Thursday, 16 January 2025

(10.00 am)

LADY HALLETT: Ms Stephenson.

MS STEPHENSON: Good morning, my Lady. The first witness today is Dr Salman Waqar.

DR SALMAN WAQAR (sworn)

Questions from COUNSEL TO THE INQUIRY

MS STEPHENSON: Good morning.

Please can you say your full name.

A. It's Salman Waqar.

Q. Dr Waqar, thank you for attending today to assist the Inquiry. A few preliminary matters. Can I just ask you to speak up, keep your voice nice and loud and directed towards the microphones and speak slowly, please.

You have made a witness statement on behalf of the Federation of Ethnic Minority Healthcare Organisations, dated 6 June 2024, INQ000485278. Can you confirm that you've read your statement recently.

A. Yes.

Q. And are its contents true?

A. They are.

Q. I just want to touch briefly on some background matters. You are a practising GP; is that right?

A. That's right.

Q. You hold a number of senior training roles and

fellowships and you're one of the founder members of FEMHO as I'm going to call the organisation?

A. Correct.

Q. FEMHO, briefly touching on the nature of the organisation, is a voluntary multi-disciplinary consortium, so it comprises of over 55,000 individual members, belonging to 45 organisations and networks, and brings together organisations on behalf of black, Asian and minority ethnic health and social care workers at all levels within health and social care; is that correct?

A. That's correct.

Q. Can you just set out for us what the aims of FEMHO are?

A. So we are healthcare workers who have been working in our day jobs in the system but also a part of the communities that we hail from, so we recognise many of the issues that affect us. So we are trying to address some of those structural issues that impact us and to try to offer solutions in a workable way to the system. So we engage with the health policy individuals and organisations as well as back to our communities as well.

Q. Thank you. And --

LADY HALLETT: Dr Waqar, I'm terribly sorry, it's probably my age -- you'll be able to tell me as a GP -- if you

could speak up I'd be really --

A. Sorry.

MS STEPHENSON: If we can begin with one of the most fundamental of areas of concern that you raise within your statement, which is the issue of historic mistrust amongst ethnic minority communities.

Your statement explains how those historic experiences have fed into mistrust of the healthcare system and of vaccines, as we're looking at obviously in this module in particular.

Can you explain, please, how some of those past experiences contribute to lack of confidence in vaccination programmes.

A. Certainly. So I think it's important to recognise, as the Inquiry has vitally heard in the past, that these are not new issues; these are historic. But they're not historic for us because they're lived realities as well. And we also have the skin in the game as well, if I may put it that way, in that we know that our relatives and ourselves experience disproportionate outcomes in many other areas. We know, for example, that if you're a black woman you're three to four more times likely to die during childbirth. So if you're carrying that into the pandemic, you're obviously going to be looking at this is and thinking: are the same things going to be

happening to our communities as well?

And I would say that there may be -- and this isn't an academic point, but I think there may be a difference between distrust and mistrust as well. I think you may have misgivings about a system but if you have more than misgivings, if you think the system is actively harming you, by evidence, by -- you can -- the evidence for that you can give through your lived experience, and through the fact that in the past, when it comes to vaccination, we have several examples such as the Tuskegee trial in America, such as -- in this country, in the UK, we had radioactive chapatis given to ladies in the sixties without their consent, these things filter through the generations. And so when we are exposed to the Covid-19 Inquiry, as we set out in the evidence as well, I think those things are very much at the tip of people's thoughts, and they drive the behaviours that they -- that we saw in many of these communities.

Q. Thank you. Can I just ask you to slow down in your answers so that the stenographers can record your evidence in full.

You cite as a factor in eroding trust the use or misuse of personal data of ethnic minority people as being an experience that's been reported to you. How does that feature in the issues that you've just talked

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

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

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

programmes?
A. Sorry, yes, that's correct, yes.
Q. You also refer to the rapid development of vaccines, as many of your members saw it, as a factor affecting trust and confidence in the Covid vaccines. Can you explain how the speed of development fed into issues of trust?
A. On the one hand it was phenomenal that we managed to do that, as a nation, as humanity, that we were able to put those vaccines to market. But when you're dealing with a community which has got these issues around where are you going with this? What is the ultimate goal of this? When you have other people out there that are taking advantage of that, which I know you'll talk about in a moment, around communications, it just means that if that's not appropriately communicated, that just enhances that divide that people have in terms of understanding what those -- why has it come about so quickly, and have we made some shortcuts here and could that potentially harm our communities more, given the fact that -- what we know about the historic issues that affect them.
Q. So really it's about communities being satisfied that all the proper safety procedures have been followed, and that this has followed a thorough course of trials and regulatory approval?

A. Correct, yes.
Q. That brings us on to, then, the issue of clinical trials and diversity in trials. It's a concern that you highlight within your statement that there has been a historic issue of underrepresentation in clinical trials. Can you expand on why that was a significant issue for the communities that you speak for in terms of Covid vaccines?
A. So when you are communicating to people about any sort of therapy, you want to reassure them that this is the right therapy for them and any risks are outweighed by the benefits that they will have, and often people will ask questions around safety, as you've alluded to, and people want to know, is this right for me and people like me, given all these things that we just discussed about around the inequalities that they experience.

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

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

And we know that ethnic minority communities have got inequalities, as I mentioned earlier, and these social determinants of health don't necessarily come forth in the way the data are presented, and so when we put that to communities, it's important that we're able to say that these medicines, these vaccines, have been tested on people like yourself, and that's why you can have more confidence in the data that they show around the safety and effectiveness.
Q. So would it be fair to say it's not just about ensuring that the trials include a representative group from society, but also that healthcare professionals who are giving people information about the vaccines are well informed enough to be able to tell them that people, to borrow your words, who are like them, have been included in trials?
A. Correct.
Q. I want to move on now, please, to the effectiveness of the post-marketