specific  
13 data around what about our community and the context  
14 that we're in. It wasn't easy to have those  
15 conversations.

16 So I think being invited to those platforms and  
17 being given a -- you know, having that equity of access  
18 to information is important, and then being resourced to  
19 do that. And we set this out later, that all of us in  
20 FEMHO, the 45 networks that are in our organisation, are  
21 all doing this in our spare time and we're all working  
22 as clinicians as well.

23 I think there's -- I mean, I would say this, but  
24 I would say that there is great value in having someone  
25 who is a clinician, who is able to understand the

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1 being set out about what was going on in our  
2 communities, but these were not the most effective  
3 messengers for the communities of interest that we are  
4 talking about.

5 And so you didn't necessarily even need to translate  
6 any of that; you just needed to have the right person in  
7 the right room talking to those people. And then  
8 I think it just goes back to that point that I made  
9 around you had those people available, you had ethnic  
10 minority healthcare workers and other leaders within  
11 ethnic minority communities at the ready, doing lots of  
12 great work -- I should add, as I mention in the  
13 evidence, lots of work was done, and still is being done  
14 to this day -- but it's just not seeing the light of day  
15 and being resourced equitably to do so.

16 **Q.** There was, of course, a government-run scheme, the  
17 Community Champions scheme, and you speak in your  
18 statement about how effective that was. Could you tell  
19 us the views of the organisations you represent about  
20 that?

21 **A.** Our organisation members did not have visibility of  
22 that, unfortunately.

23 **Q.** When you say they didn't have visibility, what do you  
24 mean by that?

25 **A.** We didn't -- we didn't know that that was available.

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1 clinical issues but also from the communities that are  
2 affected to act as that boundary spanner and to bridge  
3 some of those issues around trust and mistrust but also  
4 present the good work that we're doing as well. And  
5 I think there was an opportunity there that wasn't taken  
6 up.

7 **MS STEPHENSON:** So if we summarise those practical changes  
8 that might help: the properly resourced ability to go  
9 out into communities and disseminate information, the  
10 social media or online campaigns that you have  
11 described, and you also referred earlier to translation  
12 or translation services, and you said it's not just  
13 about translating. From a practical point of view, what  
14 did you mean by that and what could change to improve  
15 things?

16 **A.** Sorry, translation is very important. It is very  
17 helpful for people to feel more confident, and feel more  
18 aware that they are having an equitable offering of  
19 health resources made to them. But we often made this  
20 point during the pandemic: that the messenger was  
21 sometimes more important than the message.

22 By which we mean that it was wonderful having  
23 Professor Chris Whitty and the other chief medical  
24 officers on our television telling us about what we must  
25 to do, it was wonderful to see the graphs and those data

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1 I think any members that did, it wasn't clear how they  
2 might access it because I think it was distributed  
3 through local councils, not centrally through local  
4 government -- through government, excuse me -- and via  
5 health professional organisations working within the  
6 health sector not necessarily within the local  
7 government space.

8 So I think the other element is also because we are  
9 voluntary organisations. Anyone who works in the VCS  
10 sector knows that you need to have a certain degree of  
11 organisational maturity to be able to access some of  
12 that funding, and so I think that made that more  
13 difficult for us -- for those individuals who were aware  
14 of it to be able to access it.

15 But certainly, from the majority of our 45 members,  
16 if I may say, all of them, none of them accessed that  
17 funding.

18 **Q.** Is there anything else that you would like to add about  
19 the issue of engagement with government? And I'm  
20 thinking in particular of something you touched on  
21 earlier about including people in -- as stakeholders in  
22 the committees or parts of government that are making  
23 decisions? Can you tell us about whether that's  
24 important and how you'd like to see that change?

25 **A.** Yes. I think a recognition that -- and you've heard

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1 through the Inquiry already that these systemic issues  
 2 do exist -- I think is incredibly critical to allow  
 3 those other doors to open. We have found it  
 4 a concerning and consistent issue that the issue of  
 5 racism is one that is just not discussed. We seem to  
 6 skirt around it, around the issue of should people have  
 7 vitamin D or not, as we heard in earlier modules; should  
 8 people be prioritised or not for the vaccination based  
 9 on other issues other than race; should people get  
 10 access to PPE because they wear beards, or not? But the  
 11 issue of race still seems to be one that we are still  
 12 quite squeamish about to discuss, and I think it's a  
 13 very important issue for us to discuss because, as we  
 14 have heard, it's one that consistently comes up and the  
 15 lack of our ability to be at these top tables to make  
 16 some of these decisions means that we are not able to  
 17 bring all of this information that I'm able to tell you  
 18 now effectively into those spaces.

19 And again, earlier we've heard about, I think it was  
 20 the previous module, when my colleague Professor Bamrah  
 21 talked about issues around some of the terminology  
 22 around communities being hard to reach and consistently  
 23 using terms such as "vaccine hesitancy" when describing  
 24 what for these communities was actually a very logical  
 25 decision. I mean, we should be hesitant because of what

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1 the pandemic already an excess death amongst your  
 2 co-workers -- I think something like 63% of people who  
 3 died during Covid who were health workers were from BAME  
 4 backgrounds, when you've experienced issues around  
 5 accessing PPE, when you've experienced issues around  
 6 every time you raise your voice to talk about can we  
 7 have more inclusive things for our communities, you're  
 8 shut down, and then you're told that you've decided not  
 9 to take the vaccine on the basis of the fact that you  
 10 haven't got the confidence around the issues to do with  
 11 the trials and issues to do with the side effects, and  
 12 so on, that you're told you're going to lose your job,  
 13 in an environment where it wasn't necessarily discussed  
 14 as an issue around role and task rotation, it was a case  
 15 of you either have your job or you don't, I think it  
 16 wasn't surprising that we had so many people deciding  
 17 that they weren't going to continue their work if they  
 18 weren't vaccinated, had they made the choice not to be  
 19 vaccinated.

20 I think in terms of a solution for that, because we  
 21 want to try to avoid this happening in the future,  
 22 I think if you do all of what we have already discussed,  
 23 we should hopefully find ourselves in a situation, as we  
 24 did with Covid, that we didn't need to use vaccines as  
 25 a condition of deployment because enough people had

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1 we've experienced. It's actually an issue of  
 2 confidence.

3 I think that, you know, that language and the  
 4 ability to be effective all stems from the fact that we  
 5 haven't necessarily understood that there are issues of  
 6 racial inequalities and racism that affect these  
 7 communities.

8 **Q.** And is your concern also that if government are using  
 9 the language of "hard to reach", for example, that that  
 10 might lead to alienation amongst communities who are  
 11 hearing that language and feed into the cycle of  
 12 mistrust?

13 **A.** Certainly. And I would add too, not only the  
 14 communities but the policymakers and the individuals who  
 15 are involved in setting these policies, it externalises  
 16 the problem that it's not us, that we need to do more,  
 17 that it's those communities, that they need to do more.

18 **Q.** The final topic I would like to ask you about,  
 19 vaccination as a condition of deployment. Why was this  
 20 such a key area of concern for those you represent,  
 21 please?

22 **A.** For all the issues that we've already discussed. If you  
 23 are experiencing bullying, harassment, ostracisation,  
 24 anyway at your place of work, just because of the colour  
 25 of your skin, and on top of that you've experienced in

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1 confidence to get vaccinated, but I hope to be able to  
 2 do that sooner using some of the things that we have  
 3 already discussed, so that more ethnic minority health  
 4 workers and, indeed, other members of the public and  
 5 other healthcare workers will feel confident and they  
 6 won't need to have it made a condition for deployment.

7 **MS STEPHENSON:** That concludes the questions that I have for  
 8 you.

9 Does my Lady have any questions?

10 **LADY HALLETT:** No, I don't. I am extremely grateful to you,  
 11 Dr Waqar, please continue your good work both as a GP,  
 12 trainer and, obviously, acting for FEMHO, I'm really  
 13 grateful to you for what you do.

14 **THE WITNESS:** Thank you.

15 (The witness withdrew)

16 **MS STEPHENSON:** My Lady, the next witness will be Yvonne  
 17 MacNamara.

18 **MS YVONNE MACNAMARA (sworn)**  
 19 **Questions from COUNSEL TO THE INQUIRY**

20 **LADY HALLETT:** Thank you for coming to help us,  
 21 Ms MacNamara.

22 **THE WITNESS:** Thank you for inviting me.

23 **MS STEPHENSON:** Please can you say your full name.

24 **A.** Yvonne MacNamara.

25 **Q.** A few preliminary matters. Can I just ask you, as you

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1 may already have heard to keep your voice up and into  
2 the microphone nice and loud and to speak slowly.

3 You have made a witness statement on behalf of the  
4 Traveller Movement, dated 8 January at 2025,  
5 INQ000474770.

6 Can you confirm that you've had the opportunity to  
7 read that statement recently, and that its contents are  
8 true?

9 **A.** Yes, I did, and the contents are true.

10 **Q.** Thank you. I just want to go briefly to the background  
11 of your organisation. The Traveller Movement is  
12 a charity which advocates on behalf of Gypsy, Roma and  
13 Traveller people, and you are its chief executive  
14 officer; is that right?

15 **A.** That's correct.

16 **Q.** Traveller Movement you describe as an advocacy movement,  
17 particularly important in a society where the voices of  
18 Gypsy, Roma and Traveller people often go unheard, and  
19 you're the largest organisation in the UK which  
20 represents the interests of those three communities. Is  
21 all of that correct?

22 **A.** Yes, that's all correct.

23 **Q.** I'm going to, if I may, adopt the language that you use  
24 in your statement, the shorthand of GRT to describe  
25 those communities.

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1 health outcomes in the UK, including the lowest life  
2 expectancy of any group, which of course makes  
3 communities more vulnerable to Covid-19. It's also  
4 important to acknowledge that the Inquiry has received  
5 some expert reports which will be considered, but give  
6 an indication that, at least in a study in Scotland,  
7 towards the end of 2022, it was estimated that just 55  
8 or, rather, 55% of Gypsy and Traveller people had not  
9 had their first dose of the Covid-19 vaccine. So is  
10 that the context in which you are --

11 **A.** Yes.

12 **Q.** -- giving the evidence that you are giving today?

13 **A.** Yes.

14 **Q.** Thank you. I'll move first, then, to asking you about  
15 the barriers in access to information about Covid-19  
16 vaccinations. The first you speak about in your  
17 statement is that rates of literacy have historically  
18 been low in GRT communities. Can you explain how that  
19 affected accessibility when it came to the Covid-19  
20 vaccinations and information about them?

21 **A.** Well, many individuals, you know, truly faced many  
22 barriers, one of which is the low literacy levels,  
23 digital exclusion, Internet access, use of pay-as-you-go  
24 phones.

25 In relation to the literacy, a lot of that would

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1 **A.** That's absolutely fine. The only thing I would  
2 emphasise is that we are talking about three separate  
3 communities, so we're talking about Irish Travellers,  
4 Romani Gypsy, and Roma, and I think it's important that  
5 we kind of acknowledge that, but it's fine to use the  
6 shorthand.

7 **Q.** Yes, and I assume that you're pointing that out because  
8 all of those communities have different cultures,  
9 different needs.

10 **A.** Yes, yes, similar but different.

11 **Q.** We will go on, I think, to talk about the fact that  
12 there is poor government data on the number of GRT  
13 people in the UK. But as an estimate, could you give us  
14 an idea of the size of the communities that you advocate  
15 on behalf of?

16 **A.** It's a difficult one, a very, very difficult one.

17 I mean, we have the data from the census, the ONS, and  
18 there is a very crude Gypsy caravan count which  
19 identifies 260, currently, caravan sites in the UK.

20 That's a very crude way of doing it. But we estimate  
21 that we're probably looking at over half a million  
22 people.

23 **Q.** You summarise in your statement that the health position  
24 of the communities you advocate for in this way, that  
25 Gypsies and Travellers experience some of the poorest

22

1 very much be about, you know, historically you have had  
2 a lot of people not being able to, kind of, from those  
3 communities, being able to access appropriate education  
4 services, and excluded from school, and this is well  
5 documented. So that has been going on for a number of  
6 years, and in relation to information, any information  
7 that would be shared by the health authorities during  
8 the Covid pandemic, people aren't going to be able to  
9 receive that information, or avail of that information  
10 if they have poor literacy.

11 I mean, I think the thing on all of this in terms of  
12 a lot of the barriers and the exclusion, I have three,  
13 kind of, key areas that I would suggest are about the  
14 exclusion, and that's the relationship around trust and  
15 visibility and communication. And to expand on that,  
16 without visibility and inclusion in official statistics,  
17 these communities don't exist.

18 So let me expand further on that. The NHS Data  
19 Model and the NHS Data Dictionary do not include these  
20 communities. They don't include them. And without this  
21 inclusion, people are going to be overlooked in local  
22 and national health strategies and delivery.

23 **Q.** Can I just pause you there because I assure you we're  
24 going to come to those issues of data and of the NHS  
25 dictionary. I just want to make sure, before we move on

24

1 to those issues, we're clear on the barriers that were  
 2 faced. So we've talked about the combination of  
 3 literacy levels and digital exclusion, meaning that if  
 4 you're getting a vaccine invitation by letter or you're  
 5 being asked to look at government alerts that might be  
 6 in writing on the Internet, that's going to be a barrier  
 7 to access.

8 **A.** Well, you're not even getting that, you're not even  
 9 getting that information because you're not on a system;  
 10 you're invisible. So for example, the text message that  
 11 would have been sent out to vulnerable communities  
 12 around shielding, most Gypsies and Travellers wouldn't  
 13 have got that because they're not in the system. So it  
 14 goes further than the literacy, much further.

15 **Q.** Yes, and I know that GP registration and data is key in  
 16 that, and we will get there. But before we get there,  
 17 can we just cover the topic of the availability of  
 18 health services for people who do not live in  
 19 a permanent address and some of the issues that may come  
 20 around moving house or moving site. Would I be right in  
 21 summarising your concerns like this: that if people are  
 22 moving address frequently then they are less likely to  
 23 have a GP who is local to them who is a regular GP, who  
 24 they are registered with, and therefore they may not  
 25 have ready access to their health records, and those

25

1 **A.** Exactly.

2 **Q.** And that might have been very useful when vaccinations  
 3 were rolled out, because if they had questions about  
 4 vaccinations then that would have been a health  
 5 professional who they knew and trusted?

6 **A.** Absolutely. Like the mobile health service would have  
 7 been a critical resource, absolutely a critical resource  
 8 for communities, because they would -- they would have  
 9 been able to explain about the virus, what the virus  
 10 entails. They would have been able to, kind of -- some  
 11 of the fears and anxieties people had about what they  
 12 were -- what was happening, they would have been able to  
 13 answer that. And they would -- by having those regular  
 14 mobile services, people would have had the handheld  
 15 records.

16 **Q.** So that --

17 **A.** Absolutely.

18 **Q.** -- that second issue of handheld records is about people  
 19 owning their own health information --

20 **A.** Yes, absolutely.

21 **Q.** -- so that they can understand, for example, if they  
 22 might fall into --

23 **A.** Well, they have all their records. And if they're  
 24 moving to a different location, it is easier, in terms  
 25 of GP registration, to be able to go into a GP service

27

1 health records may be very important in helping them and  
 2 healthcare professionals to understand whether they fall  
 3 into a vulnerable group for prioritisation?

4 **A.** Yes.

5 **Q.** Is it right that, in the past, there have been mobile  
 6 health services for --

7 **A.** Yes.

8 **Q.** -- these communities?

9 **A.** Under the -- I think it was probably we're looking  
 10 around 2008 under the Pacesetters Programme, there would  
 11 have been a lot more development and engagement around  
 12 mobile services and there was also the development which  
 13 I specifically, the Traveller Movement, along with other  
 14 organisations, worked on: the handheld records. Our  
 15 understanding is they no longer exist. A lot of that  
 16 kind of stuff was stripped away. So they are few and  
 17 far between. I can't identify any mobile services at  
 18 the moment and I don't know anybody that currently has  
 19 the handheld records. So that is non-existent at the  
 20 moment.

21 **Q.** So two issues there, then, really: the first is that the  
 22 mobile health services allowed people to have someone  
 23 they could go to with health concerns or issues who they  
 24 could build up a relationship of trust and confidence  
 25 with?

26

1 with the handheld record. But, you know, as I say, none  
 2 of that is in existence now.

3 **Q.** Well, that perhaps leads us on, then, to the issue of GP  
 4 registration, obviously interlinked, as you have already  
 5 explained.

6 You explain that many members of the GRT community,  
 7 whether they move frequently or not, are not registered  
 8 to a GP surgery, which can result in poorer health  
 9 outcomes generally, but also contributed to issues with  
 10 booking vaccinations. Would it be right to say that,  
 11 put simply, because the invitations to vaccinate were  
 12 linked to GP registration, if you're excluded from that  
 13 system, as you put it, you're just not getting the  
 14 information?

15 **A.** Yeah, absolutely. You're excluded from that system, but  
 16 that system hasn't got you on the system. So it doesn't  
 17 know, it doesn't know that you exist, you're totally  
 18 invisible.

19 **Q.** The interlinked issues that we've just talked about to  
 20 do with visibility on the healthcare system and having  
 21 access to mobile health units, what more do you think  
 22 could be done or improved in the future to address those  
 23 difficulties?

24 **A.** Well, I think the reinstatement of the mobile health  
 25 service is actually crucial, and by developing the

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1 mobile health service, that is an outreach. You're  
 2 building the relationship with local communities.  
 3 As part of a programme like that, you can also  
 4 develop your education, programmes around that, because  
 5 people get to know that health worker, they get to know  
 6 when the mobile service is coming, they can ask the  
 7 questions they need, they -- there would be regular  
 8 contact, so they're more familiar with the need for  
 9 vaccines. They're also kind of getting -- building up  
 10 their health and wellbeing in so many different ways  
 11 because they're getting proper health, you know, so  
 12 they're getting access to dental care, they're getting  
 13 access to health and wellbeing in so many other  
 14 different ways, they're becoming aware, so that when  
 15 something like a pandemic happens, they're much more  
 16 familiar with the health system and who people are.

17 So, yeah, absolutely vital. We need more investment  
 18 in the health service, the mobile services and  
 19 developing the handheld records.

20 **Q.** I'll move now to an issue you've already mentioned which  
 21 it's clear from your statement is a very key concern for  
 22 your group, and that is the representation of your  
 23 communities in the NHS Data Dictionary.

24 Can you tell us about that concern, please.

25 **A.** Yeah. Well, this is a drum we've been banging for many  
 29

1 will never address any of the health inequalities for  
 2 these communities if we don't start to recognise and  
 3 acknowledge that they are -- they're here and they're  
 4 part of the local community.

5 **Q.** So there is an importance in making sure that when  
 6 people are registered or engaged with healthcare  
 7 services, their membership of a GRT group is properly  
 8 reflected in their records, and that is important for  
 9 commissioning services, as you have explained.

10 **A.** Vital.

11 **Q.** But also is it important so that when local or central  
 12 government are looking at uptake of vaccinations, who is  
 13 taking the vaccinations from which groups, where are  
 14 they taking it, that you need that data in order to be  
 15 able to follow trends --

16 **A.** You need the data. It is just so, so important. And  
 17 because the community is so excluded.

18 So, you know, I will give you an example of why this  
 19 is really important and why the mobile services -- you  
 20 know, I'm thinking of -- and this happened on numerous  
 21 sites but I'm thinking of one particular site where  
 22 there was an incredible amount of vulnerable people on  
 23 that particular site that should have been shielding.  
 24 Now, within that site, as indeed a lot of sites across  
 25 the country, many people will use generators for their

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1 years. You know, and the NHS Data Dictionary, NHS Data  
 2 Model is really, really important. If you're not there,  
 3 you can't commission services. You can't be part of  
 4 local planning. So, you know, it's very much about --  
 5 and particularly with what has happened with the  
 6 pandemic, it has failed miserably these communities  
 7 simply because the trust wasn't there, the visibility  
 8 wasn't there and the communication wasn't there. So you  
 9 can't build the ark when the flood is happening.

10 So if you want to develop those local commissioning  
 11 services and you are serious about addressing health  
 12 inequality for a community, you have to capture -- you  
 13 have to know who is in your local community, you have to  
 14 know your local demographics. And in most of the local  
 15 authorities I would say there is no local authority in  
 16 this country that doesn't have a local Gypsy and  
 17 Traveller community.

18 And we have to remember, we're not talking about  
 19 a new community, we're talking about a community that  
 20 have been here for the last 500, 600 years but are just  
 21 not being captured in any of the data.

22 So it is absolutely vital, moving forward, that the  
 23 NHS start to address this issue, and include these  
 24 communities, because these will happen time and time  
 25 again, and we will never -- separate to the pandemic, we

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1 electricity and their refrigeration of medicines. They  
 2 will also use things like pay-as-you-go mobile phones.  
 3 They were -- because they're not captured in local data,  
 4 or commissioning, no service, no contact was made with  
 5 that site. When people from that particular site tried  
 6 to get the information and the access they needed, but  
 7 equally, equally, tried to get petrol or diesel for  
 8 their generators or tried to renew a prescription or top  
 9 up their phone, it wasn't the local mobile service or  
 10 a health service that was sent to that site: it was the  
 11 police, to prevent them from moving and coming off the  
 12 site because of the restrictions. So those people were  
 13 left incredibly -- they were completely abandoned and  
 14 isolated.

15 Now, had they been captured in local data, had there  
 16 been a mobile service in place, had that trust been in  
 17 place, we may not have had a lot of the issues that  
 18 arose, and that's one particular type, right across the  
 19 country for these communities. And I can absolutely  
 20 guarantee you that uptake of the vaccine would have been  
 21 much better. We would have -- we would have seen some  
 22 statistics on it. Like, you know, one of the things  
 23 that has actually happened -- and I'm delighted to be  
 24 here in this Inquiry, but, you know, yesterday a graph  
 25 was produced by lead counsel for the Inquiry, and on

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1 that graph, and rightly so, numerous communities were  
 2 detailed about their vaccine uptake. Gypsies and  
 3 Travellers were again excluded, and that's in the  
 4 Inquiry's own data. We weren't on that graph yesterday.  
 5 But yet, if we go to Scotland and we look at what has  
 6 happened in Scotland, which has a significant but a much  
 7 smaller Gypsy, Roma, Traveller community and doesn't  
 8 have the same resources and certainly wouldn't have the  
 9 sector in terms of the not-for-profit sector in  
 10 Scotland, they had captured the data.

11 So that's what happens when you continuously exclude  
 12 and not include people.

13 **Q.** And what is able to be included in the graph you're  
 14 talking about shown by the Inquiry reflects the data  
 15 that was available to the experts --

16 **A.** Exactly, in Scotland --

17 **Q.** -- who have assisted the Inquiry.

18 **A.** -- and not here.

19 **Q.** And so is what you're saying that it isn't enough to  
 20 include Gypsy, Roma, and Traveller people in the other  
 21 category when it comes to ethnic minority groups,  
 22 because Gypsy, Roma, and Traveller communities have  
 23 specific needs and circumstances that mean that they  
 24 ought to be, as a group, specifically reflected in --

25 **A.** Yeah, you can --

33

1 inclusion, they haven't had the education. So one of  
 2 the concerns from the community around the vaccine would  
 3 have been infertility, another one would have been high  
 4 rates of autism.

5 Now, a lot of work for different communities has  
 6 been done around educating people around these areas,  
 7 but it hasn't, nothing has actually happened or been  
 8 delivered to Gypsy, Roma, Traveller communities, or  
 9 bought them in to alleviate some of those fears and  
 10 anxieties. And we've got to remember that Gypsy, Roma,  
 11 Traveller communities are traditionally an oral  
 12 community. So the rumour mill will take hold very, very  
 13 quickly and if somebody is saying, "Don't participate in  
 14 having this vaccine because of, you know, you'll be  
 15 infertile or your child will end up with autism", or  
 16 whatever, there is no literature, there is no education  
 17 programmes to try to counteract at that information,  
 18 other than what organisations like the Traveller  
 19 Movement and our colleagues in the sector are trying to  
 20 do. But we are a drop in the ocean and we are very,  
 21 very small.

22 **Q.** I'm going to ask in a moment about practical changes can  
 23 be made to help with that but you're explaining that  
 24 where there is a lack of trust and also a lack of  
 25 outreach and information, into that space can move

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1 **Q.** -- in government data?

2 **A.** Yes, they have their own -- they are a protected group.  
 3 They should, they should have been captured within all  
 4 that data separately.

5 **Q.** I'm going to move on now to the issue of historic  
 6 mistrust and reasons for lack of confidence in Covid-19  
 7 vaccinations. You speak in your statement about some  
 8 overarching reasons for the mistrust of public health  
 9 advice which, in turn, affected the level of trust that  
 10 some people had in vaccines.

11 Are you able to talk to us about that, please?

12 **A.** Yeah, I mean, you know, as I said earlier, we're not  
 13 talking about a community that has just arrived on these  
 14 shores; we're talking about Romani Gypsies in particular  
 15 who have been on record here for the last 500 years and  
 16 have been continuously excluded from any kind of  
 17 provision or service.

18 So mistrust is going to develop, they're very much  
 19 persecuted communities, some mistrust is going to kind  
 20 of develop, and over that time, because there's been no  
 21 proper outreach programmes, no political will, no  
 22 gestures of trying to include people in the development  
 23 of these services, people are incredibly suspicious when  
 24 something like Covid-19 happens and they're told that  
 25 they have to get a vaccine, because they haven't had the

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1 rumours --

2 **A.** Yes.

3 **Q.** -- and false information as you've described?

4 **A.** Yes, misinformation.

5 **Q.** And was that a particular problem, in your view, in the  
 6 Roma/Traveller communities?

7 **A.** Yes, absolutely, absolutely, yeah.

8 **Q.** Was there a specific concern that -- you explain in your  
 9 statement about -- that that link between vaccines and  
 10 infertility or harm to children from vaccinations. Was  
 11 the community particularly vulnerable to that because of  
 12 some of the disproportionately high levels of child  
 13 mortality --

14 **A.** Yes.

15 **Q.** -- stillbirth and miscarriage being a real concern for  
 16 those communities?

17 **A.** A total concern, absolutely. That would be a massive  
 18 concern for the community. You know, they are aware of  
 19 the high mortality rates, infant mortality rates of  
 20 their children, and miscarriage. And we as an  
 21 organisation have done a lot of work specifically with  
 22 maternity care. It would have been a huge issue for the  
 23 community, and they would have just seen, well, we don't  
 24 know enough about this vaccine, we don't know what's  
 25 going on, so we're not going to, kind of, engage with

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1 this, because the relationship wasn't there previously,  
 2 with the health services.  
 3 **Q.** And what changes do you think could be made to address  
 4 that?  
 5 **A.** Well, I think, moving forward, building trust with the  
 6 community before any public health crisis, you know, and  
 7 as I mentioned earlier, as the saying goes, there is no  
 8 point in building the ark when the flood has happened,  
 9 but trust can be fostered through sustained outreach,  
 10 culturally appropriate services, and inclusion of Gypsy,  
 11 Roma, Traveller advisers in policy making.

12 I think some of the other areas, in terms of  
 13 building that kind of support, we've been talking for  
 14 a number of years about the development of  
 15 cross-government strategy, and this is not new  
 16 information, they call it -- the Women and Equalities  
 17 Committee, which I gave evidence to a number of years  
 18 ago, have called for a cross-departmental strategy, so  
 19 we need some joined-up thinking.

20 And in that strategy we would be looking at  
 21 a national framework for better development of mobile  
 22 services, a national immunisation strategy with advisers  
 23 of the community involved, proper education programmes  
 24 that will include these communities. For example, in  
 25 terms of, you know, communicating and how to get

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1 So the invitations in one sense are coming. It's  
 2 about the implementation, the political will, and the  
 3 action. That's what's not happening.

4 **MS STEPHENSON:** Those are all of my questions. Thank you  
 5 very much for your evidence.

6 My Lady, do you have any questions?

7 **LADY HALLETT:** No. Thank you very much indeed for your  
 8 help, I'm really grateful to you. You raise some  
 9 important issues and obviously I'll give them very  
 10 careful consideration. Thank you.

11 **THE WITNESS:** Okay, thank you very much.

12 **LADY HALLETT:** Thank you.

13 (The witness withdrew)

14 **MR KEITH:** My Lady, the next witness is Lara Wong.

15 **MS LARA WONG (affirmed)**

16 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 4**

17 **LADY HALLETT:** Before we go on, can I just repeat something  
 18 I said yesterday, and I know that the hearing manager is  
 19 very conscious of this, people are moving around and  
 20 making noise when the oath is being taken. I must  
 21 insist that nobody moves whilst the oath is being taken.  
 22 It's too important.

23 But it's all right, I'm not going to ask you to take  
 24 it again, Ms Wong.

25 **MR KEITH:** Ms Wong, could you commence your evidence,

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1 information out, communities are excluded from, you  
 2 know, digitally, hugely excluded digitally. They need  
 3 to be included in digital strategies, moving forward.

4 So there's number of things top down that -- top  
 5 down and bottom up that really need to happen here.

6 **Q.** Perhaps to add to that very comprehensive list, is it  
 7 important that when there are roundtables, stakeholder  
 8 meetings, that are run by governments, that there are  
 9 representatives of the Gypsy, Roma, Traveller community?

10 **A.** Well, the interesting thing is there are a number of  
 11 roundtable meetings and, you know, as an organisation in  
 12 the past we have been directly commissioned to produce  
 13 policy by the Department of Education. I just said  
 14 earlier we've been banging this drum for a number of  
 15 years. Our first briefing paper calling for inclusion  
 16 in the NHS Data Dictionary was in 2012. We have been  
 17 there.

18 Now, as I say, a lot of that stuff has been stripped  
 19 away, but there are plenty of us going to these  
 20 meetings, plenty of us going to these meetings, plenty  
 21 of us picking up the phone and trying to talk to,  
 22 whether it's the NHS or Public Health England and  
 23 hopefully, you know, a number of these people will be in  
 24 the room today and I encourage you to come and still  
 25 talk to us.

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1 please, by giving us your full name.

2 **A.** My name is Mrs Lara Wong.

3 **Q.** Thank you very much.

4 Ms Wong, thank you for attending today and assisting  
 5 the Inquiry with the provision of your witness statement  
 6 of 1 November 2024. But we'll look at a few parts of  
 7 that statement in a moment.

8 Could you please tell us something about the  
 9 Clinically Vulnerable Families Group, of which you are  
 10 the founder. Was it founded in the summer of 2020?

11 **A.** That's correct.

12 **Q.** And was there a particular event or series of events  
 13 that formed the genesis for the foundation of the group?  
 14 What was about to occur in the summer of 2020 that led  
 15 to the concerns formulated now in your statement on the  
 16 part of your group?

17 **A.** So, in terms of my background, I'm a former teacher, and  
 18 I was very concerned about the risks that our group was  
 19 about to be exposed to in schools. They were reopening  
 20 and at that time, in August 2020, families were going to  
 21 be forced into those situations, with all children being  
 22 told that they must be in schools. And so we were  
 23 incredibly concerned as they exposed not only clinically  
 24 vulnerable children but children in clinically  
 25 vulnerable households.

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1 **Q.** So because children, by and large, were not vaccinated,  
2 the great concern held by those of your members who  
3 comprise the clinically vulnerable, the clinically  
4 extremely vulnerable, for example severely  
5 immunosuppressed, was that children would go to school,  
6 would become infected, would spread the infection around  
7 vulnerable households, and more generally, of course  
8 with terrible consequences for your members?

9 **A.** Yes. And not only were not children vaccinated at the  
10 time but nobody was vaccinated.

11 **Q.** Yes, of course, August 2020 was before the rollout of  
12 the vaccination programme.

13 So the genesis of the group was in a concern about  
14 the spread of infection, particularly in the school  
15 setting, but the group now represents all those who are  
16 clinically vulnerable, those who identified as high risk  
17 by living in clinically vulnerable households, and that  
18 includes clinically extremely vulnerable people and, for  
19 example, the severely immunosuppressed.

20 Your statement sets out the very laudable aims of  
21 your group.

22 Could we please have up INQ000474526, and  
23 paragraph 9, which commences on page 4, in particular,  
24 please.

25 I want to just look at some of the aims of your

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1 are, kind of, new. And our needs were certainly not met  
2 prior to the pandemic, we would very much agree with  
3 that, and needs such as clean indoor air was never  
4 considered before. Access to schools, workplaces, job  
5 losses, are serious issues that our members have faced  
6 as a consequence of the pandemic.

7 You know, they would have viewed themselves as  
8 healthy enough, prior to the pandemic, and then those  
9 risks seriously impacted on them. So I wouldn't say  
10 that it was the same --

11 **Q.** Because of Covid-19?

12 **A.** Because of, yes. It was a new --

13 **Q.** So the heart of the concern is that the pre-existing  
14 needs of your group members were exacerbated, made  
15 worse, by the danger posed by Covid-19 itself?

16 **A.** Very much so, yes.

17 **Q.** So what you're most concerned about is improving the  
18 systems and processes for delivery of vaccines and  
19 access to therapeutics in response to the heightened  
20 risk posed by Covid and other pathogenic diseases?

21 **A.** Very much so. And, I mean, we've failed to recognise  
22 those needs. Access to vaccines, there were issues  
23 there, and I know we will go to that. But there will be  
24 issues in the future for us as well.

25 Access to antivirals has always been hugely

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1 group in order to tie the most important of those aims,  
2 as far as this Inquiry is concerned, to the scope of  
3 Module 4. Because your group does many things: it  
4 provides support to your members, it educates the wider  
5 world and those who are concerned with these issues, and  
6 it obviously assists members with their urgent needs,  
7 those people who have come up against the state, and of  
8 course, those people who particularly need medical  
9 support.

10 But on page 6, at paragraph 9(d), you've set out  
11 very helpfully a list of goals and key issues. But many  
12 of those issues and goals, of course, are properly and  
13 sensibly designed to meet the needs of your members who  
14 suffered from medical conditions and were clinically  
15 extremely vulnerable or vulnerable even before the  
16 pandemic came along. But are some of those aims of  
17 course directly related to the systems and processes for  
18 delivery of vaccines and eligibility for and access to  
19 therapeutics?

20 **A.** Well, certainly I think it's important to consider  
21 clinically vulnerable, clinically extremely vulnerable,  
22 severely immunosuppressed as a group of clinically  
23 vulnerable people, and, yes, certainly they did have  
24 those barriers early on.

25 They are not recognised as an equality group, they

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1 problematic. It is still problematic for us to this  
2 day. Access to prophylactics, we've never had  
3 prophylactics available to us on the NHS.

4 So, yes, we have been let down.

5 **Q.** But obviously you appreciate that this Inquiry can't  
6 investigate the far wider, more general topic of access  
7 to or eligibility for therapeutics or, of course, for  
8 vaccines generally; it can only focus on the systems for  
9 their production and delivery.

10 **A.** Yes.

11 **Q.** All right. In paragraphs 13 and 14 on pages 8 and 9,  
12 you provide some information about the definition of the  
13 members of your group and also about their extent. Give  
14 us, please, some idea of the numbers of people who, in  
15 your approach, would be said to be clinically vulnerable  
16 and, in particular, clinically extremely vulnerable; how  
17 many people are we talking about?

18 **A.** I mean, if we're talking across the country, then we  
19 believe that around 20 million people, based on the  
20 original kind of vaccine prioritisation list that they  
21 had. For our group, Clinically Vulnerable Families, we  
22 represent, we believe, around 50,000 people across  
23 various social media platforms, Twitter, Facebook,  
24 Bluesky and others. Our Facebook group is very active  
25 and a lot of support is offered there to around

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1 2,600 people on Facebook.

2 **Q.** So around about 50,000 in your group.

3 Do you recall that in the course of the pandemic --  
4 you may not have known then, but you'll have seen it now  
5 from the documentation disclosed to this Inquiry -- that  
6 the government attempted to identify the numbers of  
7 people who might be described as immunosuppressed, and  
8 they put a figure very broadly on that group as being  
9 around about 500,000 people, although it varied over  
10 time, and different parts of the government took  
11 different approaches.

12 Can you say now what the number of people broadly is  
13 who are or might be described as immunosuppressed?

14 **A.** Well, we are stakeholders in the NICE consultation  
15 around Evusheld, and within that consultation process  
16 they pointed to 1.8 million people. So we believe it's  
17 that.

18 **Q.** So when that organisation, NICE, approached you, and  
19 said, "Would you like to take part in our assessment  
20 process for the development and production and  
21 authorisation, or rollout of therapeutics?", they  
22 indicated that that was their view of the number of  
23 people who might be affected by that decision --

24 **A.** That was the number that was published in one of their  
25 consultation documents.

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1 those people did not understand where they fit in, into  
2 this. So it was only when, very often, they were  
3 contacted either with shielding letters or, for the  
4 clinically vulnerable group, until they were invited for  
5 vaccination by their GPs, that they understood where  
6 they fit in.

7 **Q.** So the nub of it, there was a high level of confusion  
8 about eligibility where, for example, clinically  
9 vulnerable people came in the scheme of prioritisation,  
10 as well as, on the ground, practical difficulties with  
11 ensuring that they were being invited in for  
12 vaccination?

13 **A.** Certainly, and also where you're looking at people with  
14 rare diseases, or complex conditions with multiple  
15 conditions, sort of overlaying with each other, it was  
16 problematic because they weren't necessarily clearly  
17 prioritised into a particular group, and they had to  
18 fight for their own eligibility.

19 **Q.** And in terms of sites, so the practical delivery of  
20 vaccines, vaccination centres, GPs, pharmacies, mobile  
21 units, and across the United Kingdom different health  
22 boards, were there very real difficulties faced by your  
23 members in terms of physically getting access to  
24 vaccines?

25 **A.** Hugely. We struggled, there were all sorts of barriers

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1 **Q.** Right, thank you.

2 In your statement you identify a significant number  
3 of concerns and issues and we're just going to focus on  
4 some of them, but starting with vaccination. The broad  
5 concern held by your group in relation to the events  
6 during the pandemic fall under the heading, I suppose,  
7 of lack of access to vaccination, lack of access to  
8 priority vaccination, lack of access to specific  
9 vaccines where, for one reason or another, they couldn't  
10 take one vaccine if they needed another, as well as lack  
11 of access to the booster programme, and then there's all  
12 the practical issues concerning delivery of  
13 vaccinations. So I suppose issues concerning the  
14 conditions, the crowded nature of some of the  
15 vaccination centres, the wearing masks in centres, the  
16 lack of specific mobile delivery of vaccinations and so  
17 on?

18 So you've got delivery and you've got availability  
19 of vaccines, boosters and specific vaccines. Is that  
20 a fair summary of the main concerns in relation to the  
21 vaccination programme?

22 **A.** Yes, and there was considerable confusion, because you  
23 have to remember that nobody identified as clinically  
24 vulnerable or clinically extremely vulnerable or even  
25 severely immunosuppressed prior to the pandemic, so

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1 we faced. We faced safety risks, infection prevention  
2 control did not consider airborne risks. Airborne  
3 transmission of this virus is a huge problem for us, and  
4 it goes into all areas of life, but within the context  
5 of this module, of course we're looking at vaccination  
6 centres, they were very good at wiping down seats. We  
7 weren't worried about seats being wiped down; we can  
8 wash our hands. We were concerned about the quality of  
9 air in those environments, the lack of ventilation, and  
10 the lack of proper masking.

11 There were good examples of vaccination centres,  
12 drive-through vaccination, people felt very safe heading  
13 out. You have to remember this was a population who had  
14 been shielded, they had lived very limited lives, or  
15 they had shielded themselves informally, and so this was  
16 their first kind of exposure to a particular risk, and  
17 so heading into these environments was very concerning  
18 for many of Clinically Vulnerable Families' members, and  
19 so yes, some GPs were great. There were examples of  
20 outdoor vaccination centres where, you know, there were  
21 tents and things, and the great -- air in the area, but,  
22 you know, otherwise it was overwhelming for people and  
23 there was a postcode lottery: people did not know what  
24 to expect.

25 **Q.** You, of course, appreciate that this Inquiry cannot

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1 prescribe the precise means by which vaccines are  
 2 delivered, that must be left to the specialists and  
 3 clinicians, the administrators, vaccinators, and so on,  
 4 but you would say, I expect, going forward in the  
 5 future, systems setting up the delivery of vaccines have  
 6 to pay closer attention to specific and slightly  
 7 unusual, but no less worthy, needs of the clinically  
 8 vulnerable?  
 9 **A.** Yes, and we would like people to be informed of how to  
 10 reduce their risks. So wearing better masks, these  
 11 close-fitting masks that don't -- that filter the air  
 12 coming through and massively reduce people's risks, 99%  
 13 for an FFP3 mask, 95% for an FFP2 mask. People were  
 14 never informed about these. When they attended  
 15 vaccination centres they were given a paper mask and  
 16 they may have been asked to remove a better mask. The  
 17 same problem we saw also in healthcare.  
 18 **Q.** All right. By the time the booster campaigns commenced,  
 19 Mrs Wong, obviously the system had bedded down to a very  
 20 greater extent, but there appeared to have been  
 21 considerable difficulties with an understanding of the  
 22 eligibility for boosters. What was the problem there?  
 23 Why were your members so concerned about the rollout of  
 24 the booster campaign?  
 25 **A.** So the booster campaign was problematic, certainly,  
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1 expected to have for subsequent doses, there was an  
 2 impact there.  
 3 **Q.** Right, so there are issues there which overlap data,  
 4 overlap communication, knowing what their entitlements  
 5 were in terms of eligibility, and also the practical  
 6 mechanics of delivering the vaccination on the ground?  
 7 **A.** Very much.  
 8 **Q.** And an important part of your statement, indeed much of  
 9 your statement, is concerned with the issue of  
 10 therapeutics. The Inquiry obviously cannot become  
 11 concerned in directing clinical groups, NICE, the NHS,  
 12 the many bodies which are concerned in the process by  
 13 which therapeutics come to be trialled, authorised, and  
 14 then made available. But in the context of the Covid  
 15 pandemic, the very great problem faced by your members  
 16 was that ultimately, there was simply not sufficient  
 17 access to you, or eligibility for, as wide a range of  
 18 therapeutics and antivirals as would have brought them  
 19 health and support, and given them a greater degree of  
 20 protection; is that the nub of it?  
 21 **A.** I would say with regard to range it very much depended.  
 22 So some treatments, for example, Paxlovid, are not  
 23 suitable for many clinically vulnerable people. They  
 24 are very good for older, healthier people, but there are  
 25 many contraindications for that particular medication.  
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1 and -- sorry, are we talking about the third primaries?  
 2 **Q.** We are.  
 3 **A.** We are, okay, just to clarify. So third primary doses  
 4 were only offered to a small group of severely  
 5 immunosuppressed that we have mentioned previously, and  
 6 it wasn't widely known that this third dose was on  
 7 offer. They very often did not know that they were  
 8 within this group, and whilst CVF was very good at  
 9 informing our members who might be eligible for this,  
 10 people were -- found it very difficult. They attended  
 11 these vaccination centres, they would have to  
 12 self-advocate, bringing documents and things with them  
 13 to prove that they might meet these criteria, that they  
 14 had certain medications or that they had certain  
 15 conditions that should qualify. But even when they did  
 16 attend those vaccination centres they found very often  
 17 that the staff did not necessarily understand that even  
 18 this was something that was on offer, or how to report  
 19 it or record it within the NHS computer system.  
 20 **Q.** Right.  
 21 **A.** So they were overwriting people's records. Sometimes  
 22 they'd overwrite and then they'd have the wrong date for  
 23 their last dose and then there was a knock-on to their  
 24 future doses. If they didn't record it properly or  
 25 record it at all, then the six-month gap that they were  
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1 So the need for different antiviral treatments certainly  
 2 was there, and --  
 3 **Q.** I mean, in your statement, Mrs Wong, you make plain that  
 4 there were obviously a number of therapeutics authorised  
 5 and made available, authorisation and being made  
 6 available aren't the same topic, of course, but  
 7 eventually there were a number of therapeutics that made  
 8 it to the end of the process, and you describe Paxlovid,  
 9 nirmatrelvir and ritonavir, there was sotrovimab, the  
 10 Xevudy therapeutic, and importantly, Evusheld, which  
 11 is tixagevimab and cilgavimab. We've heard some  
 12 evidence, and we'll hear a great deal more evidence  
 13 about the Evusheld decision, but what your members were  
 14 concerned about was why, in particular, Evusheld wasn't  
 15 made available and why there weren't other antivirals  
 16 and therapeutics made available despite the prospect  
 17 that they might be. Is that the heart of it?  
 18 **A.** Okay, so to kind of put Evusheld within sort of the  
 19 context of this, Evusheld was more sort of similar to  
 20 a vaccine for the group of people.  
 21 **Q.** It was a prophylactic --  
 22 **A.** It was a prophylactic --  
 23 **Q.** -- (overspeaking) --  
 24 **A.** -- treatment, exactly. It was not post-infection  
 25 treatment, and so it would have levelled the playing  
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1 field for these people. It would have given them the  
2 freedoms that other people received through their own  
3 vaccination, and the consequence of not protecting this  
4 group was phenomenal in terms of their mental health, in  
5 terms of their social connections, in terms of their  
6 general ability to re-engage with the rest of the world.

7 So we have to remember that this is a group of  
8 people who, through no fault of their own, and through  
9 the lack of the government's action to find or procure  
10 this treatment, left them essentially locked up without  
11 any route out, and these people still live today with  
12 these same issues, still with no opportunity and no  
13 other thing other than waiting to be infected and then  
14 having a treatment and hoping that it's effective for  
15 them.

16 **Q.** Let's be clear about this, the reason why, of course,  
17 access to and eligibility for antivirals and  
18 therapeutics is so important is that there is a large  
19 number of people, whom you represent, for whom vaccines  
20 come as no remedy; they either cannot take vaccines  
21 because it would harm them, or because vaccines may not  
22 have as much or a greater beneficial effect as for  
23 others. So they're more reliant on therapeutics and  
24 antivirals to help.

25 **A.** They are indeed, although there is a positive benefit

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1 burdens even to the conditions from which they already  
2 suffered? So in terms of the timing of those trials,  
3 the capacity of the trials, the treatment they received  
4 in the trials, the geographical inequalities as to where  
5 the trials were being undertaken. So, many of your  
6 members had problems with engagement in the trial  
7 processes.

8 **A.** So it wasn't just that.

9 **Q.** But it included that?

10 **A.** It certainly included that, however I think we also have  
11 to remember there was a group of people for whom --  
12 already did qualify under emergency approvals for those  
13 treatments, and yet that group, who had 100% chance of  
14 receiving those treatments, were also being invited onto  
15 a trial where they may only have a 50% chance of  
16 receiving those treatments, if they are to be accepted.

17 So it was hugely problematic. And they may not have  
18 understood, and they may have been invited by their GP,  
19 which gave these trials legitimacy, and they may not  
20 have understood the potential consequences of those.

21 **Q.** So there was an issue about eligibility and an issue  
22 about communication?

23 **A.** Very much so.

24 **Q.** Another topic, another issue raised in your statement,  
25 is that of vaccination of children. As you've already

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1 from vaccination, and this particular group is invited  
2 twice a year for vaccinations in comparison to the other  
3 clinically vulnerable groups who are only invited once  
4 a year.

5 **Q.** All right.

6 **A.** So there is a benefit that's been proven. However, we  
7 have to bear in mind that, yes, for some of them, they  
8 may have no immune response or they may have a very low  
9 immune response, and so they still remain at great risk,  
10 as they were at the start of the pandemic. They were  
11 always the greatest risk group.

12 **Q.** Because they suffered from pre-existing conditions.

13 Another topic that is raised in your statement is  
14 the issue of the trials, the clinical trials, which were  
15 undertaken by, broadly, the government. The trials  
16 obviously were of themselves extremely valuable, and  
17 many of the trials led to life-changing results.

18 Dexamethasone, for example.

19 But insofar as your members were concerned, was it  
20 the position that those who didn't qualify for  
21 antivirals, for example, might be directed to particular  
22 trials where antivirals and therapeutics might be tested  
23 on them as part of that perfectly proper and  
24 understandable trial process, and therefore your members  
25 became involved in trials which imposed on them greater

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1 said, the proper vaccination of children and the extent  
2 of that programme was vital to your members because, of  
3 course, vaccination of children would reduce  
4 transmission in the community, which would give  
5 a greater degree of protection to your members.

6 Is, therefore, the way in which the government went  
7 about considering authorising and delivering vaccination  
8 to children something you want the Inquiry to look at?

9 **A.** Very much so. I mean, as you can see, in terms of our  
10 submission to the Inquiry, it's a considerable bulk of  
11 our statement. And that's because there were so many  
12 and varied issues that our children faced.

13 The risk to children impacts on the clinically  
14 vulnerable household, but there are also, obviously,  
15 clinically vulnerable children, who we very often did  
16 not hear about. There was a suggestion in the media  
17 that clinically vulnerable children did not exist, to an  
18 extent, or that children were not at risk. And there  
19 were children who were at risk, there were children who  
20 died, and it's really important to understand that.

21 And for those families who are trying to protect  
22 their vulnerable children and keep them safe, it was  
23 incredibly difficult to not have access to these  
24 treatments, for the delays -- if you can imagine as  
25 a child, waiting for Christmas, how difficult that is,

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1 but if Christmas came, everybody else was given their  
2 freedoms and you remained locked up, how does that feel  
3 to a child? How do you explain it to them? And as you  
4 go down the ages, the younger and younger children had  
5 to wait longer and longer.

6 **Q.** And of course there is the sequential impact, of course,  
7 on the rest of the household, and of course on other  
8 vulnerable person, so that's in important topic?

9 **A.** Yes.

10 **Q.** Then finally, you raise the issue of disinformation, and  
11 misinformation, and you set out a number of what I might  
12 call the conspiracy theories, some of the tropes, some  
13 of the myths concerning vaccination and in particular,  
14 but therapeutics as well.

15 Why is the issue of disinformation and  
16 misinformation, and the steps which can be taken by  
17 government, in your view, to challenge it, of importance  
18 to your members?

19 **A.** I would say it was twofold. So there is the issue of  
20 the wider communities, those who are not clinically  
21 vulnerable, being impacted, and how that knocks on to  
22 everybody in the clinically vulnerable community. If  
23 people -- if the vaccination is undermined, then people  
24 will not take up the vaccination. But there's also the  
25 direct impact on clinically vulnerable people who are

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1 (11.24 am)

2 (A short break)

3 (11.45 am)

4 **LADY HALLETT:** Mr Keith.

5 **MR MATT HANCOCK (affirmed)**

6 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 4**

7 **LADY HALLETT:** Mr Hancock, thank you for returning to help  
8 us. I do understand how difficult it must be to keep  
9 having to come back. All I can say is that the vast  
10 range of my terms of reference meant I had to break the  
11 Inquiry down into modules, and that's why you're having  
12 to keep coming back, because you played such a central  
13 role. All I can add by anyway of consolation, if it is  
14 any, had I done one whole report you'd probably have  
15 been in the witness box for weeks.

16 So thank you for your help.

17 **THE WITNESS:** Well, it is what it is, but it is also a very  
18 important inquiry.

19 **LADY HALLETT:** Thank you.

20 **MR KEITH:** Could we commence with the formality of you  
21 identifying yourself please, Mr Hancock.

22 **A.** Yes, I'm Matt Hancock, and I was the Secretary of State  
23 for Health and Social Care during the --

24 **Q.** Thank you very much.

25 **A.** -- until June 2021.

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1 not immune to this message. They are already suffering  
2 from serious health issues, and the idea that for them,  
3 their issues would get significantly worse, you know,  
4 it's hugely problematic. So people are nervous of  
5 taking a risk.

6 However, I think for Clinically Vulnerable Families'  
7 members, we are a very informed group, people are  
8 looking out to learn and to be educated on these issues,  
9 and, actually, I think our group was probably  
10 disproportionately not impacted by this issue.

11 **MR KEITH:** Thank you very much, that was very fairly put.

12 Those are all the questions I have for you.

13 **LADY HALLETT:** Thank you very much indeed, Mrs Wong. I hope  
14 that your attendance here hasn't raised any kind of  
15 risk. We do our very best to make any risk as  
16 reasonably low as possible and I can assure you,  
17 Mr Wagner keeps us on our toes, and I'm sure you'll want  
18 to have a word with him and the rest of the team before  
19 you go.

20 So I'll break now and I'll give an extra five  
21 minutes for the break to enable Mr Wagner and the team  
22 to talk to you. So thank you very much for your help.  
23 11.45, please.

24 **THE WITNESS:** Thank you very much.

25 (The witness withdrew)

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1 **Q.** I add my thanks to you for attending on what is now the  
2 fourth occasion. You are a recidivist, Mr Hancock.

3 You have also provided a further witness statement,  
4 an extremely helpful statement, INQ000474375, consisting  
5 of around about 70 pages.

6 You were, of course, Paymaster General, and Minister  
7 for the Cabinet Office. You were then Secretary of  
8 State for Health and Social Care from 9 July 2018, when  
9 you took over from Jeremy Hunt MP, to 26 June 2021, and  
10 of course, you and your department were vitally and  
11 centrally concerned with the issues of vaccines and  
12 therapeutics.

13 By the metric of the need to protect at a population  
14 level against the SARS-CoV-2 virus, the vaccine  
15 programme was in the provisional view of the Inquiry --  
16 no final decision has of course yet been made -- an  
17 overwhelming success.

18 In terms of therapeutics, the research, development,  
19 clinical trial, authorisation, and eligibility  
20 procedures also led to world-breaking successes,  
21 dexamethasone is an obvious example, a repurposed drug  
22 that saved hundreds of thousands of lives, and  
23 therefore, the therapeutics programme, although there  
24 were issues with it, was also in an important way  
25 a great success.

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1 So I want it to be made absolutely plain that your  
2 attendance here today is to help us address literally a  
3 handful of discrete issues, which arise out of both of  
4 those programmes, on which you can help us prepare for  
5 the next pandemic, and indicate ways in which  
6 improvements can be made, where they are capable of  
7 being made, and where also, lessons have been learned as  
8 to how well the job was done and therefore why it is  
9 necessary to embed some of those successes into the  
10 system.

11 I know you want to pay tribute to all those who  
12 contributed to that outcome.

13 **A.** I do. I broadly assess (sic) with that. I wouldn't  
14 agree with your assessment. I wouldn't say the  
15 therapeutics programme was world-breaking but I think we  
16 know what you meant. The -- both programmes were  
17 incredibly successful, saved an enormous amount of  
18 lives, allowed us to come out of the lockdown and  
19 measures that were themselves damaging, and as you say,  
20 in many cases, the UK was the first country in the world  
21 to introduce measures. And so it was an enormous  
22 success.

23 I put a very large part of that down to the fact  
24 that it was an extremely effective and cohesive team  
25 effort, and if you think of it, the vaccine programme

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1 It's important to remember, when you look at it with  
2 hindsight, that there was also an Imperial College  
3 vaccine which in the end didn't come to the fore but was  
4 a serious candidate in the early days.

5 **Q.** That team was led by Robin Shattock?

6 **A.** That's right. And the -- and although GSK didn't come  
7 up with a vaccine that played a major role, they have  
8 a great capability in this space as well as do a number  
9 of other British companies.

10 So in the research space we had a great depth and  
11 strength.

12 **Q.** One of the vaccine technologies, we've heard much about  
13 it of course, and we'll hear more about it, was the mRNA  
14 technology.

15 **A.** Yeah.

16 **Q.** That had been around for quite some time, had it not,  
17 and it had already led to considerable development of  
18 vaccines, particularly in the sphere of cancer?

19 **A.** Well, there had been this whole series of vaccine  
20 technologies which had advanced significantly over  
21 the -- or, well, the time -- I mean, since Jenner, but  
22 especially in the decade or so before the pandemic, and  
23 really, a change towards these platform technologies  
24 which could then be adapted to a particular pathogen.

25 **Q.** In terms of the state of the UK's research and

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1 was essentially led by four people in their elements of  
2 it, in their parts of it, and a very effective team in  
3 the department coordinating that, and from the team at  
4 Oxford, Catherine Green and Sarah Gilbert, the team  
5 doing the buying, led largely by Kate Bingham, then the  
6 team doing the validation and the regulatory affairs,  
7 led by June Raine, and then the rollout, led by Emily  
8 Lawson, an incredible group of people who worked very  
9 effectively together, and then with myself and Nadhim  
10 Zahawi and Alok Sharma, and Steve Barclay at the  
11 ministerial level.

12 So it was an extraordinary team effort.

13 **Q.** Thank you. We'll be hearing from many of the persons  
14 whom you've mentioned during the course of this module.

15 As the pandemic programme in the United Kingdom,  
16 what was the general state, in your view -- you  
17 obviously had to immediately address the position -- of  
18 the UK's vaccine research and development capacity?  
19 Were we in a good position at that time?

20 **A.** We were in an excellent position with respect to  
21 research and development, not with respect to  
22 manufacture. The Oxford vaccine came out of a project  
23 that had been, for instance, deeply involved in  
24 developing a vaccine against Ebola and the  
25 research-level capabilities were extraordinary.

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1 development sector, was much of that foundational work  
2 due to the very extensive work done in academic  
3 institutions, you've mentioned Imperial and Oxford, as  
4 well as across the research and development industry,  
5 the bioindustrial sector, all of whom had been looking  
6 for years, of course, at therapeutics and at vaccines  
7 for a variety of conditions and pathogenic diseases?

8 **A.** Yes, and in peacetime, if you like, before the pandemic,  
9 as in the pandemic itself, the best pharmaceutical  
10 research happens with a combination of academia,  
11 industry and government. You need all three to make it  
12 work effectively.

13 **Q.** In her book, Dame Kate Bingham says that  
14 notwithstanding, there was very little by way of an  
15 apparent plan to deal with the unknown but ever likely  
16 pathogenic outbreak of Disease X, that is to say having  
17 prototype vaccines and therapeutics in place for dealing  
18 with an unknown pathogenic outbreak that might of course  
19 come to pass, and would require that entire system to be  
20 re-calibrated towards a new disease. Would you agree?

21 **A.** Well, by -- I'd agree in large part. By its nature, of  
22 course, the next pandemic will be caused by a novel  
23 pathogen, so that preparation can't be done perfectly,  
24 by its nature. I think where the greatest gaps were in  
25 terms of that response, which -- we learnt a huge amount

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1 because of the success of the vaccine programme but we  
2 must retain that learning and retain those capabilities  
3 and, indeed, strengthen them now in peacetime -- is  
4 especially in the manufacture. And I mean that in the  
5 broadest sense: from the ability to target a vaccine  
6 platform at a new pathogen, that part happened pretty  
7 quickly, and I'm sure would happen again pretty quickly.

8 The bit that needs acceleration is essentially  
9 everything from there onwards, through clinical trials,  
10 the -- we should have the use of challenge trials ready  
11 and available with all of the ethics codes signed off in  
12 advance, which we didn't have last time.

13 The accelerated regulation, which the MHRA did do  
14 absolutely brilliantly, but since the pandemic they've  
15 gone backwards on how quickly they do that, and that  
16 needs to be fixed. And then the manufacture, all the  
17 way through to fill and finish, where there was an  
18 assumption that it didn't matter where that happened in  
19 the world within the system, because in normal times it  
20 doesn't. And one of my contributions was to say the  
21 moment a vaccine gets signed off there's going to be  
22 enormous demand and geopolitical-level demand for this,  
23 and therefore having that manufacture and fill and  
24 finish onshore, physically within the UK, is critical in  
25 the way that it simply isn't in normal times, because

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1 A. Yeah.

2 Q. -- of the G7 a few years --

3 A. Yes, but I kind of don't care about the G7 element  
4 of it; I care about the UK element of it, and we should  
5 be -- it should be the UK Government policy for the UK,  
6 irrespective of who else we also encourage to --

7 Q. Quite, but it's a policy.

8 A. Yes.

9 Q. No policy will success, Mr Hancock, unless there is the  
10 research and development infrastructure there to make it  
11 work.

12 A. Yes.

13 Q. And in terms of vaccines, there needs to be, does there  
14 not, a continued focus on developing prototype generic  
15 vaccines that can be used and tailored for any future  
16 outbreak, Disease X or whatever?

17 A. Yes, I suppose the reason I was giving the answer, the  
18 broader answer, is that that is one small part of a much  
19 broader set of things that need to be in place in order  
20 to be able to hit that target.

21 Q. Quite so, but we're only looking at research and  
22 development at the moment.

23 A. Okay.

24 Q. In terms of therapeutics, did your time as Secretary of  
25 State cause you to appreciate that, in terms of the

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1 governments will take a very strong interest and use  
2 extraordinary measures, as indeed we saw especially from  
3 the European Commission.

4 And so making sure that we don't forget that, that  
5 we build that capacity now, is critical.

6 Q. Before we leave the topic of research and development,  
7 in terms of vaccines, how important is it that there is  
8 a capability to research and develop and ultimately  
9 authorise a prototype vaccine that can be tailored  
10 towards a particular pathogenic outbreak?

11 A. Well, I think that is important but I wouldn't say it's  
12 the most important item on the critical path. So I have  
13 a very strong view, post-pandemic, that we need to have  
14 a vaccine available as soon as possible, and I think the  
15 goal of having a vaccine available to any reasonably  
16 expected pathogen within 100 days at scale is the right  
17 target.

18 I know that's also become a sort of G7 objective but  
19 I mean this about the UK policy. It should be for the  
20 UK to be able to develop and manufacture and be ready to  
21 deploy a vaccine at scale within 100 days. That should  
22 be the UK Government's role --

23 Q. But that's a policy, and so that everyone can  
24 understand, the 100 Days Mission is something that was  
25 propagated by the UK Government when it was in charge --

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1 development of new therapeutics, it was vital to have  
2 a platform capability, that is to say a research and  
3 development infrastructure that could develop new  
4 therapeutics as well as having a system in place for  
5 their platform trialling, for example, RECOVERY.

6 A. Yes.

7 Q. To have a system that you could use to trial  
8 therapeutics effectively and at speed?

9 A. Yes. That's absolutely critical. Again, RECOVERY was  
10 put in place very, very quickly, and in my view is the  
11 most successful clinical trial in the history of  
12 clinical trials because it was done at such scale and  
13 such pace.

14 Again, unfortunately, and much more so than on the  
15 vaccine side, that capability has degraded very  
16 significantly since the pandemic and --

17 Q. Can you say why?

18 A. It's very hard to know.

19 Q. Or in what way?

20 A. It's broadly -- I think it's probably a combination of  
21 the pressures on the NHS, the day-to-day pressures,  
22 meaning that the priority of clinical trials is lower  
23 when there's so much immediate challenge. There is  
24 definitely a funding issue that needs to be sorted. And  
25 there may be an element that's to do with the regulatory

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1 system having got tougher.

2 But I think I would strongly recommend to the --  
3 a future piece of work that need -- it's critical, and  
4 it's good for the contrary in peacetime anyway, but  
5 critical for pandemic response is to ensure that our  
6 clinical trial capability is stronger.

7 The Lord O'Shaughnessy report into this, two years  
8 or so ago, gives a good indication of the sorts of  
9 things that need to happen.

10 **Q.** Yes. And then finally on this topic, you've mentioned  
11 vaccine manufacturing capability, onshore vaccine --

12 **A.** Yes.

13 **Q.** -- capability, that is to say within the United Kingdom.  
14 What was the general state of the UK's manufacturing  
15 capacity in early 2020?

16 **A.** It was weak. We'd been working to try to build the  
17 JMIC (sic) and to try to enhance that capacity before  
18 the pandemic, and we had to accelerate that very  
19 aggressively from the start of the pandemic before we  
20 knew that a credible vaccine would be available. But  
21 thankfully, it's something that Jonathan Van-Tam in  
22 particular had a very strong background in, and we were  
23 able to do as much as we were able to, but it still  
24 wasn't perfect because a whole load of our vaccines  
25 still were manufactured on the European continent and

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1 **MR KEITH:** No, no, no, forgive me, Mr Hancock, we've got  
2 very little time and I'm afraid you have to focus on the  
3 questions --

4 **A.** Yes, but --

5 **Q.** We will come back to the question of manufacturing  
6 capacity at the end of your evidence.

7 **A.** Yes.

8 **Q.** I'd like to ask you, please, about the research call  
9 process, which was the first stage in the getting ready  
10 process at the beginning of 2020. You received  
11 a submission on 31 January recommending that a research  
12 call process be put in place.

13 We'll have that, please, INQ000057497, page 2.

14 Essentially, was this position, that you were asked  
15 to note, and obviously to lead and encourage and assist,  
16 a process by which a research call could be put out to  
17 academia and industry as rapidly as possible in order to  
18 be able to commence and provoke the process of research  
19 and development?

20 **A.** I'm afraid I'm going to complete my answer to the  
21 previous question because it is not outwith the scope of  
22 this Inquiry, which is very broad, to consider the ways  
23 in which a domestic vaccination programme could be  
24 knocked off track, and I would insist that that is an  
25 important part of the Inquiry, and is important to look

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1 that caused us significant problems when they chose to  
2 behave extremely badly over the distribution of that  
3 vaccine.

4 **Q.** All right. Well, we don't need to go into that.

5 **A.** Well, we do, actually.

6 **Q.** Mr Hancock --

7 **A.** Because it happened and it caused us enormous problems.

8 **Q.** Yes, it's not within the scope of this Inquiry to delve  
9 into the relationships or the arrangements with our  
10 European colleagues.

11 **LADY HALLETT:** But I take the point that we need to have the  
12 capacity to do it here, if we're going to have  
13 a pandemic which is global.

14 **A.** Yes, and my only point -- I don't want to go into the  
15 details of the EU brouhaha, but the point is that even  
16 if you have a legal contract, if the manufacture happens  
17 offshore, force majeure will be used by other  
18 organisations whether it will be -- I actually was more  
19 worried about the Trump administration, which was why  
20 I stopped the Oxford vaccine going to the US, but --

21 **LADY HALLETT:** Sorry this is my fault. We are now  
22 getting --

23 **A.** No, but it is important --

24 **MR KEITH:** With respect --

25 **A.** It is not outside --

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1 into, and to make sure we don't fall into that trap in  
2 the future, hence the need for domestic manufacture.

3 **Q.** All right --

4 **A.** Now, on this question, as you put it, is exactly what we  
5 were trying to achieve. On 28 January, I asked for money  
6 to be made available for research for vaccines and  
7 therapeutics, and the -- this note was the result of  
8 that request.

9 **Q.** Can I just pick up one or two of the points, please, in  
10 this document. This approach was obviously greatly  
11 contributed to by the Chief Medical Officer,  
12 Professor Sir Chris Whitty and the DCMO, Professor Sir  
13 Jonathan Van-Tam. We can see from paragraph 3 something  
14 of the bodies that were concerned on the funding side,  
15 obviously the DHSC was the overarching body, but we can  
16 see references to the MRC and National Institute for  
17 Health Research, now the National Institute for Health  
18 and Care Research. Was it your view that everything was  
19 generally done, as far as it was reasonably possible, in  
20 terms of trying to identify who could carry out the  
21 essential research and development and also that the  
22 funds were made available by government and through  
23 these bodies for that research to be done?

24 **A.** Yes.

25 **Q.** In the course of the following two months, your

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1 department received multiple requests or multiple  
 2 notifications that requests for funding had been made,  
 3 and they all generally received the support of yourself  
 4 and your department. In the course of the debate,  
 5 however, much was said about the need for the  
 6 United Kingdom to present itself as an expert clinical  
 7 testing site in order to assist the manufacturers who  
 8 would commence the production and the manufacture of  
 9 vaccines and therapeutics.

10 Why was having a proper clinical testing  
 11 infrastructure so important to this process of  
 12 identifying vaccines and therapeutics and getting them  
 13 produced, manufactured, and delivered?  
 14 **A.** Because it is vital to base your decisions on vaccines  
 15 and therapeutics on proper clinical science, and given  
 16 the desperation for solutions, there were many solutions  
 17 put forward before they had clinical validation, most  
 18 famously the idea that hydroxychloroquine could protect  
 19 you from the impact of Covid. And I was very strongly  
 20 of the view, of course supported by the CMO and the  
 21 scientific bodies, that we needed to make sure this was  
 22 based on science, and clinical science requires clinical  
 23 trials to validate.

24 And the bigger the trial, the more power in it, and  
 25 therefore the quicker you can get to a result.

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1 testing, being well prepared to fund the testing and the  
 2 clinical development was not only of assistance to the  
 3 manufacturers, but also hugely contributed to the global  
 4 response as well?

5 **A.** The UK and the global response, absolutely, yes.  
 6 **Q.** All right. In terms of therapeutics, there is much  
 7 written evidence before the Inquiry, in particular from  
 8 Sir Jeremy Farrar, Professor Sir John Bell, and  
 9 Dame Kate Bingham, that by contrast, perhaps, to the  
 10 overall co-ordination of the vaccination research and  
 11 development, the system by which the trialling,  
 12 particularly the phase II trialling of therapeutics,  
 13 worked rather less well. There were a great deal many  
 14 trials. There were a lot of academic bodies, perhaps  
 15 tripping over each another, there were a number of  
 16 wide-ranging disparate interests from industry and it  
 17 didn't appear to have the same degree of co-ordination  
 18 as the vaccine research and development; would you  
 19 agree?  
 20 **A.** I don't actually agree with that. The programmes were  
 21 run differently. On therapeutics, it was run much more  
 22 within the department, it didn't need the breadth of  
 23 scope. There's a perfectly good debate we can have  
 24 about the value of bringing in highly capable,  
 25 independent externals with -- given a huge amount of

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1 So it was -- and the UK is one of the few countries  
 2 in the world that can do this at scale and --  
 3 (overspeaking) --

4 **Q.** And the manufacturers have to be able to have their  
 5 product tested?  
 6 **A.** Yes.  
 7 **Q.** So the more that can be done by, for example, the United  
 8 Kingdom --  
 9 **A.** Yeah.  
 10 **Q.** -- to test possible therapeutics and vaccines --  
 11 **A.** Yes.  
 12 **Q.** -- the greater assistance it will be to the  
 13 manufacturers?  
 14 **A.** Yes, and not only the manufacturers of new drugs, but as  
 15 we discovered, it was the repurposing of existing old  
 16 drugs that actually, with dexamethasone in particular,  
 17 came to the fore in a life-saving way. So this was  
 18 directly on the critical path to saving lives.  
 19 **Q.** So if we look at this page, and in particular  
 20 paragraph 5 at the bottom:  
 21 "These calls will contribute to the global response  
 22 by actively collaborating with and being informed by the  
 23 WHO's Global Coordinating Mechanism ... for [Research  
 24 and Development ... and (GloPID-R) ... and (CEPI)]."  
 25 So being well prepared to carry out the clinical

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1 authority to do specific tasks, like Kate Bingham on --  
 2 specifically on the commercials around vaccines, which  
 3 she did brilliantly. When it came to therapeutics, it  
 4 was much more about getting an excellent set of clinical  
 5 trials in place and with RECOVERY, we put in place an  
 6 absolutely brilliant clinical trial.

7 It is, by its nature, a messier area in  
 8 therapeutics. So I can see why it might have looked  
 9 like that, but it was still incredibly effective.  
 10 **Q.** That may be so, but it's apparent from this evidence  
 11 that it didn't just look like that; there were too many  
 12 underpowered phase II trials; there was a degree of  
 13 tension between the DHSC and the BEIS, the two  
 14 government departments, over who was in charge, and  
 15 also, a real problem with recruitment, because there was  
 16 an absence of proper co-ordination and management in  
 17 terms of getting people into these trials for  
 18 therapeutics. You must have been aware of that?  
 19 **A.** Yes, but I was also aware that we were running the  
 20 largest, fastest recruited trial that had ever happened,  
 21 and came up with the first clinically valid  
 22 therapeutics. So I think it's quite hard to -- so at  
 23 the same time, it's possible to say yes, it could have  
 24 been done better, but it also worked very, very  
 25 effectively and saved many lives.

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1 You know, the same is true on the vaccines side.  
 2 There are many points of detail which could have been  
 3 done better, but it worked overall very, very  
 4 effectively, because of the effective co-ordination and  
 5 teamwork between the four groups I spoke to about  
 6 earlier.  
 7 **Q.** Quite so. We're looking to see how it could have been  
 8 done better.  
 9 **A.** Yeah --  
 10 **Q.** -- but --  
 11 **A.** -- from my seat I didn't really, I don't really --  
 12 (overspeaking) --  
 13 **Q.** It was going as well as you thought it reasonably could?  
 14 **A.** That's right, even if there was -- there's always noise  
 15 under the surface in these things when you are moving  
 16 very quickly.  
 17 **Q.** It's obvious that there was a debate about whether or  
 18 not therapeutics generally as opposed to neutralising  
 19 monoclonal antibodies should be within the remit of  
 20 Dame Kate Bingham's Vaccines Taskforce?  
 21 **A.** Yeah.  
 22 **Q.** And ultimately the position was reached that monoclonal  
 23 antibodies would be within the taskforce --  
 24 **A.** Yes.  
 25 **Q.** -- but the therapeutics would go off to a DHSC, entirely

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1 Having said that, I'm a big fan of the strongly-led  
 2 "bring in the experts" model, and I think the more  
 3 external expertise you have working alongside civil  
 4 servants, the better, so long as the accountability is  
 5 right and the direction of travel and leadership is set.  
 6 And I think, you know, the VTF demonstrated that.  
 7 **Q.** You've referred to the process of procurement and  
 8 obviously the range of vaccines that the Vaccines  
 9 Taskforce was able to procure. I was asking you,  
 10 though, about the system by which government puts into  
 11 place a body or an entity to be in charge of it.  
 12 **A.** Yeah.  
 13 **Q.** So can I press you on that? It appears to be generally  
 14 accepted that the VTF did extremely well. The  
 15 Therapeutics Taskforce and its successor the Antivirals  
 16 Taskforce did very well also, but there were distinct  
 17 problems, it would appear, about the co-ordination and  
 18 management of the clinical trial process and the way in  
 19 which antivirals and therapeutics were procured  
 20 ultimately. The system did not move and work as  
 21 smoothly as it had for vaccines.  
 22 **A.** No, I reject your characterisation into two different  
 23 groups. There were -- both worked brilliantly, had  
 24 clear accountability, from where I sat, and both had an  
 25 enormous amount of work going on underneath, some of

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1 DHSC, body --  
 2 **A.** Yes.  
 3 **Q.** -- the therapeutics taskforce. So it didn't have,  
 4 ultimately, the same degree of external influence as  
 5 Kate Bingham's Vaccines Taskforce.  
 6 Do you think in future it would be better if the  
 7 therapeutics taskforce was to be put together, if it is  
 8 utilised, in the same way as the Vaccines Taskforce was  
 9 utilised by, and managed brilliantly by, Kate Bingham?  
 10 **A.** Well, remember, the therapeutics work was managed  
 11 brilliantly by JVT, so we had very strong leaders on  
 12 each. It was very clear to me as Secretary of State who  
 13 I went to in each case. And, you know, it's perfectly  
 14 reasonable on the therapeutics side to point to points  
 15 of detail that could be improved, but overall it was  
 16 absolutely brilliant.  
 17 Precisely the same analysis applies to the vaccines.  
 18 You know, there were debates about exactly how many we  
 19 needed to order. I thought we needed to order for the  
 20 whole population, some argued only for a subset of the  
 21 population.  
 22 These are -- it is correct to have these debates,  
 23 and entirely reasonable, and that happened on both  
 24 sides. So I don't really buy this distinction you're  
 25 trying to draw.

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1 which was noisy, and there were reasonable disagreements  
 2 about process and there were things that could be  
 3 improved.  
 4 You know, for instance, if you look back, there was  
 5 an enormous amount of noise and criticism around some of  
 6 AstraZeneca's clinical trial work during the summer  
 7 of 2020, especially when the case rate fell very low in  
 8 the community. And that was on the vaccine side.  
 9 So I just think you're wrong to characterise it as  
 10 one went really well and one went really badly.  
 11 **Q.** No, Mr Hancock, I said they both went --  
 12 **A.** No, you literally said that.  
 13 **Q.** No, no, no, no, I said the Vaccines Taskforce operated  
 14 extremely well or very well. I said the Therapeutics  
 15 Taskforce overall also worked very well, but there were  
 16 problems --  
 17 **A.** But there were on the vaccine --  
 18 **Q.** -- with the --  
 19 **A.** Yeah, but -- there were on the vaccine side as well.  
 20 And what we did was we worked through the problems that  
 21 we found.  
 22 And then you also asked about the boundary between  
 23 the two and where antivirals fell. In essence, my view  
 24 was it didn't really matter which side the -- where the  
 25 boundary lay, so long as it was clear. And I remember,

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1 for instance, Kate Bingham was very clear to me early on  
2 that she thought that it was unlikely we'd get a vaccine  
3 in good time so she wanted also to work on antivirals,  
4 because they may be the solution, and so I thought,  
5 given that enthusiasm, she could do that part, and put  
6 the boundary -- put antivirals on that side of the  
7 fence. You could have cut it either way.

8 But the Inquiry would be wrong to conclude that this  
9 bifurcation in -- in one went well and the other one  
10 didn't, or even though both were a success, one didn't  
11 have problems and one did. It's just not true.

12 **Q.** Were you aware of quite heated emails within your own  
13 department, between your officials, concerning whether  
14 or not the general topic of therapeutics should be  
15 amalgamated within the Vaccine Taskforce?

16 **A.** Yes, I was aware of the debate, I'm not sure I've seen  
17 the emails, but there was an entirely reasonable debate  
18 about how best formally to structure these things.

19 **Q.** Do you acknowledge that some, rightly or wrongly, take  
20 the view that because therapeutics, other than  
21 monoclonal antibodies, were outwith the Vaccine  
22 Taskforce, there was a perception that the government  
23 cared less about therapeutics and vaccines? I'm sure  
24 you've got something to say about that.

25 **A.** I disagree. And I don't really care about the

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1 **A.** So the impacts are different in nature, but that  
2 doesn't -- so it's impossible to say which is more  
3 important. They're both incredibly important.

4 **Q.** Indemnities. The VTF, which obviously fell within the  
5 government department BEIS, business enterprise --  
6 I can't now remember the acronym.

7 **A.** Industrial strategy.

8 **Q.** Innovation and strategy?

9 **A.** Industrial strategy.

10 **Q.** Thank you. And obviously with the DHSC had to negotiate  
11 with the manufacturers, and that included having to  
12 negotiate the question of indemnities.

13 **A.** Yes.

14 **Q.** Is this the situation: broadly, and understandably, all  
15 the manufacturers sought indemnities of one sort or  
16 another. Was the issue of indemnities resolved  
17 generically or did they have to be individually  
18 negotiated with respect to each manufacturer?

19 **A.** So I wasn't involved in the individual negotiations but  
20 my understanding is that they were negotiated  
21 individually, and that would be reasonable. For  
22 instance, AstraZeneca was not taking any profit from  
23 the -- a vaccine, and therefore it would have been  
24 unreasonable to ask them to bear an uncapped risk at the  
25 same time as essentially doing something for the public

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1 perception, I cared about the substance. And the  
2 substance was that we discovered that dexamethasone  
3 saved lives before anybody else did around the world,  
4 and the Therapeutics Taskforce did brilliantly and had  
5 very clear leadership, and could -- and there were areas  
6 where it had to debate things and there were  
7 difficulties that it overcame, and that precise analysis  
8 applies to vaccines as well. Just because one side is  
9 more -- puts their points more forcefully afterwards  
10 doesn't make it true.

11 **Q.** You would say, I presume, that therapeutics at  
12 a population level are less likely to be able to bring  
13 a country out of a pathogenic crisis than vaccines?  
14 Vaccines had to be looked at with no less degree of  
15 importance than therapeutics?

16 **A.** They were no less important, absolutely, because the --  
17 the importance of them is different in nature because of  
18 the fact that the vaccine can get us out of a pandemic,  
19 but the therapeutics more directly saved lives because  
20 people going into hospital with Covid-19 were a third  
21 less likely to die after the successful clinical trials  
22 of dexamethasone.

23 So one has a more direct impact and one has a more  
24 macro impact, if you like.

25 **Q.** Quite.

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1 good.

2 And my view was that the state was the insurer of  
3 last resort that -- and therefore needed to step up in  
4 this way. So I was broadly sympathetic to the need for  
5 indemnities. Which were, of course, only to indemnify  
6 should a court case be lost.

7 **Q.** Quite.

8 **A.** It wasn't a blanket.

9 **Q.** We'll come back to that in a moment.

10 **A.** Okay.

11 **Q.** Because that's a very important point, Mr Hancock.

12 The manufacturers or some of the manufacturers  
13 initially sought full statutory immunity. That's to  
14 say, a process by which they couldn't be sued at all.  
15 And it's right to say, isn't it, that that was rejected  
16 by UK ministers and ultimately came to nothing?

17 But what was done was that an indemnity provision  
18 was agreed whereby nobody would be precluded from going  
19 to court and suing a manufacturer, for example, under  
20 the Consumer Protection Act, but if the company lost, in  
21 certain circumstances the government would pick up the  
22 tab for any award of compensation as well as the legal  
23 costs. Is that a fair summary?

24 **A.** As far as I recollect, yes, although, again, I wasn't  
25 involved in the precise negotiation of these.

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1 **Q.** In general terms, I don't want to get into the specifics  
2 of the indemnities that were agreed, but was the  
3 position taken by the United Kingdom particularly or  
4 significantly different from what ultimately was  
5 negotiated between the manufacturers and other  
6 particularly western European countries?

7 **A.** I don't know.

8 **Q.** All right. Do you consider that ultimately what was  
9 agreed with the manufacturers in terms of indemnities  
10 was reasonable and proportionate, given the need to get  
11 vaccines manufactured and developed?

12 **A.** Yes.

13 **Q.** Right. Evusheld. You've referred to Evusheld.  
14 Evusheld was, I think, Project Astronaut, it was also  
15 known as AZD7442, and just by way of summary, in June  
16 2020, you'll recall that the Vaccine Taskforce agreed  
17 provisionally with AstraZeneca to buy a large number of  
18 this drug, a long-acting antibody, and that was  
19 announced, in fact, by the government in July 2020.

20 Subsequently, the Vaccine Taskforce wrote to, in  
21 particular Professor Chris Whitty and Professor Sir  
22 Jonathan Van-Tam and Clara Swinson in your department,  
23 asking for confirmation as to whether or not that  
24 prospective advance purchase of Evusheld should be  
25 confirmed.

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1 believe, with hindsight, that it's right to protect the  
2 whole population. If you can't take a vaccine,  
3 therefore you need another protection. So I was keen to  
4 find an antibody treatment that would work, but when the  
5 clinical advice says that we should not proceed, that is  
6 obviously a reasonable clinical decision.

7 **Q.** And was the advice from the VTF, was the advice from the  
8 Office of the Chief Medical Officer, the clinicians and  
9 the policymakers organisational all, in fact, pointing  
10 in one direction: which was for a number of reasons,  
11 this advance purchase should not be made?

12 **A.** It was clear and unambiguous on the clinical grounds.  
13 My recollection is that it was because the shelf life  
14 was relatively short but it was going to take several  
15 months before we had clinical validation and therefore  
16 if we bought at that point, we weren't to know whether  
17 clinical validation would come forward and if it did,  
18 anything we'd bought early would by then be out of date.  
19 So it was essentially a logistical/clinical  
20 decision/explanation that was given to me behind the  
21 recommendation not to buy, and when faced with  
22 unambiguous clinical advice, I tended to follow it.

23 **Q.** And there were a number of other reasons, which I'll  
24 summarise for you. Professor Sir Jonathan Van-Tam in  
25 particular said that given the background of the

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1 We'll have up a document, please, INQ000497987.

2 A body called the VTF Panels Team wrote to yourself  
3 and a number of others on the 17 February 2021 enclosing  
4 an attached decision paper for ministers -- that's  
5 obviously you and Alok Sharma, I'm assuming.

6 **A.** Steve Barclay.

7 **Q.** Oh, Steve Barclay, thank you.

8 **A.** The VTF reported to the three of us, yeah.

9 **Q.** "Please find attached decision paper for Ministers on  
10 whether the VTF should proceed with the advance purchase  
11 of Astronaut antibody treatment. The VTF recommendation  
12 is that Ministers agree that VTF should not proceed with  
13 the purchase agreement."

14 Did you in fact receive a number of papers and  
15 documents from the VTF and also from the Office of the  
16 Chief Medical Officer about the merit of proceeding with  
17 advance purchase?

18 **A.** Yes. This was a live discussion, because of the  
19 importance of antivirals. I mean -- and the antibody  
20 treatments, because we knew that the vaccine would not  
21 be medically suitable for everybody, and yet we needed  
22 a solution for everybody. And in fact, I was at the  
23 forefront of the argument that we needed a protection  
24 for everyone. Some people said we should only protect  
25 the clinically vulnerable. I believed and strongly

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1 emerging success of the vaccination programme the need  
2 was perhaps, to some extent, not a great extent,  
3 reduced. There was also a lack of clarity as to how  
4 many people might benefit. It was a relatively  
5 expensive purchase but that it was important to keep the  
6 whole decision under review, particularly for treatment  
7 purposes after the event?

8 **A.** Yes. Remember, this is a decision, the one in front of  
9 us is a decision not to proceed with an advance  
10 purchase --

11 **Q.** I said that, yes.

12 **A.** -- before clinical validation. You know, I have friends  
13 who couldn't take the vaccine for clinical reasons.  
14 I understand why there was a big push for that by those  
15 in that position, and I agreed with that. But there's  
16 no point in buying something that might not work if the  
17 clinical advice is not to because if we buy it now, the  
18 stuff we -- anything we actually physically buy now  
19 won't be available because it'll be out of date by the  
20 time it could be used.

21 **Q.** There are many people who have suggested to the Inquiry  
22 that thereby the immunosuppressed and others would have  
23 benefited from it were essentially ignored or abandoned,  
24 and I want to make it plain -- can we have, please,  
25 INQ000066717 -- that although the decision taken by

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1 ministers was not to proceed with this advance purchase,  
2 they were keenly aware of the need to strategise for and  
3 provide for the immunocompromised who can't take the  
4 vaccine or might not be protected by the vaccine, and  
5 how they were to be protected.

6 **A.** There you are.

7 **Q.** And was there in fact in your department considerable  
8 work done on, firstly, thereafter setting up further and  
9 developing further the prophylaxis trials which were  
10 already under way, trying to identify the number of  
11 immunocompromised who might benefit from an advance  
12 purchase of a prophylactic treatment --

13 **A.** Yes.

14 **Q.** -- and also putting into place some other new trials,  
15 I think there was a trial called Protect V and another  
16 trial called Protect CH?

17 **A.** Yeah.

18 **Q.** So the issue was not forgotten?

19 **A.** Far from it. We were continued to push for this, and  
20 I remember regarding this decision as a decision "not  
21 now", rather than a decision "not ever".

22 **Q.** And therefore would you agree, no doubt, that although  
23 a number of people, including Dame Kate Bingham and  
24 Clive Dix, described the decision as a serious mistake,  
25 there was material before ministers on clinical and

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1 the general strategy, which is a prioritisation that was  
2 for JCVI to determine and implement.

3 There was an issue in February 2021 about the  
4 definition of cohort 6, that's to say number 6 and  
5 a list of prioritised groups in the phase I priority  
6 list issued by the JCVI, which concerned those persons  
7 who were in receipt in a Carer's Allowance or those who  
8 are the main carer of an elderly or disabled person  
9 whose welfare may be at risk if the carer falls ill.

10 And there was quite a complicated structure in place  
11 because there is also something called the Green Book,  
12 which is a semi-medical publication which gives  
13 a description, of, amongst many other groups, "adult  
14 carer".

15 Did an issue come to the fore which concerned you  
16 ultimately, and you had to take a view on it, as to how  
17 well defined that cohort 6 was and whether or not unpaid  
18 carers should be the subject of a definitional change;  
19 do you recall?

20 **A.** I recall this issue very clearly. The bit of your  
21 question that I don't quite agree with, I put it  
22 a different way, is that it was an issue that came to  
23 the fore. It wasn't an issue for my final decision,  
24 because I'd already decided that we should follow JCVI  
25 advice, whatever their advice was. We asked them to

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1 other grounds, or other reasons for the decision that  
2 they took?

3 **A.** Well, it's entirely reasonable that people can differ in  
4 their opinion on the -- on any of these decisions, which  
5 were each big decisions. But the clarity of clinical,  
6 as opposed to non-clinical advice, you know, so the  
7 advice from the commercial team that you mentioned was  
8 in favour. If the advice from the clinical team is  
9 against, and we're looking for a clinical solution, you  
10 can understand why ministers took the decision that they  
11 did. But I, you know, I hold Kate and Clive Dix in  
12 great esteem. It's totally reasonable for them to have  
13 held a different view, but what we were trying to  
14 achieve was the protection of the immunocompromised in  
15 a way that was clinically effective.

16 **Q.** On the subject of prioritisation, that was obviously an  
17 issue primarily for the Joint Committee on Vaccination  
18 and Immunisation, JCVI --

19 **A.** That wasn't a passive decision; that was a -- we took an  
20 active decision to invest in the JCVI, the authority to  
21 make recommendations, which they should rightly expect  
22 us to then have followed.

23 **Q.** We don't need to go there, Mr Hancock. I was going to  
24 ask you about two particular aspects of prioritisation  
25 with which you were generally concerned, outwith

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1 take into account the practicality of implementation, as  
2 well as -- essentially, their central goal was to take  
3 a scientific view of how to save most lives through the  
4 prioritisation. And that's why, for instance, we didn't  
5 go down a sector-by-sector approach, teachers, police,  
6 and et cetera, because more people would have died  
7 compared to doing it essentially by age and then  
8 bringing in clinical prioritisation of other priority  
9 groups only when their vaccination would save more lives  
10 than moving on to the next age cohort.

11 **Q.** Can we have INQ000059858. This a submission dated  
12 9 February 2021. It's to the Secretary of State and it  
13 concerns this issue, cohort 6.

14 If you could go over the page, please, to page 1 --  
15 page 2. There we are. It's to the Secretary of State  
16 for Health. And the recommendation says:

17 "We recommend that you:

18 "Note the method of implementation ...

19 "[You] Agree to the proposed definition ...

20 "[You] Agree to the prioritisation of the  
21 individuals under 'multiple occupancy settings' ..."

22 And then note of final issue.

23 So, although it was primarily, as I suggested to you  
24 for the JCVI, as the Secretary of State, you were  
25 undoubtedly nevertheless being asked to agree to the

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1 change in the proposed definition of unpaid carers, but  
 2 as, as you say, this was something very much within  
 3 their expert subject matter.  
 4 **A.** Correct. It was my formal authority to make this  
 5 decision. However, having asked them to come forward  
 6 with advice on what is the best way to save the most  
 7 lives, I then took that advice, rather than  
 8 second-guessing it.  
 9 **Q.** A second issue which came to you concerned people with  
 10 learning disabilities. In your diaries, your book, you  
 11 refer to quite a difficult issue in February 2021 --  
 12 **A.** Yeah.  
 13 **Q.** -- concerning whether or not only those with severe  
 14 learning disabilities were getting prioritised, and  
 15 there was a real problem with whether or not local GP  
 16 registers and other NHS systems were properly recording  
 17 who was -- who suffers from learning disabilities.  
 18 **A.** Yes.  
 19 **Q.** Do you recall how that was resolved?  
 20 **A.** Well, I -- my recollection is that this was a really  
 21 important boundary issue. All of these are difficult  
 22 judgments on where the boundary with a group should be,  
 23 given that the people who are deemed within that  
 24 boundary then get access to the vaccine, which is life  
 25 saving and incredibly valuable.

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1 **A.** Yes, and it's even worse than that because many learning  
 2 difficulties and disabilities are defined essentially  
 3 educationally, and in the world of Whitehall and the  
 4 UK Government system, that becomes a piece of data in  
 5 their education record, not in their health record, and  
 6 so if you go into their health record you might not find  
 7 any reference to it. So it's a very complicated area,  
 8 and, frankly, it could do with a huge amount of  
 9 improvement.  
 10 **Q.** This is what I wanted to ask you. There are obviously  
 11 a huge range of issues here from the simple fact of  
 12 accuracy of recording to the integration of data  
 13 systems --  
 14 **A.** Yes.  
 15 **Q.** -- as well as, of course, whether they record  
 16 disabilities and medical conditions, as well as  
 17 sectorial differences --  
 18 **A.** Yes.  
 19 **Q.** -- ethnicity --  
 20 **A.** Yes.  
 21 **Q.** -- and the like. But can you help us with this: when  
 22 this problem about registration in GP registers of  
 23 severity of learning disabilities came to your  
 24 attention, was anything done at that stage concerning  
 25 the operation of these data systems? Was it possible to

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1 I know about the areas of learning disabilities very  
 2 well, not least because I'm a campaigner on  
 3 neurodiversity. I am dyslexic. That is technically  
 4 a learning disability in some senses. I did not deserve  
 5 an earlier vaccine because of my dyslexia, but those  
 6 with severe learning difficulties were dying at  
 7 a greater rate than the general population and it was  
 8 evident that you could save more lives by ensuring that  
 9 they did. Where is the boundary between a perfectly fit  
 10 and healthy dyslexic and somebody with perhaps permanent  
 11 inpatient care with severe learning difficulties? We  
 12 had to find a boundary somewhere.  
 13 **Q.** Was it apparent to you that the foundation of this  
 14 problem and what became a definitional debate, lay in  
 15 part in the fact that GP systems, the data systems at GP  
 16 level, didn't always capture the severity of someone's  
 17 learning disability?  
 18 **A.** Yes.  
 19 **Q.** So it was impossible for anybody to say they are  
 20 entitled to prioritisation because they have  
 21 condition A?  
 22 **A.** Yes.  
 23 **Q.** Whereas Y doesn't --  
 24 **A.** Yes.  
 25 **Q.** -- and therefore --

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1 address --  
 2 **A.** Yes.  
 3 **Q.** -- the overall system at that time in the teeth of the  
 4 pandemic? Was anything done to try to improve the  
 5 overall efficiency and accuracy of this system --  
 6 **A.** Yes.  
 7 **Q.** -- the GP --  
 8 **A.** Yeah --  
 9 **Q.** -- registration system?  
 10 **A.** Yes. I mean, throughout the pandemic, as we've heard in  
 11 other modules, there was a huge amount of data work done  
 12 to progress the quality of data that was available to  
 13 government for these sorts of purposes, whether that's,  
 14 you know, in the shielding programme or in the  
 15 measurement of the vaccine -- the virus itself, and the  
 16 NHS, et cetera.  
 17 This is another area where there was some  
 18 improvement but there's still a huge amount that can be  
 19 done to -- to make these sorts of datasets more  
 20 interoperable.  
 21 **Q.** That brings us on to the wider area, if you like, of  
 22 barriers to uptake, equality of access to vaccination  
 23 because plainly, and it's obvious, despite the overall  
 24 success of both programmes, there are very real  
 25 difficulties concerning delivery and access.

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1 We needn't go into the detail of it. It is  
2 obvious -- and we could have, perhaps, INQ000256951  
3 up -- that a great deal of work was done by the  
4 UK Government in particular, because of its overarching  
5 position, but as well as by the devolved  
6 administrations, on trying to identify the basis of  
7 vaccine and health inequalities: how do you make the  
8 prioritisation programme and the delivery programme work  
9 better.

10 **A.** Yes.

11 **Q.** At a very high level, Mr Hancock, would you suggest, or  
12 do you think that as much was done as could reasonably  
13 be done by your government, the UK Government, to  
14 address the issue of barriers to uptake and problems  
15 with access? Not with practical delivery, you know,  
16 distance to vaccination or eligibility for therapeutics,  
17 but with the general state of play on why there are so  
18 many people who didn't realise that they had access, or  
19 they were entitled to access, didn't take up  
20 vaccination, or were prevented in one way or another  
21 from doing so.

22 **A.** We put a huge amount of effort into this, a huge amount  
23 of effort.

24 From before the vaccine was signed off, I kicked off  
25 a piece of work in June or July 2020, for instance,

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1 So you might have a Hindu vaccination centre -- you  
2 know, everybody was eligible to go there but it may have  
3 been run largely by people with a Hindu background --  
4 next to a largely Muslim vaccination -- population, and  
5 they may be less likely. But if you then put a team --  
6 if you then put a vaccine centre into the local mosque,  
7 then you get the pick-up on the Muslim side.

8 So that is one example. We saw that precise  
9 example -- that is a description of what happened in  
10 Leicester. And so we learnt a huge amount about how to  
11 make the state as open as possible to those who we were  
12 encouraging to come forward for vaccination. And you  
13 may want to ask Minister Zahawi, former Minister Zahawi,  
14 because I know he's appearing, and he led a lot of this  
15 work, as did Sadiq Khan --

16 **Q.** We will --

17 **LADY HALLETT:** Can I just interrupt for a second.

18 One of the issues raised in the Every Story Matters  
19 records, a number of contributors raised it, and I've  
20 heard it again in evidence this week, was the issue of  
21 misinformation, particularly on social media, and you've  
22 just mentioned social media.

23 **A.** Yes.

24 **LADY HALLETT:** This was obviously something you knew about  
25 at the time.

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1 talking to the social media platforms, and learning --  
2 having been the Culture Secretary before and responsible  
3 for this sort of area in general, in general policy  
4 terms -- and then trying to really understand how you  
5 could drive up take-up. The central insight that we had  
6 was that you just can't think of people who are distant  
7 from the -- following the recommendations of the state  
8 as hard to reach. You have to think of them as the  
9 state being far away from them. You've got to see it  
10 from their eyes.

11 If you think about it, there are many communities  
12 where there is just not the history of relatively high  
13 trust levels that -- although we knock ourselves about  
14 it in the UK, we have very high trust levels in  
15 authority, like the NHS, the Royal family, the BBC, and,  
16 to a lesser extent, the wider government. There are  
17 communities where that is simply not the case.

18 And we learnt a huge amount through the rollout.  
19 For instance, you'd look at maps and there was high  
20 vaccination sat right next to low vaccination rates.  
21 And you'd find that, even within ethnic minority  
22 communities, the single biggest determinant of the  
23 likelihood of a community who may be more hesitant than  
24 the general population to take the vaccine is the  
25 ethnicity of the vaccinator.

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1 **A.** Yes.

2 **LADY HALLETT:** What steps, if any, could the government take  
3 to try to counteract that misinformation?

4 **A.** Yes, we did a huge amount of work on this as well. So  
5 we engaged early with the social media platforms, who  
6 rose to the challenge, and the mainstream media,  
7 including the BBC. But we -- where we really learnt  
8 from was the work that had been done to tackle  
9 misinformation around ISIS, Islamic State.

10 Because what we learnt there, what the UK Government  
11 learnt, was that if you directly disagree with an  
12 anti-vaxxer, then all you do is amplify that  
13 anti-vaxxer's view.

14 And we segregated the population in terms of  
15 enthusiasm for vaccines from those active anti-vaxxers,  
16 who would try to actively persuade other people not to  
17 take the vaccine -- there's very, very few of them, but  
18 they feel it incredibly strongly.

19 Then there's a large number who are vaccine  
20 hesitant. For them you need to have enormous amounts of  
21 sympathy, because they are willing to take a vaccine if  
22 they can be persuaded.

23 Then there's the broad centre of population, then  
24 there's the broad enthusiasts, and then there's  
25 the super-enthusiasts.

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1 And you need the enthusiasts to be out there making  
2 the case but you want to basically ignore the hardcore  
3 anti-vaxxers and then use positive counter-narrative to  
4 persuade the hesitants. And the most useful tool we had  
5 to do that was positive, objective, scientific-based but  
6 well communicated messages from the NHS, because it's  
7 such a trusted brand.

8 So where we found pockets of anti-vax on the  
9 Internet, on social media and what have you, we put --  
10 we inserted into that positive, factual  
11 counter-narrative, which effectively meant messages from  
12 the NHS about the value of vaccination.

13 But it was so important that they were true and  
14 verified and -- because otherwise all you'd be doing was  
15 giving more succour to the hardcore -- I always thought  
16 it was about 2% in my head -- the people who really,  
17 really were trying to stop other people from getting  
18 vaccinated, not just worrying about it for themselves.

19 **MR KEITH:** May I just bring you back briefly to my question,  
20 because we understand you've obviously got a great deal  
21 of learning about the topic, but my question to you  
22 about barriers to uptake and inequalities was actually  
23 focused on whether you assess -- and it's an extremely  
24 complex and difficult area, but do you assess the  
25 government did enough to try to reduce barriers and

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1 proof point.

2 So we brought every part of the panoply of  
3 institutions that we could in order to persuade people  
4 of the scientific facts and truth. And the proof of the  
5 pudding is that we got one of the highest vaccination  
6 rates in the world. And I'm very, very proud of the  
7 team, the work they did on that.

8 **Q.** All right. I'm not sure about the link between the late  
9 Queen and barriers to access and ethnic minorities --

10 **A.** No, on the contrary, no, really, it had a huge positive  
11 impact, because she was a trusted figure.

12 **Q.** I want to conclude just by putting to you, please, some  
13 of the suggestions and recommendations in your sphere,  
14 your former sphere, the DHSC, which have been suggested  
15 to the Inquiry to get your brief take on them.

16 The first one I want to ask you about is the  
17 possibility of a national vaccines agency. It was  
18 specifically recommended by the VTF recommendation  
19 document in December 2020, and it's also being promoted  
20 by Dame Kate Bingham herself, by Clive Dix, and by  
21 a number of people who worked in that sphere. Would you  
22 support the creation of a national vaccines agency to  
23 deal end-to-end with the process that the VTF itself  
24 dealt with in the course of the pandemic, from threat  
25 assessment, clinical development, capability, scale-up,

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1 reduce inequalities?

2 **A.** Oh, yes.

3 **Q.** I say that because it's obvious, Mr Hancock, a great  
4 deal many elements in the government, the UK Government,  
5 from the discrimination unit, the NHS, the Public Health  
6 Agency, PHE, BIS, DHSC, DCMS, were all focusing on  
7 trying to address this problem, but it's quite  
8 a fragmented -- appears to be quite a fragmented area.  
9 Do you consider that enough was done, that the  
10 government did as much as it reasonably could, to try to  
11 tackle this problem?

12 **A.** Yes, we did everything we possibly could, yes. And of  
13 course, you know, I'd leave no stone unturned. If  
14 you -- if there are other things we could have done and  
15 that should be done in future, great. But we did  
16 everything we possibly could in this area. We  
17 anticipated it would be a problem in advance and we  
18 worked incredibly hard.

19 And you mention a whole series of different parts of  
20 the government. It wasn't uncoordinated, it was just  
21 there was a lot of activity going on. And then I'd say  
22 there were broader elements. The Palace -- you know,  
23 Her Majesty The Queen, the late Queen, did not typically  
24 disclose any of her medical details but she did disclose  
25 that she'd been vaccinated, and that was a very positive

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1 and procurement, not delivery, but up to procurement, so  
2 that next time there is a body already in place to do  
3 the role of the VTF?

4 **A.** Well, we now have that body, which is the UK Health  
5 Security Agency. It is absolutely UKHSA's role. And if  
6 all of those elements that you just mentioned aren't  
7 within UKHSA, they should be. Whether you then want,  
8 within UKHSA, to have a specific unit for vaccines, I'm  
9 pretty sure you do.

10 What I wouldn't do is have a separate agency,  
11 because you can already see in peacetime the challenges  
12 even UKHSA has of getting money out of the Treasury,  
13 frankly, to make all this happen. Their budget is not  
14 nearly high enough, given the scale of the threat from  
15 H5N1 and other pathogens right now. So, for that  
16 reason, I wouldn't have it as a separate agency, where  
17 it would wither on the vine, but the principles behind  
18 why you'd want a separate agency, ie, independence of  
19 voice and capability that you can bring in, I'd have,  
20 but I'd locate it within UKHSA.

21 **Q.** The point about the VTF, of course, Mr Hancock, as you  
22 well know, is although it was ministerially accountable  
23 to Parliament through BEIS, it had that degree of  
24 external expertise through Kate Bingham, Clive Dix and  
25 number of other people, such that it had, and you gave

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1 it, this degree of independence --

2 **A.** I know, it was good.

3 **Q.** -- so that it could operate outwith some of the well

4 known strictures of Whitehall. So isn't that what needs

5 to be replicated next time?

6 **A.** That's what UKHSA should do, yes.

7 **Q.** All right. Because it's not, of course, what the

8 Therapeutics Taskforce had?

9 **A.** Yes, I mean, I'm going to come -- because you pushed me

10 on this a lot earlier on the Therapeutics Taskforce.

11 I think it's really important for the Inquiry to take

12 into account the fact that because the therapeutics area

13 was driven by civil servants, they are less likely to

14 have a voice now in making an argument for how they did

15 things.

16 And this is an important thing to consider across

17 the Inquiry's work. Civil servants tend to be dry and

18 cautious in their response to inquiries, as opposed to

19 loquacious and -- (overspeaking) --

20 **Q.** As opposed to politicians --

21 **A.** -- in their views.

22 **Q.** -- Mr Hancock?

23 **A.** Indeed. Indeed. We're more freewheeling, I'd say.

24 **Q.** Yes, that's one way of putting it.

25 But the point, Mr Hancock, is it obviously worked,

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1 so you don't lose that enthusiasm.

2 I would add one further thing. I've seen the

3 recommendation here and I agree with it, the thing I'd

4 add to it that is absolutely vital, and doesn't get

5 enough airtime, is the need to set up challenge studies

6 and have people who are willing to take part in

7 challenge studies. These are studies where people are

8 intentionally infected, because then you can seriously

9 accelerate the clinical study work.

10 **Q.** This was in fact commenced by Clive Dix and Kate

11 Bingham; they had something called, as you know well,

12 human challenge trials, and I think the DHSC funded

13 £33 million worth of the first phase of that programme.

14 **A.** Yes, I think it was actually JVT who kicked that off but

15 it was, I think, I'm sure it was --

16 **Q.** But has it lasted?

17 **A.** I hope so.

18 **Q.** All right. But you don't know?

19 **A.** I don't know, but it should.

20 **Q.** All right. My final question, please. You've referred

21 already to the importance of onshore manufacturing

22 capability.

23 **A.** Yes.

24 **Q.** Plainly, there is no one practical measure that can be

25 taken. It's obviously a very complex topic. But what's

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1 and therefore the more we can do to replicate the bits

2 of the Vaccine Taskforce that worked, the better?

3 **A.** Yes, yes.

4 **Q.** All right.

5 A second element, finally, is this:

6 Dame Kate Bingham and others recommend the institution

7 of a vaccine national research registry, to register the

8 willingness of those who participated or want to

9 participate in vaccine trials?

10 **A.** Yes.

11 **Q.** Your department was -- played a very important role in

12 ensuring that as many people would come forward for

13 vaccine and therapeutic clinical trials as possible. Do

14 you think there is an argument for the creation of a

15 separate body to run, monitor and promote --

16 **A.** Yes.

17 **Q.** -- participation in trials, not least because of what we

18 were discussing earlier about the problems with

19 recruitment and the --

20 **A.** Yes.

21 **Q.** -- therapeutic phase II trials?

22 **A.** Yes, I would absolutely support the need for a register.

23 Again, this is -- you know, if run well and with the

24 right budget, this another role that UKHSA ought to

25 play, and but the idea of a register is very important

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1 your general position on this? Do you say that the

2 onshore manufacturing capability in the United Kingdom

3 has gone backwards since the pandemic or is your

4 understanding that we are still in a relatively good

5 position when it comes to the existence and presence of

6 various sites of manufacturing bodies who can pick up

7 the mantle in the event of a future pandemic?

8 **A.** We are in a much stronger place than we were at the

9 start of the pandemic, but even during the pandemic, we

10 didn't get to the point where we could manufacture

11 everything we needed, and of course the speed of

12 manufacture was the rate-limiting factor on the rollout

13 of the vaccine. So there is not yet enough. I don't

14 know whether it's gone backwards or advanced further

15 since the end of the pandemic. What I do know is we

16 still don't have enough, and the pandemic demonstrated

17 the vital need for a sovereign capability that is

18 onshore because the political issues will cause the same

19 sorts of problems in future as they caused us during the

20 pandemic.

21 And critically, one final point on this, back to

22 this debate about how many vaccines we needed. We took

23 the decision, against advice, to procure vaccines for

24 everybody, for the whole country, which meant

25 100 million doses in the first instance. That was the

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1 right decision, and we are going to need that scale as  
 2 fast as possible next time, because there is a huge  
 3 clamour for vaccination when one becomes clinically  
 4 valid, if it's seen as a route out of a pandemic, and  
 5 I'd want us to be able, as a country, to play the same  
 6 sort of role as we did last time in leading the charge  
 7 here and around the world and allowing many, many, more  
 8 than a billion people to be vaccinated, thanks to the  
 9 work of the United Kingdom.

10 **MR KEITH:** Let's leave it there.

11 Thank you very much, Mr Hancock.

12 **LADY HALLETT:** There are a few more questions --

13 **MR KEITH:** My Lady, yes. May I make a suggestion. I know  
 14 that Mr Leslie Thomas KC for FEMHO has another court  
 15 appearance at 1.00. I was wondering whether or not --

16 **LADY HALLETT:** I think you're a bit tight for time,  
 17 Mr Thomas.

18 **MR KEITH:** Well, he's got five minutes but I know he's  
 19 second in the list I wonder if you might invite him to  
 20 go first.

21 **LADY HALLETT:** If Ms Morris doesn't mind we'll certainly  
 22 complete Mr Hancock's evidence before lunch but we'll  
 23 take Mr Thomas first so he can -- I hope it's a remote  
 24 hearing, Mr Thomas.

25 **PROFESSOR THOMAS:** I would be in trouble.  
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1 save lives.

2 **Q.** You say that, but what was being raised was  
 3 representatives who were raising legitimate concerns,  
 4 and your approach, the words that you use, disregarded  
 5 their advocacy rather than engaging with the substance  
 6 of what the concerns were.

7 **A.** No. That's wrong. You'll see from the paperwork that  
 8 we engaged deeply with the substance on condition of  
 9 deployment -- for instance, the notes show that in  
 10 February 2021, I was cautious and said we shouldn't at  
 11 that point push for -- at this time, push for  
 12 vaccination as a condition of deployment, because we  
 13 didn't -- because it was in the early stages of the  
 14 vaccination programme, but then a month later, once the  
 15 programme was much more established, I proposed, and the  
 16 government took the position of putting forward  
 17 a vaccination as a condition of deployment.

18 I think the difference between us is that you make  
 19 the point -- you put forward that these concerns raised  
 20 by the trade unions were legitimate. Actually, they  
 21 were not legitimate because they weren't based on  
 22 science. The right position that the trade unions  
 23 should have taken was to join in the efforts to  
 24 reassure, support, and encourage vaccination for those  
 25 who were meeting a lot of vulnerable people, and who  
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## 1 Questions from PROFESSOR THOMAS KC

2 **PROFESSOR THOMAS:** Mr Hancock, as you know, I represent  
 3 FEMHO, the Federation of Ethnic Minority Healthcare  
 4 Organisations.

5 I want to take you to -- you don't need to turn it  
 6 up, but your witness statement at paragraph 195.

7 There you say this: you refer to trade unions as  
 8 being "unthinkingly against vaccination as a condition  
 9 of deployment. They will have to answer for their  
 10 rejection of care, science, and objective fact".

11 I'm sure you remember the quote.

12 Now, question: do you remember what you said about  
 13 structural racism in Module 3 and being concerned  
 14 about it?

15 **A.** Yes, of course I do.

16 **Q.** Right. Well, isn't it true that all the unions were  
 17 doing in fact were raising legitimate safety concerns  
 18 from frontline healthcare workers, particularly from  
 19 black, Asian and minority ethnic backgrounds who faced  
 20 the highest workplace exposure risks; isn't that right?

21 **A.** No, they were promoting illegitimate arguments precisely  
 22 because of their highest infection rates amongst those  
 23 groups, they would have been the greatest beneficiaries  
 24 of vaccination, and an anti-scientific approach helped  
 25 to make it harder for those of us who were trying to  
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1 could have had their own health safeguarded, and  
 2 especially the health of those in their care  
 3 safeguarded.

4 **Q.** Sorry, Mr Hancock, can I just slightly push back on what  
 5 you've just said, because we are going to hear from the  
 6 next witness, Professor Heidi Larson, who is the vaccine  
 7 hesitancy expert, who dedicates a whole section of her  
 8 report to the safety concerns among ethnic minority  
 9 groups which centered around long-term, unknown side  
 10 effects from the vaccines. She's going to give her  
 11 evidence shortly. A whole section of her report. So  
 12 these were legitimate concerns.

13 **A.** No, the vaccines were valid and safe, and saved lives --

14 **Q.** No, no, sorry, forgive me, that's not what I said.  
 15 I haven't said that the vaccines were not valid or did  
 16 not save lives; I said you were dealing with legitimate  
 17 safety concerns. There's a difference.

18 **A.** Yes. And that's why we took a careful approach to  
 19 bringing this in, but the idea that because somebody is  
 20 hesitant you should therefore not ask them to get  
 21 vaccinated, is, in my view, wrong.

22 **Q.** No, nobody said that. What's been --

23 **A.** You just said it. That's why I objected to the  
 24 proposals that they made.

25 **Q.** Forgive me, forgive me. What has been suggested is  
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1 there'd be better messaging, better communication, so  
2 that people can better understand.

3 **A.** Yes.

4 **Q.** Bring people along.

5 **A.** I was in favour of all that as well, absolutely.

6 **PROFESSOR THOMAS:** My Lady, thank you very much.

7 **LADY HALLETT:** Thank you, Mr Thomas.

8 **PROFESSOR THOMAS:** You will excuse me.

9 **LADY HALLETT:** I will. Just try not to run too fast, you  
10 might trip over.

11 Ms Morris.

#### 12 Questions from MS MORRIS KC

13 **MS MORRIS:** Thank you, my Lady.

14 Mr Hancock, I ask questions on behalf of the Covid  
15 Adverse Reaction and Bereaved groups, and these groups  
16 represent those who have suffered injury or bereavement  
17 following their voluntary acceptance of the Covid-19  
18 vaccines. First of all, do you acknowledge that there  
19 are people who sadly suffered injury and bereavement as  
20 a result of accepting the vaccine?

21 **A.** Yes, of course.

22 **Q.** I'm going to focus my questions today on the issue of  
23 pharmacovigilance and specifically what systems were in  
24 place at the time of the rollout of the vaccines to  
25 identify and monitor occurrences of adverse effects and

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1 that means -- "that we" -- so that means DHSC -- "were  
2 doing it but I worry that the details will be shonky."

3 Chris Whitty goes on to say they're reasonable but  
4 they need to get better.

5 **A.** Yes.

6 **Q.** He then says, "There will be cases".

7 **A.** Yes.

8 **Q.** Now, I can ask Professor Sir Chris Whitty about that but  
9 did you interpret him to mean there would be cases of  
10 adverse reactions?

11 **A.** It's unclear from this whether "there will be cases"  
12 means there will be cases of adverse reactions, although  
13 we knew that there would be.

14 **Q.** Yes.

15 **A.** Because there were in the clinical trials. The question  
16 with a vaccine is whether it is net positive in  
17 expectation of taking it, and they were only approved  
18 where they were net positive.

19 **Q.** So under --

20 **A.** Hold on. But the -- but he may have been referring to  
21 there will be cases like Ara Darzi where somebody gets  
22 a case after vaccination, because that was also at the  
23 time not known the extent to which, post-vaccination,  
24 people would get Covid. And, of course, we now know  
25 that people did regularly get Covid after a vaccine but

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1 whether they in fact needed improvement.

2 **A.** Yes.

3 **Q.** You understand. So my first question: at the time of  
4 the vaccine rollout, who, to your understanding, was  
5 responsible for overseeing the pharmacovigilance going  
6 forward? Was that the DHSC or other agencies?

7 **A.** Well, the majority of the pharmacovigilance occurred  
8 within the NHS and the NHS Yellow Card process was there  
9 to capture any adverse reactions, and then a data system  
10 was put in place to make sure that that information was  
11 fed in, and it came to me through the Chief Medical  
12 Officer, if I recall correctly. It was something we  
13 cared a lot about, we put a lot of effort into.

14 In the first instance the data processes were  
15 imperfect, but we improved them over time.

16 **Q.** It's that kind of first instance I wanted to ask you  
17 a bit further about, please. Can I ask you to look at  
18 a message exchange between yourself and Professor Sir  
19 Chris Whitty on 9 January 2021.

20 INQ000129666, please.

21 Thank you. You'll see there --

22 **A.** There you are.

23 **Q.** -- the WhatsApp messages there. You ask Chris Whitty:

24 "How strong is our pharmacovigilance system to check  
25 [the systems] post-rollout? I was told" -- and I think

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1 it tended to be much milder.

2 **Q.** Sure, but you would accept you knew there would be cases  
3 of adverse reactions?

4 **A.** Yes, of course.

5 **Q.** They were known about in the clinical trials?

6 **A.** And measured, yes.

7 **Q.** And that's why it's important to have an effective  
8 post-rollout monitoring system?

9 **A.** Yes.

10 **Q.** But what did you mean by "shonky"?

11 **A.** I was worried about the data collection systems and how  
12 that would be reported. And as Chris Whitty went on to  
13 say, "reasonable but needs to get better".

14 **Q.** So what specific examples or evidence did you have at  
15 that point, that you had in mind when you used the word  
16 "shonky"? What were the concerns you had?

17 **A.** The thing I was specifically concerned about was that  
18 you needed to make sure that when people had an adverse  
19 reaction, they reported it, and that those reports then  
20 fed into a data collection system that could assess the  
21 net effectiveness of the vaccine.

22 We came to see the pharmacovigilance system as  
23 effectively like a phase IV trial, as in you did the  
24 first three phases, got -- reached formal clinical  
25 validation, did the rollout across the population, but

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1 we kept essentially measuring the effectiveness of the  
2 different vaccines all the way through. And that's what  
3 led to the changes in the recommendations around the use  
4 of the AstraZeneca vaccine, for instance, that came  
5 later, in I think March 2021, because effectively, we  
6 were measuring those responses.

7 In order to get that data accurate, you need to make  
8 sure that adverse responses are notified.

9 **Q.** And the system has to be signal sensitive, doesn't it,  
10 to pick up those adverse reactions quickly?

11 **A.** Exactly.

12 **Q.** So what assurances were, if any, were you given about  
13 the system's effectiveness at the time of the rollout?

14 **A.** Oh, as you can see, this is a subject that I was  
15 querying my clinical advisers on, and, as we see at the  
16 bottom of this page:

17 "Who is best to talk to to improve the  
18 operationalisation of it?"

19 "[Chris Whitty:] JVT and Susan Hopkins ..."

20 Susan Hopkins being the chief medic at UKHSA.

21 And so I will have spoken to them about it I'm sure.

22 **Q.** You mentioned Yellow Card. Did anything during your  
23 term change at your direction in terms of how that  
24 system worked?

25 **A.** It wouldn't have changing precisely at my direction,

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1 **PROFESSOR HEIDI LARSON (affirmed)**  
2 **Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 4**

3 **MR KEITH:** My Lady, may I make plain that whilst the issue  
4 of vaccine hesitancy is more closely associated with the  
5 delivery of vaccines, which might be thought to come  
6 chronologically rather than later in the process, we're  
7 calling Professor Larson now, at the beginning of this  
8 hearing, for timetabling reasons that I needn't trouble  
9 you with.

10 **LADY HALLETT:** Don't worry, I can be flexible, or I think  
11 the modern expression is "nimble".

12 **MR KEITH:** Can you give the Inquiry, please, Professor, your  
13 name.

14 **A.** Heidi Larson.

15 **Q.** Professor, you are a professor of anthropology, risk and  
16 decision science at the London School of Hygiene and  
17 Tropical Medicine (LSHTM), a clinical professor at the  
18 Institute for Health Metrics and Evaluation at the  
19 University of Washington in Seattle, and visiting  
20 professor, Centre for the Evaluation of Vaccination at  
21 the University of Antwerp in Belgium.

22 You are also, we understand, the founding director  
23 of the Vaccine Confidence Project. What is that?

24 **A.** I founded the Vaccine Confidence Project in 2010, seeing  
25 a growing amount of questioning in different parts of

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1 because this is a deep statistical and operational  
2 question. My job was to assure myself that everything  
3 was being done to make sure that the results were as  
4 accurate as possible, rather than to design the system  
5 myself. But I know that both JVT and Susan Hopkins have  
6 a huge amount of experience in designing these sorts of  
7 systems.

8 **MS MORRIS:** Thank you.

9 Thank you, my Lady, those are my questions.

10 **LADY HALLETT:** Thank you very much, Ms Morris.

11 That completes the questions we have for you for  
12 this module, Mr Hancock. I can almost guarantee,  
13 I think, that we will be asking you to help us again,  
14 but thank you very much for your help this morning, and  
15 you're now free to go.

16 **THE WITNESS:** Thank you.

17 **LADY HALLETT:** I shall return at 2.10.

18 **(The witness withdrew)**

19 **(1.08 pm)**

20 **(The Short Adjournment)**

21 **(2.10 pm)**

22 **LADY HALLETT:** Mr Keith.

23 **MR KEITH:** My Lady, this afternoon's witness is  
24 Professor Heidi Larson. Could she be sworn, please.

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1 the world, and what we do at the Vaccine Confidence  
2 Project is we do monitoring and trying to understand  
3 what's driving that, and where it is in the world. It's  
4 a global effort, but certainly we've been spending a lot  
5 of time in our work in the UK.

6 **Q.** Have you also established a body known as the Vaccine  
7 Confidence Index?

8 **A.** Yes.

9 **Q.** Which exists, although it's obviously a related topic,  
10 to monitor vaccine confidence at regional and national  
11 levels?

12 **A.** Yes. One of the big questions that we got in the  
13 Vaccine Confidence Project was: how big of an issue is  
14 confidence, and its inverse hesitancy? And is it  
15 growing? And I said if we don't have a baseline, we  
16 can't measure any change. So the Vaccine Confidence  
17 Index is a measure that we first launched globally in  
18 2015, and have since been monitoring since then.

19 **Q.** One particular issue to which we will devote a lot of  
20 time this afternoon is the question of trust. Have you  
21 also established a project known as the Global Listening  
22 Project to investigate in particular trust and public  
23 experience and how trust operates on the public plane?

24 **A.** Yes, that's correct. Since 2021 I launched something  
25 called the vaccine -- sorry, the Global Listening

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1 Project, which expands on the Vaccine Confidence  
 2 Project, but one of the big things we learned in the  
 3 first 10 years at the Vaccine Confidence Project, that  
 4 many times the issue of confidence is not about the  
 5 product; it's about trust in systems, trust in  
 6 government, trust in individuals. And so the Global  
 7 Listening Project is looking more broadly at what are  
 8 the different strands of trust so we understand better  
 9 where we need to build trust.

10 **Q.** Did you also previously lead vaccine strategy and  
 11 communication at UNICEF, and did you also serve on the  
 12 World Health Organisation SAGE Working Group on Vaccine  
 13 Hesitancy?

14 **A.** Yes.

15 **Q.** If you'd answer "Yes" or "No", then the stenographer can  
 16 pick up your answer. Thank you, Professor.

17 And in a plug for this well-known book, are you  
 18 author of *'Stuck: How Vaccine Rumors Start and Why They  
 19 Don't Go Away'*?

20 **A.** Yes.

21 **Q.** In the preparation of your report for my Lady and this  
 22 Inquiry, were you also assisted by a number of fellow  
 23 expert professionals in the field of vaccine hesitancy,  
 24 Alexandre De Figueiredo, Caitlin Jarrett, Ed Pertwee,  
 25 Rachel Eagan, all of whom are either professors or  
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1 scepticism, or anything else?

2 **A.** Yes, I would say it does matter. Confidence is  
 3 a positive sentiment. You can have a little bit or  
 4 a lot. And hesitancy is a state of indecision. But --  
 5 I won't get into wordsmithing but they do have different  
 6 implications.

7 **LADY HALLETT:** And scepticism is going one further towards  
 8 the negative, isn't it?

9 **A.** Exactly, yes.

10 **MR KEITH:** The concept of hesitancy is there, is it not,  
 11 because there may be any number of reasons why somebody  
 12 might be in a state of indecision about whether to get  
 13 vaccinated. So within the rubric of hesitancy, there is  
 14 a nod to the barriers that might stop somebody taking up  
 15 a vaccine to historical, deep-rooted, institutional  
 16 reasons why they might not, as well as the practical  
 17 barriers associated with delivery on the ground, and  
 18 whether or not the state, or whichever organisation it  
 19 is, actually affords them the ability to go and get  
 20 a vaccine?

21 **A.** Yes.

22 **Q.** So it's a very wide church?

23 **A.** Yes.

24 **Q.** And just on this point of the acceptability, there are  
 25 some who say that one shouldn't use the phrase "vaccine  
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1 I think assistant professors or research fellows at  
 2 a number of august institutions but primarily the LSHTM?

3 **A.** Yes. Alex, as you mentioned, was the lead author of the  
 4 report, but we worked as a team throughout that.

5 **Q.** All right.

6 Professor, there is much in your report, it is  
 7 a very lengthy and learned document, so what we're going  
 8 to do this afternoon is I'm going to take you, in  
 9 a pre-determined order, to particular paragraphs in your  
 10 report, in order to provide you with a platform to try  
 11 to answer the questions I will put to you, and to see  
 12 whether we can extract the heart of the learning which  
 13 you have very kindly provided.

14 I want to start on the topic of defining vaccine  
 15 hesitancy.

16 If you would turn, please, to page 6 of your report,  
 17 you say there that:

18 "Vaccine hesitancy is a state of indecision about  
 19 whether to get vaccinated."

20 And the Inquiry has already had some evidence,  
 21 Professor, about the accepted of the terminology, the  
 22 phrase "vaccine hesitancy". We note that you describe  
 23 the report as being into vaccine hesitancy. Ultimately,  
 24 does the terminology matter? Does it matter whether we  
 25 call it vaccine hesitancy, vaccine confidence, vaccine  
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1 hesitancy". Does anything turn on that, in your  
 2 professional opinion?

3 **A.** I think the issue is not using the term "anti-vax".  
 4 I think hesitancy is a reasonable thing, can be  
 5 a reasonable thing. If you're a young mother with  
 6 a first child and there's a brand new vaccine, I think  
 7 it actually is not -- I understand hesitancy, but you  
 8 don't want it to stay as hesitancy. So I think that's  
 9 the important thing.

10 **Q.** All right. In that first paragraph on page 6, you've  
 11 set out something called the 3Cs, in fact something that  
 12 expanded to what was called the 5C definition. Was that  
 13 an attempt by the World Health Organisation and its  
 14 committee of experts to try to identify some of the main  
 15 drivers which need to be looked at, if one is doing as  
 16 we are doing, examining the causes of vaccine hesitancy  
 17 and what steps can be taken to deal with them?

18 **A. (Witness nodded).**

19 **Q.** And they are, in their original format, complacency,  
 20 convenience and confidence, but have been expanded to  
 21 deal with calculation, collective -- and collective  
 22 responsibility.

23 In truth, does it help to try to identify the main  
 24 drivers, or is the picture rather more nuanced than  
 25 that?  
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1 **A.** It's more nuanced but I think the only reason you want  
2 to understand what's driving it is if you want to  
3 develop some interventions to help address it. So if  
4 the issue is one of convenience and access, that's  
5 a different kind of intervention to increase vaccine  
6 acceptance, whereas if it's an issue of confidence or  
7 trust, that's a different kind of intervention. So to  
8 the extent that it helps you inform and change the  
9 picture, that's, I think, the most important reason  
10 for it.

11 **Q.** So it gives us a framework around which my Lady could  
12 wrap recommendations and learning --

13 **A.** Exactly.

14 **Q.** -- about the way forward. That's extremely helpful.

15 I've asked you already about whether or not, within  
16 the broad rubric of vaccine hesitancy, there is the  
17 important topic of barriers, practical barriers, to  
18 access.

19 In paragraph 3 on page 7, do you try to identify,  
20 just preliminarily, what some of those barriers might  
21 consist of, and also make the point that when addressing  
22 vaccine hesitancy, you must always remember that there  
23 may very well be real, practical, specific reasons why  
24 an individual isn't able to take up a vaccine?

25 And you identify them particularly in the context of  
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1 the Vaccine Confidence Project is trend data, the whole  
2 situation of vaccine hesitancy, in the last 10 years has  
3 become extremely volatile. In the environment with  
4 social media it's changing a lot.

5 So I think data is important for looking at trends  
6 and also for understanding what's driving the issues,  
7 and of course, you'd need to see who is taking vaccines  
8 and who isn't.

9 **Q.** May it be put this way: if you don't have proper data by  
10 way of surveys, monitoring trends, evidence of drivers,  
11 you won't properly understand the nature of the problem,  
12 and you will be less able to design effective  
13 interventions?

14 **A.** Yes, that's correct.

15 **Q.** And on that page, page 8, do you identify a number of  
16 different ways in which data might be assembled? So you  
17 refer to surveys, and presumably there are no end of  
18 national and international surveys?

19 **A.** That's correct.

20 **Q.** Are many of them done in fact by the World Health  
21 Organisation?

22 **A.** Yes.

23 **Q.** And during the course of the pandemic and since, have  
24 there been numerous surveys across the United Kingdom  
25 including in each of the devolved administrations?  
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1 ethnic minority communities, migrants, people with  
2 disabilities, people with mental health conditions,  
3 vision impairments and hearing difficulties, and also  
4 asylum seekers and migrants, I think I have mentioned  
5 migrants already, how there are very prominent barriers  
6 which may prevent them from practically taking up  
7 a vaccine.

8 In no particular order, they may stem from physical  
9 access, getting to a vaccination centre, or mobility  
10 issues, or access to communication, linguistic problems,  
11 all the way across the range to the impact of  
12 institutional discrimination, believing that the state  
13 and the healthcare system doesn't care, to issues about  
14 trust and misinformation? So it's a very -- again,  
15 a very broad church.

16 **A.** It's a very broad church and it's rarely all of those  
17 reasons and that's why it's important to try to  
18 understand which are the reasons, and to have a bit of  
19 empathy with maybe why they're not getting their vaccine  
20 and help them get there.

21 **Q.** In order to understand the causes of vaccine hesitancy  
22 and to try to attempt to identify the solutions, how  
23 important is data?

24 **A.** Data is crucial. It depends on what kind of data,  
25 though. I think one of the big focuses of our work at  
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1 **A.** Yes.

2 **Q.** At paragraph 10 you make the point that there is,  
3 however, no universally accepted metric, there is no one  
4 tool or survey or data system that can tell you the  
5 precise nature of the degree of vaccine hesitancy. Does  
6 that matter if you've got what appears to be a profusion  
7 of different pieces of data and monitoring systems?

8 **A.** I think what's important is that you understand the  
9 local situation, and I think having some kind of  
10 comparability is helpful, but even if you have it local  
11 and it's different from another country, it's valuable.

12 **Q.** Happily, page 9, paragraph 11, the most widely deployed  
13 tool is the Vaccine Confidence Index, which is the very  
14 same index to which you referred earlier, which you  
15 helped establish in 2015. Does that of itself give you  
16 a sufficient tool to be able to understand the extent of  
17 the problem and how it might be prevented or improved,  
18 or have you had to, and do people in your professional  
19 position, have to look for wider sources of information?

20 **A.** The Vaccine Confidence Index has four components:  
21 confidence in the safety of vaccines, confidence in the  
22 effectiveness, do they work; confidence in the -- or the  
23 religious compatibility; and what we're doing right now  
24 is expanding on those domains to look at what else is  
25 important but it does give us at least a metric that we  
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1 can follow over time. But, of course, you do need  
2 still, if you do that at a national level, you still  
3 need to look locally because people's reasons are highly  
4 varied.

5 **Q.** To what extent is it therefore important to have, in  
6 addition, the results of focus groups, in-depth  
7 interviews, as well as social media analysis?

8 **A.** Yes, it's very important to have the different --  
9 I mean, we often say no single metric tells the story,  
10 so it's very important to also have different types of  
11 data.

12 **Q.** I want to jump forward, please, in your report so we can  
13 see everything you have to say about the issue of data  
14 at one fell swoop. If you would just look at  
15 paragraph 29 on page 14, is accurate data and relevant  
16 data also very important as part of the process of  
17 establishing or rebuilding trust with communities? So  
18 if the state goes into communities and tries to rebuild  
19 trust and tries to promote uptake of vaccination, is an  
20 important part of that process, and the extent to which  
21 they will be listened to, having accurate data about  
22 their interlocutors, whom they're speaking to?

23 **A.** Yes, having accurate data is very important because one  
24 thing is if you go into a community trying to build  
25 trust, and you're giving them information about safety

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1 **A.** It's a challenge, yes.

2 **Q.** -- willing are people prepared -- how willing are they  
3 to give up the information?

4 **A.** It is a challenge, but I think you want to get what,  
5 gather whatever information you can, but you certainly  
6 don't want to put people in a situation that makes them  
7 more anxious.

8 **Q.** No. And I'm just focusing now on where the problems are  
9 in terms of the fullness or the completeness of the data  
10 that you're trying to gather.

11 **A.** Yes.

12 **Q.** And is there also another broad issue concerning the  
13 degree to which data about ethnicity is overbroad, it's  
14 not sufficiently disaggregated?

15 **A.** That is correct. It is not sufficiently disaggregated.

16 **Q.** Are there also issues concerning the number of ways in  
17 which data in the United Kingdom is collated? So, for  
18 example, by different bodies, different government  
19 structures, and also across each of the devolved  
20 administrations? There's no similar or unitary  
21 approach?

22 **A.** No, there isn't.

23 **Q.** All right. And therefore, and -- in fact, actually,  
24 there's one other aspect of this. If we could just go  
25 over the page to page 14, at paragraph 28 you say

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1 but their issue is not about safety, they feel like  
2 you're not listening to them. So I think that having  
3 that understanding is very important.

4 **Q.** Then if we go back to page 13, paragraph 26, standing  
5 back from that, and in a very general sense, how good  
6 a picture does the data in relation to vaccine hesitancy  
7 in the United Kingdom give? How good is our data about  
8 vaccine hesitancy in the United Kingdom?

9 **A.** I think there's a reasonable amount of data. I think  
10 there's enough to get some decisions but again, it's  
11 a constantly changing picture so the important thing is  
12 that you keep collecting it, and not sit on a -- keep  
13 referring to a study that's a year or two, or three  
14 years old.

15 **Q.** It would be quite impossible for the Inquiry to be  
16 overly prescriptive about recommending changes in data  
17 collection.

18 **A.** Yes.

19 **Q.** We don't have the skill for that. But do you,  
20 nevertheless, at paragraph 27, identify where some of  
21 the main problems in data collection can be found? The  
22 whole issue about the willingness of participants to  
23 report details about themselves, their ethnicity, their  
24 proclivities, their heritage, their geographical region,  
25 their religious outlook, that's a big problem, how --

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1 another significant barrier related to the difficulty in  
2 accumulating data is that the unwillingness or hesitancy  
3 to give up data stems in part from a mistrust of  
4 institutions and uncertainty. So we're now introducing  
5 this huge topic of institutional distrust. But it has  
6 an impact not just on vaccine hesitancy, but also on the  
7 collection of data.

8 **A.** That's correct.

9 **Q.** And you therefore recommend, and we can go straight to  
10 this area, and then not worry about coming back to it  
11 later, is it for all those reasons that an important  
12 part of your recommendations -- and we'll go straight to  
13 page 66 if we may -- is that there needs to be enhanced  
14 data collection, data monitoring and data evaluation.  
15 And you make number of data strengthening  
16 recommendations, as you call them.

17 And if we just keep the page there as we are, 178.1  
18 down to 178.7, you've set out the importance of:  
19 understanding practical barriers; when collating data  
20 focusing much more on migrant communities, ethnic  
21 minority groups, disabled persons and others who face  
22 structural barriers; getting in much more detailed  
23 demographic information so that you can capture more  
24 accurately the real degree of hesitancy; as well as  
25 trying to standardise -- (overspeaking) --

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1 **A.** Yes, I think all these different points that we outline  
 2 in the report speak to trying to get the breadth of  
 3 that. And even though there is hesitancy amongst some  
 4 people to share their information, it's not a good  
 5 enough reason to not make that effort because not all of  
 6 them will have that problem.

7 So I think making this effort, to the extent that  
 8 people are willing, is really important.

9 **Q.** And are there three related recommendations you make, by  
 10 way of supportive recommendations, at 179, on page 67,  
 11 180 and 181, dealing with having a more open access to  
 12 data because it fosters trust --

13 **A.** Mm-hm.

14 **Q.** -- adapting the type of data collected to make it more  
 15 suitable for pandemic preparedness, and also, when  
 16 designing structures for accumulating data, making sure  
 17 that that body or group is much better informed by  
 18 members of the ethnic minorities, amongst others, as to  
 19 how best to go about their task?

20 **A.** Yes.

21 **Q.** Is that a fair summary?

22 **A.** Yes.

23 **Q.** All right. Thank you very much.

24 If we then go back, please, that's the issue of  
 25 data. We can then pick up the thread, please, on  
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1 was slowly going down. The UK lost their measles  
 2 elimination status, recovered it again. But there has  
 3 been a slow trend. Now of course you can't put that all  
 4 on vaccine hesitancy, it was a real mix of issues, but  
 5 indeed there was relatively high but a slow declining  
 6 trend.

7 **Q.** There were two significant bumps in the road, were there  
 8 not? The pertussis controversy in the seventies and  
 9 eighties --

10 **A.** Yes.

11 **Q.** -- and you have referred to MMR in the late 1990s and  
 12 2000s. Did both those controversies set back the cause  
 13 of vaccination and immunisation but did the system  
 14 generally recover? So it did resume a generally quite  
 15 healthy picture, notwithstanding those two  
 16 controversies?

17 **A.** It has recovered but it took a very long time, several  
 18 years.

19 **Q.** And it's important, I think, that I emphasise that, as  
 20 you said, we lost our measles status. What does that  
 21 mean? What is that reflective of in terms of risk to  
 22 the British population?

23 **A.** Well, losing measles elimination status means you start  
 24 to get measles again circulating. And once that  
 25 happens, you need to boost your immunisation. And we  
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1 page 13 at paragraph 25.

2 You identify at this early part of the report some  
 3 of the main sectors or groups or cohorts of people who  
 4 were very much concerned with the issue of vaccine  
 5 hesitancy, because they are the people who, for  
 6 a variety of reasons, have barriers to access placed in  
 7 their path or are prevented from full access to  
 8 vaccination for a variety of reasons. And they are, in  
 9 a very broad sense, ethnic minorities, particular  
 10 religious groups, the Gypsy, Roma, and Traveller  
 11 community, the migrant community -- and that includes  
 12 asylum seekers, of course, as well -- the homeless and  
 13 the rough travellers. And you identify all of those  
 14 groups as being groups amongst whom there are  
 15 historically lower rates of childhood immunisation, and,  
 16 linked to that, higher rates of vaccine hesitancy.

17 **A.** That's correct.

18 **Q.** Before the pandemic, what was the general state of  
 19 vaccine coverage for non-Covid -- obviously,  
 20 pre-pandemic, non-Covid -- vaccines?

21 **A.** Yes.

22 **Q.** The general state of vaccine coverage in the  
 23 United Kingdom?

24 **A.** I think overall it was good, very good, for a long  
 25 period of time, but over the last decade, pre-Covid, it  
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1 were able, as the UK, to again get back to measles  
 2 elimination, but the fact that it dipped was really an  
 3 important flagging of the need for more attention.

4 **Q.** And measles is a very dangerous disease, is it not?

5 **A.** It's very dangerous and it is the most infectious of all  
 6 the childhood diseases.

7 **Q.** All right. Do you identify -- page 11, paragraph 19 --  
 8 two main drivers, two notable elements in the drivers of  
 9 non-Covid pre-pandemic hesitancy: vaccine safety risk  
 10 and information; and then, over the page, vaccine  
 11 hesitancy and minority groups?

12 So they're very different issues. There's a broad  
 13 issue about -- or worries about safety. And also  
 14 a significant driver of vaccine hesitancy are the views  
 15 of and the position, through no fault of their own, of,  
 16 in particular, ethnic minority communities.

17 Dealing with them in turn, to what extent has there  
 18 always been concern about safety and risk in the context  
 19 of vaccines, and to what extent did that matter,  
 20 pre-pandemic?

21 **A.** Well, safety issues go back to the 1800s. So -- but  
 22 I think that particularly around new vaccines, whenever  
 23 there's a new vaccine or a new combination of vaccines,  
 24 it's not uncommon, and it's -- I think it's reasonable  
 25 to have questions when you have something new, people  
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1 want to understand, but you want to address the concerns  
 2 and, here -- and build confidence.

3 **Q.** You've said that the issue of worry about safety is  
 4 a longstanding one. Was there, once upon a time, in  
 5 fact, a piece of English or UK legislation providing for  
 6 mandatory vaccination?

7 **A.** Yes, in fact the first anti-vaccine group was actually  
 8 not anti-vaccine, it was anti-compulsory vaccine, and it  
 9 was around the smallpox vaccine. And it really was  
 10 prompted by a mandate, particularly when they lowered  
 11 the age to I think it was 16, and that created protests  
 12 in the streets, not unlike some of the protests we saw  
 13 during Covid. But what relieved the public a bit, and  
 14 the protests, was giving people the opt-out, the option,  
 15 and that at least made people feel like they had  
 16 a choice.

17 **Q.** But did the process by which exemptions could be given  
 18 widen and widen?

19 **A.** Yes.

20 **Q.** Further, more and more people asked for exemptions until  
 21 the very effect of the mandatory inoculation act was  
 22 completely undermined?

23 **A.** Absolutely.

24 **Q.** And was the general position that it came to be obvious  
 25 that the more you mandate vaccination and immunisation,

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1 and look at each of those in turn. Just to put a bit  
 2 more flesh on the bones in terms of pre-pandemic vaccine  
 3 uptake, page 16, 17, 18, 19, on through to page 22, do  
 4 you provide some figures relating to non-Covid, that is  
 5 to say childhood immunisation uptake in the  
 6 United Kingdom?

7 And as you say, the general picture wasn't bad, it's  
 8 quite favourable. But was there a general decline in  
 9 routine childhood immunisation coverage between 2010 and  
 10 2019?

11 **A.** Yes, there was.

12 **Q.** And what do you assess was the reason for that?

13 **A.** Well, it was, to the extent we understand it, it was  
 14 a mix of changes in the system, both delivery as well as  
 15 some hesitancy but it was really a mix of factors and  
 16 I don't think there was any one single factor.

17 **Q.** How did the United Kingdom, in relation to non-Covid  
 18 childhood immunisation fare in comparison to other  
 19 countries? Where do we come in the global comparison  
 20 stakes? Where did we come in the global comparison  
 21 stakes?

22 **A.** Not the highest globally but among the highest in  
 23 Europe.

24 **Q.** You provide at page 20 some specific figures concerning  
 25 how acceptance levels towards flu, so not childhood

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1 the more you run the risk that there will be a backlash?

2 **A.** Certainly in the longer term, yes.

3 **Q.** All right. And that's important, isn't it, for the  
 4 debate about vaccination as a condition of deployment?

5 **A.** That's correct.

6 **Q.** The second main driver you've already identified as  
 7 being the position of, in particular, ethnic minority  
 8 groups, who are prevented, for a variety of reasons,  
 9 from full access to vaccination. And you identify at  
 10 paragraph 23, don't you, some of those reasons? They're  
 11 very diverse, are they not?

12 **A.** Yes.

13 **Q.** Could you give us some idea of what those drivers in  
 14 particular ethnic minority communities are?

15 **A.** Well, some of the drivers are religious, things like,  
 16 among the Muslim community, haram and halal, there's  
 17 porcine, which is derived from pork, is used as  
 18 a gelatine in some vaccines and there are some  
 19 communities that do not want those vaccines and we need  
 20 to think about alternatives. And then in other cases it  
 21 is language. Some of it is beliefs, just also in  
 22 different ethnicities and groups, cultural beliefs, but  
 23 it is also distrust and feeling like they're  
 24 marginalised and sometimes discriminated.

25 **Q.** We're going to come back to some of those, Professor,

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1 immunisation but flu, influenza vaccine, have changed.  
 2 Has that generally "not bad" position for childhood  
 3 immunisation been the same in relation to flu vaccines,  
 4 and has there also been a general decline in confidence?

5 **A.** Actually with -- and you're talking about adult flu?

6 **Q.** Adult flu.

7 **A.** Adult flu vaccine. Adult flu vaccination started to  
 8 decline a bit, but with the news of Covid it got a real  
 9 boost because particularly before we had a Covid  
 10 vaccine, I think people felt like we'll get what we can,  
 11 it's a respiratory virus, and so there's kind of an  
 12 ironic boosting of the older adult confidence, while we  
 13 had a more wobbly confidence among -- for children's  
 14 vaccines.

15 **Q.** What was the impact of the pandemic, the Covid-19  
 16 pandemic, on childhood immunisation rates and on adult  
 17 flu rates? Obviously they're different, but has there  
 18 been an impact from the pandemic on those other  
 19 pre-existing acceptance rates?

20 **A.** Oh, absolutely. I mean -- you're talking about uptake  
 21 and not confidence, is that correct?

22 **Q.** I'm actually talking about both but you're quite right,  
 23 I didn't make it absolutely plain.

24 **A.** Yeah.

25 **Q.** But let's deal firstly with confidence.

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1 **A.** There was a real negative hit on confidence during the  
 2 pandemic for the childhood vaccine, for the importance  
 3 of the same Vaccine Confidence Index domains, the  
 4 perceived importance of vaccine for children, the  
 5 perceived safety, and effectiveness, dropped from being  
 6 over 90% before Covid to being 70, 72%. That's a very  
 7 significant drop in public confidence for childhood  
 8 vaccines.

9 **Q.** And then what about uptake?

10 **A.** Uptake also declined, but some of that during Covid was  
 11 access, for sure.

12 **Q.** And then what about adult flu?

13 **A.** Adult flu, as I said, there was kind of a boost in  
 14 wanting to get a flu vaccine, particularly in the  
 15 absence of a Covid vaccine, but that too has been  
 16 wobbled a bit. There was a stronger decline among the  
 17 childhood vaccines.

18 **Q.** Then in relation to uptake for adult flu?

19 **A.** Initially up, and then down.

20 **Q.** All right. Coming now forward, I won't say going  
 21 forward, coming now to the pandemic period itself, on  
 22 the cusp of the pandemic, so in December 2019,  
 23 January 2020, and as the pandemic evolved, and we found  
 24 ourselves in that terrible predicament, what was the  
 25 general state of hesitancy or confidence towards taking

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1 **A.** Yes.

2 **Q.** -- defined by the people who expressed doubt or  
 3 confidence beforehand, why does general levels of  
 4 vaccine hesitancy matter at all?

5 **A.** Well, I mean, the reason we monitor it, and as I say, we  
 6 monitor confidence, and if you have very low confidence,  
 7 that's more the hesitancy, but the reason we monitor  
 8 confidence is it's a predictor. It gives a system  
 9 a heads-up that people's confidence is waning, and you  
 10 should pay attention to it, and build confidence. It  
 11 may or may not have an immediate effect but we see that  
 12 if it doesn't go uncorrected, it does have an effect on  
 13 uptake.

14 **Q.** So it may, over the course of time, become a practical  
 15 problem --

16 **A.** Yes.

17 **Q.** -- if it's not addressed?

18 **A.** Not necessarily in the same moment, and that's what  
 19 we -- that's why we picked that, was to try to be an  
 20 earlier -- early predictor, a risk mitigator.

21 **Q.** So this is absolutely vital. You say on page 32 that as  
 22 the practical reality of the rollout became more and  
 23 more apparent, vaccine hesitancy declined. People were  
 24 taking up the vaccine --

25 **A.** Yes.

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1 a Covid-related vaccine?

2 **A.** Well, I think initially there was a big -- a bigger  
 3 appetite initially in the immediate crisis, in the  
 4 immediate, kind of, shock to the system when they --  
 5 vaccines first became available, I believe December 8  
 6 was the first vaccine given, but particularly in January  
 7 when they started to get more widely distributed, there  
 8 was an initial positive eagerness for it, but that  
 9 started to decline over time.

10 **Q.** It's obvious and common ground that there was  
 11 a generally very high level of uptake in the  
 12 United Kingdom. So if doubts were being expressed to  
 13 any level before the pandemic or on the cusp of the  
 14 pandemic, do doubts necessarily translate into an  
 15 absence of uptake? So putting it bluntly, even if  
 16 people say that they're concerned about a vaccine or  
 17 unwilling to take one, does that necessarily mean to say  
 18 that when it's offered, they won't?

19 **A.** No, it -- they might say that they would take it and  
 20 they don't, and they might say, "No, I don't think I'd  
 21 take it" but when push comes to shove and they might  
 22 take it, and "I'll hesitate around the next one".

23 **Q.** So if the actual level of uptake was higher in  
 24 percentage terms than the level that might have been  
 25 thought to be the case --

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1 **Q.** -- and therefore doubts were being quashed, to some  
 2 extent, vaccine hesitancy reduced.

3 So whatever the doubts were that were being  
 4 expressed before the pandemic didn't necessarily follow  
 5 through into a lack of uptake but in April 2021, a few  
 6 months after the introduction of the vaccine, did  
 7 vaccine hesitancy begin to increase again?

8 **A.** Yes, but we're talking about the Covid situation versus  
 9 routine childhood vaccine, which is a much more stable  
 10 state. And in the context of the hesitancy around the  
 11 Covid vaccine, this was a highly volatile time, and when  
 12 the first questions were being asked, people didn't see  
 13 the extent of mortality and illness and, you know, the  
 14 TV images of people, the amount of people dying, and  
 15 what was going on, and that pushed, I think, more of  
 16 an appetite for vaccines, but later on -- so, I think we  
 17 have to keep in context the highly volatile epidemic  
 18 environment that really affected people's decisions.

19 **Q.** And was there a broad similar picture across the  
 20 United Kingdom, or did that decision-making process or  
 21 appetite, as you described it, vary between different  
 22 sectorial groups, religion, socioeconomic features,  
 23 educational levels, and no doubt age as well?

24 **A.** Yes. Absolutely.

25 **Q.** And was there data available during the course of the

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1 pandemic, in the early part of the pandemic, showing the  
2 degree of hesitancy or lack of appetite between those  
3 various sectorial groups?

4 **A.** There was some, but the reality is it's the same groups  
5 that had issues before the pandemic.

6 **Q.** So there was a crossover between barriers to access and  
7 degrees of vaccine hesitancy between childhood  
8 immunisation, flu, vaccine uptake, and Covid?

9 **A.** What did change during Covid was hesitancy. We saw --  
10 and we'll probably get on to talking about this, but  
11 there was a pretty dramatic change, which is not typical  
12 pre-Covid, around with young, like, 18- to 24-year-olds.  
13 That took a different trend that was totally different  
14 than before Covid.

15 **Q.** Could you please have a look at page 35, and  
16 paragraph 76. Has the area of the impact of vaccine  
17 side effects on attitudes to specific vaccines been  
18 extensively studied? So we've -- I've asked you some  
19 questions already about data collation, but is this  
20 an area on which there is a clear picture?

21 **A.** Yes, there's been quite a bit of attention to it and  
22 alongside of the changing epidemic or Covid disease  
23 environment, was also the beginning of some of the  
24 safety issues being announced. All of this changing  
25 information that people had, including these safety

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1 another factor that came in. Again, it was  
2 a combination, of what was the state of the epidemic,  
3 what's the news on vaccine safety events, and these  
4 additional restrictive policies that you could only go  
5 certain places if you had a vaccination, all of these  
6 factors were, in different ways for different people,  
7 affecting their willingness to go with the programme, as  
8 it were.

9 **Q.** Now if you would then turn, please, to page 39, this  
10 section, section III of your report, addresses head on  
11 the causes of vaccine hesitancy. And I said we'd come  
12 back to look in more detail at these various sectors or  
13 cohorts or population groups.

14 You have had already referred to this, but you  
15 identify firstly, in paragraph 82, safety and  
16 risk-benefit perceptions are widely established as a key  
17 driver to vaccine uptake, and that may be -- it might be  
18 self-evident.

19 Are those perceptions common across the population,  
20 or are they particularly prevalent in any particular  
21 sectoral area such as healthcare workers, amongst  
22 pregnant women or ethnic minorities?

23 **A.** Yes, I think healthcare workers were affected also  
24 because they were getting a lot of the questions. They  
25 were the front line of questions from the public, and

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1 events, did affect people's hesitation or willingness.

2 **Q.** Then what about the four nations? Were there  
3 differences in levels of hesitancy between the four  
4 nations in relation to Covid-19 before the uptake --  
5 before the rollout?

6 **A.** Yes, for the same diversity reasons. A lot of these  
7 issues have subpopulation characteristics.

8 **Q.** I think there were particularly high levels of vaccine  
9 hesitancy in parts of London, overall lower levels of  
10 hesitancy in Scotland, Wales, Northern Ireland than  
11 England. London appears to have been a bit of an  
12 outlier, perhaps associated with its population. But  
13 there was nevertheless a strong correlation between  
14 pre-vaccine rollout predictions and observed uptake?

15 **A.** Yes.

16 **Q.** So such hesitancy as there was, didn't necessarily  
17 translate again into lack of uptake.

18 Did that data show also, in the original or the  
19 initial assessments of degrees of vaccine hesitancy on  
20 the Covid vaccines, an emerging backlash issue? So to  
21 what extent was any backlash in response to government  
22 policies on vaccine passport or certification or  
23 deployment apparent?

24 **A.** Well, I think that the -- and what we've seen is the --  
25 creating the requirements for vaccination, that was

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1 some of them felt like they didn't have enough  
2 information to answer the questions of the public.

3 The issue around pregnant women was a concern.  
4 I mean -- and part of that was because the data  
5 available around the safety of the Covid vaccine for  
6 pregnant women was evolving over time, and that made  
7 people very anxious that: wait a minute, you said one  
8 thing, now you're saying something different. And  
9 I think in the context of a brand new vaccine under  
10 emergency authorisation, I think the -- needing to  
11 constantly remind people that "You need to understand  
12 we're giving you the best evidence, information we have,  
13 as we learn more we'll bring you along with it", but it  
14 did make people more uncertain.

15 **Q.** A second area, broad and important area, is the issue of  
16 structural discrimination.

17 **A.** Yes.

18 **Q.** You refer to a number of aspects of what is described as  
19 structural discrimination, such as pre-existing mistrust  
20 of state services, in particular healthcare services,  
21 misinformation, negative vaccine attitudes from various  
22 information sources, all within a general perception  
23 that particular groups have been marginalised, ignored,  
24 or treated unfairly.

25 This important issue of historical discrimination,

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1 a perception that they've been treated badly, how  
2 prevalent is that belief?

3 **A.** Well, in those communities, in some of the communities,  
4 it's very prevalent. The reality is we can't change  
5 history but we can change the present. And I think that  
6 that's something very important to remember. And  
7 there's -- every day is an opportunity to rebuild trust,  
8 and I actually -- I mean, I think Covid was a huge  
9 opportunity to try to rebuild that trust, and now is  
10 a big opportunity.

11 **Q.** We'll look in more detail in a moment at what those  
12 steps might consist of, but just trying to identify what  
13 is driving this historical -- this perception of  
14 historical unfairness and mistrust, does it have its  
15 foundations in a number of different areas?

16 So, perhaps by way of example, past engagement with  
17 the healthcare services, past engagement with the  
18 political structures of the United Kingdom, past  
19 engagement or lack of involvement in or engagement with  
20 clinical trials, a perception that they haven't been  
21 properly represented in that important feature of  
22 vaccine research and development. Are those the three  
23 broad areas, if you like, which have driven the  
24 discrimination which they undoubtedly feel subjected to?

25 **A.** Yes, those are the key areas.

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1 investigators and manufacturers, enrolment strategies  
2 and to ensure better, diverse recruitment at the  
3 clinical trial stage?

4 **A.** Yes, absolutely.

5 **Q.** All right. One particular group of people, migrant  
6 people, so comprising asylum seekers, people with  
7 refugee status, are they similarly affected by issues of  
8 structural discrimination and distrust of the state in  
9 the NHS or are they in a particular category of their  
10 own when it comes to levels of perceived discrimination?

11 **A.** Well, I think it's important to recognise that some of  
12 the distrust may have nothing to do with the health  
13 system per se, but an anxiety about being caught or  
14 being found, or maybe they're not -- you know, if they  
15 sign up for a vaccine and maybe they're not sure of  
16 their status to be here ...

17 So the trust environment is sometimes not about  
18 either the vaccine or the health system, but --

19 **Q.** It's the state?

20 **A.** -- a broader distrust -- yeah.

21 **Q.** So it's all mixed up with their relationship and  
22 perception of the state?

23 **A.** Absolutely.

24 **Q.** And, bluntly, there appears to have been a very  
25 widespread view on the part of migrant people that if

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1 **Q.** Has that level of perceived -- and when I say  
2 "perceived", I don't mean it doesn't exist, I'm saying  
3 that's their sense of -- discrimination, does it vary?  
4 Has it varied over time? Is it the same today as it was  
5 pre-pandemic? Or what has been the impact of the  
6 pandemic?

7 **A.** Well, I think in different communities -- again, there  
8 is a lot of diversity in the United Kingdom, and --  
9 which is a healthy thing, and I think in some cases  
10 where there were -- I -- some people say you can't build  
11 trust during a crisis. I tend to disagree with that  
12 because I think the more trust you have going into  
13 a crisis, the better, but there are opportunities to  
14 build trust, and there were communities which did come  
15 together, and did get some more attention and more trust  
16 building than maybe beforehand, but it wasn't  
17 everywhere.

18 **Q.** Before we look at some of the particular groups and  
19 cohorts in the population in particular, and focusing on  
20 one of those three drivers, clinical trial recruitment,  
21 is it because of the belief, the perception -- grounded,  
22 it may very well be, in reality -- that there was  
23 insufficient representation in clinical trials, that one  
24 of your recommendations, as we'll see at the end, is  
25 that more is done to report, on the part of

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1 you go to a vaccine centre and seek to get a vaccine,  
2 there is a risk that you either might be charged for it,  
3 and be reported to the Home Office if you didn't pay it,  
4 or that your details would in some way percolate back  
5 through to the Home Office and your immigration status  
6 would come under review? That's the nub of it, isn't  
7 it?

8 **A.** Yes, probably more the latter.

9 **Q.** All right. Was there also, particularly with migrant  
10 people, issues concerning the practical barriers of  
11 language and communication? So a more forensic level of  
12 concern.

13 **A.** Can you say that again?

14 **Q.** Yes. We've been talking about the perception of  
15 discrimination and the fear and distrust of government.

16 **A.** Right.

17 **Q.** But on a practical level, were there also particular  
18 problems concerning language and communication barriers  
19 insofar as migrant people were concerned?

20 **A.** Yes, yes. Language is certainly a key issue.

21 **Q.** All right. And lastly on this topic, is it important to  
22 identify that, for many people, there won't just be  
23 a single problem or a single practical barrier or  
24 a single discriminatory impact; many people will be  
25 subject to overlapping what is called inequities?

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1 **A.** Yes, it's usual multiple factors, that can also change  
2 over time.

3 **Q.** And does that make this whole subject matter even more  
4 complex and probably more difficult to resolve?

5 **A.** Yes.

6 **Q.** I've mentioned migrant people. In relation to disabled  
7 people, are they another particularly important group in  
8 relation to whom there were issues about trust of  
9 government, perceived past discrimination, as well as  
10 intensely difficult practical barriers, communication,  
11 access, transport, and so on?

12 **A.** Yes, particularly in the disabled community but also in  
13 the context of Covid, there were a lot of technology  
14 requirements that you really needed to be able and have  
15 access to, whether it's digital devices, or whatever,  
16 for making appointments, for getting to places, that  
17 were more easy for some people than others.

18 **Q.** All right. We can now come to an entirely new topic,  
19 which is misinformation and disinformation, part III.4  
20 of your report, page 44, please. There appear to be  
21 a number of definitions in play: misinformation is false  
22 or misleading information; disinformation might be said  
23 to be the deliberate dissemination of false or  
24 inaccurate information.

25 It may seem blindingly obvious, but during the

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1 **A.** Well, they weren't looking for misinformation, they were  
2 looking for --

3 **Q.** No, that's why I said carefully --

4 **A.** They were looking for a vaccine -- (overspeaking) --  
5 because they were --

6 **Q.** Why were they doing it?

7 **A.** Because before Covid they didn't have to think about  
8 vaccines. If I were a truck driver or a hairdresser or  
9 somebody who -- it's not part of my life, unless I had  
10 a child or maybe an elderly parent who needed a vaccine,  
11 I wouldn't have had any reason to look online about  
12 vaccines. It was not like in the scope of what I think  
13 about. But in Covid, everybody needed to get a vaccine.  
14 And that took them down -- so that was the driver.

15 **Q.** We needn't investigate the source or the origin of the  
16 many stories or pieces of information or, if one wants  
17 to be pejorative, conspiracy theories or tropes or  
18 myths, but they covered a vast, perhaps an indefinite  
19 range of points and claims, some with their foundations,  
20 perhaps in a kernel of truth, some completely  
21 outlandish, outrageous and tendentious.

22 Why, in a very general sense, did so many people go  
23 to the Internet to get the answers that they deserved,  
24 as opposed to government sources? So putting it another  
25 way, why was social media and the Internet trusted

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1 pandemic, Professor, were there many different ways in  
2 which dis- and misinformation emerged?

3 **A.** Yes, there was an explosion of mis- and disinformation.

4 **Q.** And no doubt fuelled or accelerated by, of course, the  
5 Internet?

6 **A.** Yes, and social media, and I think there's another  
7 really important thing to think about with that: the  
8 explosive spread of mis- and disinformation, and that's  
9 the fact that during Covid or pre-Covid, most people,  
10 particularly in the hesitancy -- or in people who were  
11 in groups who had issues or had questions, were those  
12 who were specifically looking for information on  
13 vaccines. Parents, maybe young girls looking about HPV,  
14 maybe some older people, but there was a huge part of  
15 the population that weren't looking for information on  
16 vaccines and had no idea that there were any questions  
17 about vaccines, and in Covid, everybody, everybody, was  
18 pushed to look for information on vaccines, and a huge  
19 part of the population that previous to Covid had no  
20 idea that there was any debates or hesitancy, were  
21 exposed to a lot of, frankly, very toxic and confusing  
22 information, and -- (overspeaking) --

23 **Q.** Why were they pushed? Who pushed them or why were they  
24 pushed, in a way they hadn't been before, to the  
25 Internet to look for this information?

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1 perhaps more than government?

2 **A.** Well, sometimes it was just an issue that they weren't  
3 getting the information they were looking for through  
4 a government source, because official information was  
5 pushing out what the government and the health, public  
6 health felt was important for people to know, but didn't  
7 necessarily answer the questions that people had, and  
8 therefore, they would turn to alternative sources.

9 **Q.** Can we look at that in more detail for a moment. It's  
10 obvious, and I'm sure my Lady has that point already,  
11 it's obvious that there was no end to government  
12 information. There was masses of information being  
13 pumped out by the NHS --

14 **A.** Yes.

15 **Q.** -- in each country, the public health agencies in each  
16 country, the UK Government in the form of the  
17 Department for Culture, Media & Sport, the DHSC, what  
18 became the UKHSA, the JCVI, the MHRA.

19 **A.** Yes.

20 **Q.** Masses of information was out there. Why didn't it get  
21 traction or, I suppose, relative traction compared to  
22 the Internet?

23 **A.** Well, again, in a way there was, like, too much  
24 information, but I think that, again, there were some  
25 questions that people had particularly around safety or

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1 where they had to go or what they had to do, that maybe  
 2 they weren't sure, particularly in some of the cases or  
 3 some of the groups that we were talking to before, maybe  
 4 they just weren't sure where to go to get that  
 5 information and how to ask the question. It wasn't  
 6 the -- the sheer scope of information made it, in some  
 7 ways, less easy to find what you're looking for.

8 **Q.** I appreciate that the Inquiry didn't ask you to address  
 9 the detail or the nature of the way in which government  
 10 put information into the public domain, or why it didn't  
 11 perhaps work as well as the government might have  
 12 wished. Do you think there is room nevertheless here  
 13 for a message or a recommendation to government that  
 14 more needs to be done to focus on the impact of the vast  
 15 amounts of information that it pumps into the public  
 16 domain, it's coherency, the impact of the overarching  
 17 message, or just maybe the routes by which they put  
 18 information into the public domain?

19 **A.** I think the coherence is important but I think another  
 20 thing that's important is to try to be listening to the  
 21 public to the extent that you can, in ChatBots, and  
 22 there's all kinds of options these days, but to make  
 23 some of the information relevant to people's questions,  
 24 to try to engage them so they don't go somewhere else.

25 **Q.** And does that bring us back to the issue of trust?

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1 the proper routes to communicate information to the  
 2 communities, such that they're more likely to trust it  
 3 more?

4 **A.** Yes, I think -- and I think a combination  
 5 is -- (overspeaking) --

6 **Q.** It's a combination of the two?

7 **A.** Yes.

8 **Q.** Right.

9 Now a new topic: vaccination policies.

10 There are two broad areas here, I suppose. One is  
 11 vaccine certification or passports: producing a document  
 12 which allows you to travel or to go into a nightclub or  
 13 whatever it is. And then there is the issue of  
 14 vaccination as a condition of deployment.

15 **A.** Say that --

16 **Q.** VCOD, vaccination as a condition of deployment.

17 **A.** Yes, a condition of --

18 **Q.** I want to focus, please, on the second one.

19 As a general rule, pre-pandemic, had there been much  
 20 support for any type of mandatory vaccination?

21 **A.** No.

22 **Q.** Number of countries, including the United Kingdom, did  
 23 put into place policies for certification. You know, if  
 24 you produced -- I can't now remember -- a Covid pass or  
 25 you -- if you --

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1 **A.** Yes.

2 **Q.** As a member of the population, if you're not minded to  
 3 listen to the government because you don't trust it --

4 **A.** Yes.

5 **Q.** -- you're less likely to be amenable to receiving the  
 6 important public health messages that it wants you to  
 7 receive?

8 **A.** That's correct.

9 **Q.** So any recommendations about communication need to be  
 10 grounded in addressing the issue of trust or, more  
 11 particularly, mistrust?

12 **A.** Yeah, and I think it's very much about trust but there  
 13 are many ways, and there were some very good examples  
 14 during Covid, where you identify trusted community  
 15 members in some of these communities that you work with,  
 16 that you kind of engage them, get them the information  
 17 that is going to be needed in the community, so that you  
 18 partner with and collaborate with people within these  
 19 communities that can help be a partner in making this  
 20 better.

21 **Q.** And so are there two aspects to trust or distrust or  
 22 mistrust that need to be focused on: one is how do you  
 23 make people believe in government better or more, and  
 24 that's to do with how the government behaves; and then  
 25 there is the perhaps much more important issue of using

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1 **A.** Yeah.

2 **Q.** -- produced a document on your app, you could -- on your  
 3 phone, you could show that you're entitled to go in.

4 Did many or any western European countries go  
 5 further and mandate vaccination as a condition of  
 6 deployment?

7 **A.** Yes.

8 **Q.** France and Germany?

9 **A.** Yes. And it depended too on -- predominantly health --  
 10 people who are working on the front lines and -- of the  
 11 response, but also, as I said, for travelling and ...

12 **Q.** There is a balance, isn't there, in this policy, quite  
 13 difficult policy area, between driving rates of uptake  
 14 up and inadvertently fostering a backlash?

15 **A.** Yes.

16 **Q.** By and large, did schemes of vaccinations as a condition  
 17 of deployment work in Western Europe for the purposes of  
 18 driving vaccination rates upwards?

19 **A.** Yes, there's quite a bit of evidence that these  
 20 requirements, in the short-term, increased uptake, but  
 21 in the long-term was a trust breaker.

22 **Q.** And how do we know that in the long-term it was a trust  
 23 breaker?

24 **A.** Because there's been a good bit of research on it.  
 25 France in particular has done quite a bit, where they

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1 show that people -- both qualitative research and  
 2 surveys, that they felt like they did not take a -- the  
 3 Covid vaccine because they were confident about it, they  
 4 took it because they wanted to travel, they wanted to go  
 5 to that restaurant, they wanted to meet with colleagues  
 6 or friends. But you can be sure that they would say,  
 7 "You're not going to see me in that vaccine clinic  
 8 again", and they resented the fact that they had to get  
 9 it. But they did it because they had a bigger ambition,  
 10 which was to travel or to go to that restaurant or to go  
 11 somewhere.

12 So it was more a functional thing for the immediate  
 13 frustration of not being able to do things, but in  
 14 retrospect they regretted or resented it. And then  
 15 that's where sentiments hardened.

16 **Q.** And then when the sentiments harden, that contributes to  
 17 a general growth in vaccine hesitancy or lack of  
 18 confidence?

19 **A.** Yes, absolutely.

20 **Q.** Which then, coming full circle, has a tendency to have  
 21 an impact in the months and the years to come?

22 **A.** Potentially, yes.

23 **Q.** Potentially. On the subject of VCOD, can we just please  
 24 look at page 28 of your report because you've set out in  
 25 a number of pages the main highlights of the

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1 that policy.

2 November 2021, the UK Government announced that  
 3 frontline health workers would be required to be  
 4 vaccinated from, I think, 15 March 2022.

5 **A.** Yes.

6 **Q.** The Northern Irish decided that was not a route they  
 7 would go down, and they didn't consult on it, and  
 8 Scotland similarly decided, as a matter of policy, they  
 9 wouldn't pursue VCOD for healthcare workers. And then  
 10 on page 30, March 2022, following that consultation  
 11 process for the wider VCOD scheme, in fact on 1 March,  
 12 the UK Government, in England, scrapped the policy two  
 13 weeks before it was due to be introduced. Is that  
 14 a fair summary?

15 **A.** Yes.

16 **Q.** What was the outcome, as far as you're able to tell, in  
 17 terms of whatever backlash there may have been to those  
 18 consultation processes, and the introduction of the  
 19 first policy, that's for care home workers, as well as  
 20 the withdrawn second policy which was the wider  
 21 healthcare staff? Was there a general backlash?

22 **A.** Well, there were definitely protests with NHS workers in  
 23 Trafalgar Square, who were very much against this, and  
 24 I think it was a bit of a surprise to people to see them  
 25 spread their scrubs across Trafalgar Square with

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1 UK Government and then the Scottish, Welsh and  
 2 Northern Irish approach to VCOD.

3 In April 2021, we can see from the bottom of that  
 4 top paragraph, there was a public consultation by the  
 5 UK Government, for England of course, between April and  
 6 May on a proposal to make Covid-19 vaccination  
 7 a condition of deployment in care homes. That's to say  
 8 in registered care homes.

9 **A.** Yes.

10 **Q.** If we then go down the page to June, following that  
 11 consultation process the UK Government confirmed  
 12 vaccination would be mandatory for staff working in care  
 13 homes with effect from October.

14 And then the Welsh Government said they weren't  
 15 going to consult on that issue because they took the  
 16 view that the uptake rate was sufficient already, in  
 17 essence.

18 Then over the page, page 29.

19 In September there was then a fresh consultation for  
 20 mandatory vaccination for healthcare staff and related  
 21 professions in England. The response was heavily  
 22 divided. So there were -- some sectors of the health  
 23 sector were strongly in support, mainly employers and  
 24 health bodies, but individual staff and workers and the  
 25 unions were very concerned about the implications of

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1 posters, but I think what can be confusing to the public  
 2 is it looked like they were against vaccines, but they  
 3 were against the mandate, and the requirement. And  
 4 I think the whole discussion towards this mandate  
 5 hardened some people, because they felt like they  
 6 weren't trusted, and they felt like they're working  
 7 24/7, and now you're, you know, pushing this on us, and  
 8 you don't trust us to make up our own mind, and I think  
 9 it took a toll.

10 I mean, on the one hand, the consultations are  
 11 a good thing. On the other hand, the issue fired up  
 12 some sentiments and --

13 **Q.** So we are exactly back to there we were with the  
 14 compulsory Vaccination Act of 1853?

15 **A.** Yes, we're back to square one.

16 **Q.** Back to square one. And in terms of -- are you able to  
 17 say anything about whether or not that first policy, the  
 18 care home worker policy of VCOD, did it work at all in  
 19 terms of pushing rates of uptake upwards, or were they  
 20 in fact already at quite a high rate already?

21 **A.** Well, I think it -- it was an issue of also the  
 22 confidence of the residents and the families of the  
 23 residents. I think it was already a good rate, but  
 24 I think it did help. Again, what helps from a public  
 25 health practical sense versus the sentiments --

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1 Q. The individual --  
 2 A. Yes.  
 3 Q. -- or discriminatory --  
 4 A. Yes.  
 5 Q. -- or societal impact?  
 6 A. Yes, is different.  
 7 Q. So the rates did actually go up in terms of the uptake  
 8 of vaccination, notwithstanding the backlash, but there  
 9 may have been trouble stored up for the future?  
 10 A. Exactly.  
 11 Q. And in terms of the numbers of staff in that sector, are  
 12 you able to say whether or not there was an impact in  
 13 terms of people leaving the care home sector and then  
 14 subsequently as a result of the second policy  
 15 consultation process, the wider healthcare --  
 16 A. People did leave their jobs because of these.  
 17 Q. All right. So is it your view that -- well, it's an  
 18 intensely difficult balance, and that obviously any  
 19 government attempting to mandate vaccination in the  
 20 future as a condition of deployment has to weigh up  
 21 extremely carefully the public health benefit against  
 22 the wider, longer-term societal impact?  
 23 A. Yes.  
 24 Q. Do you think it would be a good idea for the government  
 25 now, for the purposes of any future pandemic, to have

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1 said you can take a pause from your job, if you really  
 2 don't want, because this is -- we understand this is  
 3 a new vaccine, it's under emergency authorisation, if  
 4 you're really uncomfortable and don't want to take this,  
 5 we just ask that you stay at home and you come back when  
 6 this storm is over.

7 That would have been maybe something that was  
 8 a compromise. It was a difficult time because we needed  
 9 all hands on deck.

10 But I think we need to look at ways to be sensitive  
 11 to the issues. And again, this was a particularly  
 12 complex situation because of the nature and the newness  
 13 of the vaccine, and the -- and of, you know, the  
 14 stresses and emotions on these people.

15 Q. In the context of a pathogen that killed --

16 A. Yes.

17 Q. -- the primary driver has to be first the medical creed  
 18 "first do no harm"?

19 A. Exactly.

20 Q. And that might have to --

21 A. That's a very good reference.

22 Q. That might win out over individual societal or human  
 23 rights individualism?

24 A. Exactly.

25 MR KEITH: My Lady, is that a convenient point?

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1 a better understanding of how that balance might  
 2 properly be struck, and of the, I suppose the mechanics  
 3 and the facts and the figures underpinning it?

4 A. It's a very difficult sentiment. I think the particular  
 5 period when this was going on, emotions were running  
 6 high already, people were stressed, people were ... it  
 7 was a very difficult time, as you know. Well, there are  
 8 vaccine requirements for some healthcare workers,  
 9 particularly hepatitis B. I think -- personally,  
 10 I think that people who work in settings with very  
 11 vulnerable person for health or elderly, vulnerable  
 12 reasons, should have their vaccines.

13 I mean, I think people sometimes look at the  
 14 mandates as requiring it for you as an individual when  
 15 in fact it's about protecting others. It's about  
 16 putting other people at risk. And I worked in the UN  
 17 for 12 years, and in terms of the issue of human rights  
 18 and responsibilities, you have your rights and your  
 19 personal freedoms until they harm other people, and then  
 20 it's -- you start to move into responsibilities. And  
 21 I think this really sits on the line of: this is not  
 22 just about you, this is about -- and in some cases like  
 23 in this case with the Covid vaccine, it's -- it wasn't  
 24 that they had to do this forever. I mean, it was, like,  
 25 if you don't want to get your vaccine, they could have

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1 LADY HALLETT: Certainly. I shall return at 3.45.  
 2 (3.28 pm)

(A short break)

4 (3.45 pm)

5 LADY HALLETT: Mr Keith.

6 MR KEITH: Professor Larson, we're in the final furlong.

7 You set out from page 52 onwards the number of ways  
 8 in which the UK Government and the devolved  
 9 administrations tackled what was obviously an issue  
 10 concerning vaccine hesitancy, so just a number of very  
 11 brief questions.

12 From the evidence you've seen and all the material,  
 13 was it absolutely obvious and foreseeable that in the  
 14 context of the delivery and rollout of vaccines, there  
 15 would be issues about barriers to access and vaccine  
 16 hesitancy that the government would have to address?

17 A. Yes, the extent of it was not clear and not obvious --

18 Q. It was worse than they thought or more difficult than  
 19 they thought?

20 A. No I think that, actually, some places managed in very  
 21 creative ways that you might not have expected, but I do  
 22 think -- well, not just think, there were clear  
 23 pre-Covid issues in some of the same groups we were  
 24 talking about before Covid, and those were predictable  
 25 as being challenges.

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1 Q. Right. And nobody seriously disputes that many parts of  
2 the government machinery, in all four nations, did their  
3 bit to try to meet those challenges, and you've set out  
4 in very broad terms the work done by the Public Health  
5 Agencies, by the NHS and care sectors in each of the --  
6 by particularly NHS boards and trusts in each of the  
7 countries. How, in England, Scotland and Wales, there  
8 were vaccine equity committees of one shape or another.  
9 In Scotland there was a vaccine equities committee and  
10 the vaccine directorate, in England there was a vaccine  
11 equity group, and similarly in Wales. The Race  
12 Disparity Unit in London issued four quarterly  
13 reports -- could we have page 53 -- the final report of  
14 which we can see, in 130.1 down to 4, some of the main  
15 broad lessons which it sought to promulgate: ensuring  
16 that success of normal vaccine deployment is carried  
17 over to other public health programmes; not treating  
18 ethnic minorities as a homogenous group; don't  
19 stigmatise; and improve data.

20 So all the topics broadly that we've discussed.

21 But in general terms, do you think all the  
22 governments or any of the governments went far enough in  
23 terms of what they were able to do practically? Did  
24 they miss opportunities or misstep? Did they do enough,  
25 in the course of the pandemic, to reduce barriers to

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1 necessary degree of clear and cohort communication. The  
2 pre-existing rates of hesitancy and of existence of  
3 barriers continued, in particular amongst ethnic  
4 minority communities, amongst pregnant women, amongst  
5 disabled people and the migrant population so in fact  
6 all the areas we've discussed already, and there was  
7 a generally quite a high rate of under-vaccination in  
8 the young?

9 A. Yes.

10 Q. Are those the broad main areas?

11 A. (Witness nodded)

12 Q. So in light of that, do you set out in your report from  
13 page 63 onwards the lessons which we must learn and what  
14 might be done by way of recommendation to address the  
15 problems that we've just highlighted.

16 You identify, and we've done this already today, the  
17 broad policy areas that need to be readdressed and they  
18 are these: there's the issue of trust and distrust; the  
19 issues about longstanding structural discrimination and  
20 perception of being treated badly or unfairly or being  
21 forgotten or marginalised amongst in particular ethnic  
22 minority groups; there is the issue of communication and  
23 misinformation; and there is the important topic of how,  
24 practically, the government might introduce policies to  
25 try to address hesitancy, for example VCOD.

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1 access and challenge vaccine hesitancy at a very high  
2 level?

3 A. Well, I think it's always easier to be critical in  
4 retrospect, but I would find it difficult to say that --  
5 it's always -- there's always things you -- we could  
6 have done better, but at the time I think people were  
7 doing what they could in a very uncertain situation.

8 I do think that extra attention to the places that  
9 were predictably going to be challenged would -- more  
10 work could have been done there, particularly in this  
11 context.

12 Also, and I know I should keep this short, but these  
13 were not typical situations. I mean, some of the issues  
14 we heard were, like with the elderly: why am I going to  
15 a tent to get my vaccination? Why aren't I going to my  
16 doctor? Some people wanted to be walked through. It  
17 was unfamiliar, it was different.

18 So I do think that there is always more you could  
19 do. There was ...

20 Q. Looking at this section of your report, you note that,  
21 notwithstanding the steps that were taken, and just by  
22 way of identifying the broad headlines, there was still  
23 quite a high degree of failure in terms of the clarity  
24 or coherence of communications and guidance. Important  
25 parts of the population simply didn't receive the

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1 And you identify from page 65 onwards four broad  
2 areas, is this right, and I hope you'd agree that these  
3 are the approached areas that you've sought to focus on,  
4 I've addressed data already, but the three remaining  
5 areas might be described as: trust building,  
6 communication planning and educational initiatives.

7 So on the first one, trust building, that tackles  
8 this issue of trust and distrust and marginalisation and  
9 historical discrimination.

10 How best can one rekindle, if it was ever there at  
11 all, trust in government and in healthcare services and  
12 particularly in vaccination?

13 A. Well, I think one, we shouldn't wait for the next  
14 pandemic, or next crisis. That can start now. And  
15 I think there were a lot of missed medical appointments,  
16 vaccinations, during Covid, and I think making that  
17 extra effort to -- so that people feel like what they  
18 didn't get then, there's an explicit effort to catch  
19 people up with their vaccinations, to ask them about  
20 their other issues. We are trying not, I think,  
21 paying -- personally, I don't think we're paying enough  
22 attention to Covid recovery, we kind of wanted to bounce  
23 back quickly. But there is quite a bit of recovery that  
24 still needs to happen.

25 I think one of the things that is already going on,

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1 that I think is a positive contributor to trust  
 2 building, is things like the listening, like what you're  
 3 doing here, and the listening to Every Story Matters.  
 4 It's giving an opportunity for people to talk about  
 5 their issues, and that's a trust builder, the fact that  
 6 you're willing to listen.

7 **Q.** And if, through the practical prism of clinical trial  
 8 and that process, and the delivery process, marginalised  
 9 or ignored groups can be brought closer into the  
 10 planning process, so by way of, perhaps, the institution  
 11 of expert groups and panels to help design better the  
 12 clinical trial process, the research and development  
 13 process, the delivery, the rollout of vaccines, would  
 14 that help, do you think, to engender more trust?

15 **A.** Absolutely.

16 **Q.** And therefore, that links into the second topic:  
 17 communications and planning.

18 If people who are required to be brought into the  
 19 planning process and the communication networks are  
 20 brought in in that way, do you think that would help?  
 21 Do you think that would help the dissemination of  
 22 communications in the teeth of a crisis? So if groups,  
 23 ethnic minority groups or disabled people, or migrant  
 24 people, or pregnant women, are listened to more when it  
 25 comes to planning these structures, when they come to be

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1 prevent Covid, you don't directly react to that post or  
 2 whatever it is, but you start to, in your own  
 3 communication, start saying things like garlic and  
 4 other, you know, are not going to help you; they may be  
 5 good for your nutrition but they're not going to prevent  
 6 Covid.

7 So you listen and pay attention to the  
 8 misinformation and disinformation to hear what are the  
 9 issues you need to give a better story, a more accurate  
 10 story to, and then pre-bunk or you inoculate people  
 11 around so that they're hearing another story.

12 The problem is when you don't react to it at all,  
 13 you're rolling out the red carpet for it to spread. But  
 14 we have learnt that if you engage in, and maybe that's  
 15 not -- and I didn't mean to -- you need to deal with the  
 16 issue head on but not directly react to the post because  
 17 it just makes it go more viral.

18 **Q.** Bluntly, Professor, Professor Sir Chris Whitty and  
 19 Professor Sir Jonathan Van-Tam and the head of  
 20 NHS England, and a number of others, including the heads  
 21 of the public health agencies, are clear in their  
 22 written evidence that they didn't try to engage with  
 23 misinformation head on. What they did was try not to  
 24 engage with it and get into a fight, but to repeat the  
 25 facts, to repeat, through government communications, NHS

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1 used, they're likely to have more trust in them?

2 **A.** Absolutely, and I don't think that should be seen as --  
 3 as they say, it's not a luxury, it's an essential,  
 4 because they understand the days and the ups and downs  
 5 in the community, they understand what the issues are in  
 6 general, so I think it's only an asset.

7 **Q.** And then the final topic I've identified as educational.  
 8 You make the point on page 66, I think at 176, thank you  
 9 very much, about pre-bunking.

10 "In the context of the growing challenges of  
 11 misinformation, consider educational initiatives on  
 12 misinformation such as 'pre-bunking' ..."

13 Much of what we've discussed has focused on the  
 14 planning and the procedures and the technical aspects of  
 15 delivery of vaccines. But do you think the government  
 16 needs to be more proactive in terms of educating us all  
 17 and attacking head on some of the myths, some of the  
 18 tropes, some of the disinformation or misinformation  
 19 that's out there?

20 **A.** I don't think head on is productive, with some of the  
 21 mis- and disinformation, but I do think we have to  
 22 listen and pay attention to the mis- and disinformation,  
 23 and have a better story.

24 **Q.** How do we do that?

25 **A.** Well, if the misinformation is eating garlic is going to

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1 communications and all the various communication routes  
 2 available to the government, the broad facts again and  
 3 again and again. This is the position. This is the  
 4 position.

5 But to a large extent it didn't appear to gain  
 6 traction. It may not have worked quite as well as they  
 7 expected. Should they have gone about it in a different  
 8 way? Should they have tried to engage more in the  
 9 detail of what was being propagated? Or do you think  
 10 that was the right approach, which is simply to stand  
 11 back and just hold your position and repeat the reality  
 12 of what you believe the position to be?

13 **A.** Yeah, I don't think that's the best way to do it.  
 14 I mean, I think it's fine to keep repeating coherent and  
 15 important facts, but it's not going to help to address  
 16 the mis- and disinformation.

17 The information -- what is needed is to make  
 18 information relevant to people's concerns and  
 19 misunderstandings, but also, it's not just about the  
 20 information, it's about the way it's communicated.

21 **Q.** So trusted community figures?

22 **A.** Trusted community figures, in stories, in -- I mean,  
 23 engaging on social media. Getting there in a way that's  
 24 not kind of dry facts but appeals, and relevant. And  
 25 that's where we're working with communities to say:

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1 listen, we need to get the community to -- it's  
 2 important that the community understands that drinking  
 3 chlorine is not going to cure your Covid. You know, who  
 4 in the community -- we've done this with 10, 12-year old  
 5 girls in designing strategies around HPV, on social  
 6 media. They -- you know, when you engage them, they --  
 7 you can do very creative -- it's also about the style of  
 8 communication, not just the content.

9 **Q.** So as the witness earlier today said, sometimes the  
 10 messenger is more important; perhaps is as important as  
 11 the message?

12 **A.** Certainly, as important.

13 **MR KEITH:** Certainly as important.  
 14 Thank you very much, Professor.

15 **LADY HALLETT:** I think we have two sets of questions, nearly  
 16 finished. Mr Thomas is over there.  
 17 I hope you made your appointment, Mr Thomas.

18 **Questions from PROFESSOR THOMAS KC**

19 **PROFESSOR THOMAS:** I did, my Lady, thank you very much. And  
 20 I didn't have to fly.  
 21 Good afternoon, Professor.

22 **A.** Good afternoon.

23 **Q.** My name is Leslie Thomas and I'm representing FEMHO, the  
 24 Federation of Ethnic Minority Healthcare Organisations.  
 25 I have a small handful of questions for you in relation

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1 seen -- and it's in other countries too -- I think some  
 2 of the points have been raised already, and that's,  
 3 really, engaging with the communities and trusted  
 4 figures. I mean, and it doesn't even have to be that  
 5 local health community. We've done things with barbers,  
 6 with shopkeepers in the Bangladeshi community. Of all  
 7 the people that came out as being proactive in their  
 8 community were the restaurant owners, who were doing  
 9 selfies of their Covid -- getting their Covid shot. And  
 10 why the restaurant owners? They know that it's not just  
 11 getting back to business, they knew that they had a lot  
 12 of mortality in their community, but also the  
 13 restaurants, especially in crowded housing and large  
 14 families, is a social gathering. It's a family  
 15 gathering.

16 So they actually rose up as proactive vaccine  
 17 advocates in the community. And I think different  
 18 communities will have different -- I'm not saying that  
 19 that's necessarily the solution, and it'll be in  
 20 different communities, but it really needs taking the  
 21 time and sitting down with certain communities and  
 22 creatively thinking it through, and not just doing it as  
 23 an exercise, but actually following up on it.

24 **Q.** Can I just piggyback just on something you've just said,  
 25 and then I've finished, and it's this. Would you agree

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1 to this matter, so I trust I won't keep you too long.

2 **A.** Okay.

3 **Q.** In your report you cite many causes of vaccine  
 4 hesitancy, including safety concerns, historical  
 5 distrust, and inequalities. This went in tandem, you  
 6 say, with ethnic minority groups also experiencing  
 7 disproportionate Covid-19 morbidity and mortality  
 8 burdens, largely linked to pre-existing inequalities.

9 Then you say this, then you say:  
 10 "[Overall], there ... [is] a legacy of mistrust  
 11 among ethnic minorities in the UK ... and ongoing  
 12 discrimination which [has shaped] their perspective  
 13 on ... health and wider governance systems."  
 14 Yes?

15 **A.** Yes.

16 **Q.** Right. So here's the question, can you help us with  
 17 this: how best is this legacy of mistrust addressed to  
 18 improve vaccination outcomes?  
 19 Can you help us with that?

20 **A.** Well, I think legacies can change, and I think -- but  
 21 it's going to take a lot of attention. It's not a --  
 22 there's no quick fix for this kind of situation.  
 23 It's not unique to the UK. I'm -- although I've  
 24 lived here for 12 years, I am from the US. We have  
 25 similar -- different kinds of issues. And what I've

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1 with this: in terms of this concept of legacy of  
 2 mistrust, earlier you were having a conversation about  
 3 vaccine hesitancy, yes, and whether that's problematic  
 4 or not. But would you agree that a term like that tends  
 5 to put the emphasis on individual behaviour and  
 6 attitudes, and therefore diverts attention from known  
 7 causes of unequal vaccine uptake, and a lot of which,  
 8 following your report, tends to be to do with historical  
 9 and/or deep-rooted issues about systems and  
 10 institutions? Would you agree with that?

11 **A.** I do think we have to take it away from the individual.

12 **PROFESSOR THOMAS:** My Lady, that's all I ask. Thank you  
 13 very much.

14 **LADY HALLETT:** Thank you very much, Mr Thomas.  
 15 Ms Mitchell. Ms Mitchell is over there.

16 **Questions from DR MITCHELL KC**

17 **DR MITCHELL:** I'm obliged.  
 18 Professor, I appear on behalf -- as instructed by  
 19 Aamer Anwar & Company on behalf of the Scottish Covid  
 20 Bereaved. And an issue that arises particularly in  
 21 relation to Scotland is the fact that it has  
 22 a significant amount of its community in rural and  
 23 island areas.  
 24 We've heard a lot about issues of hesitancy and  
 25 I was wondering whether geographical factors such as

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1 having to travel a long way to get a vaccine could prove  
 2 to be something which makes people more hesitant to  
 3 accept it?  
 4 **A.** Absolutely. I think access is a big issue, particularly  
 5 in remote or rural areas. Also, when there's -- you're  
 6 trying to reach as many people as possible, and you have  
 7 limited manpower, it can be challenging. But I do think  
 8 again, thinking about alternative ways, I believe it was  
 9 yesterday we heard from community pharmacists, they were  
 10 talking about, you know, how could they be more engaged  
 11 early. And I think one of the things that we've heard  
 12 in a lot of interviews with people about their  
 13 experiences, a lot of people wished they could have done  
 14 more, who were sitting at home, who felt like, you know,  
 15 I can contribute in some way. Help me find a way to  
 16 contribute, and maybe there were more able people in  
 17 that -- a remote community who could help get better  
 18 access, who might be more mobile, who might be able to  
 19 help on that.  
 20 I think -- I'm not giving an easy answer because  
 21 really I don't know the communities themselves but just  
 22 in general, I think the more we can try to engage  
 23 locally. And again, that doesn't have to wait and  
 24 shouldn't wait for another crisis.  
 25 **Q.** Well, that helpfully leads into the second question  
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1 halls, retail parks, et cetera, some distance away. And  
 2 looking to assist her Ladyship in the future, we're  
 3 wondering whether or not we should go back to the other  
 4 model --  
 5 **A.** Yes.  
 6 **Q.** And given what you've said about locality and given what  
 7 you've said about using trusted figures, would you agree  
 8 that it might be best to return to a system which places  
 9 people close to vaccines, with trusted members of the  
 10 community delivering it?  
 11 **A.** I would absolutely support any effort that tries to  
 12 bring the vaccines or, frankly, other health services  
 13 closer to the people that need them.  
 14 **DR MITCHELL:** I'm obliged, my Lady.  
 15 **LADY HALLETT:** Thank you very much indeed. I'm very  
 16 grateful.  
 17 That completes the questions. That last furlong has  
 18 now been run. Thank you very much indeed for your help,  
 19 Professor, I'm very grateful to you. And although,  
 20 obviously, Mr Keith wasn't able to go, in the time  
 21 available, through all of the report -- probably to your  
 22 relief -- I will make sure that all of the relevant  
 23 matters in it are covered and I'm advised on them by  
 24 Counsel to the Inquiry. So I'm really grateful to you.  
 25 **THE WITNESS:** Thank you very much.  
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1 that I wanted to ask you about. You said in your  
 2 evidence just earlier that people might ask, "Why am  
 3 I going to a tent, why aren't I going to my doctors?"  
 4 And yesterday, her Ladyship heard in Scotland a new  
 5 system is in place where doctors no longer give  
 6 vaccines, and that's, I think, been in place since  
 7 April 2022.  
 8 The question that I would like to ask you, based on  
 9 the fact that people are now no longer going to their  
 10 doctors for vaccines, would it assist in combating  
 11 hesitancy amongst those in rural and island communities  
 12 for the vaccine to be delivered at the most local level  
 13 possible, such as their GP surgery?  
 14 **A.** I didn't actually hear everything, but I do think  
 15 getting -- whether it's through a local GP or  
 16 a pharmacy, the more we can bring vaccines closer to  
 17 people is only an asset.  
 18 **LADY HALLETT:** I was surprised, and Ms Mitchell obviously  
 19 spotted that I was surprised, yesterday to hear that the  
 20 system -- basically in Scotland, they've moved to the  
 21 vaccination centre/clinic model, and so your GP doesn't  
 22 give you your vaccine.  
 23 **A.** Oh boy, yeah.  
 24 **LADY HALLETT:** That's the basis of the question.  
 25 **DR MITCHELL:** People are invited, for example, to attend  
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1 **(The witness withdrew)**  
 2 **LADY HALLETT:** Very well, 10.00 tomorrow, please.  
 3 **MR KEITH:** Thank you, my Lady.  
 4 **(4.11 pm)**  
 5 **(The hearing adjourned until 10.00 am the following day)**  
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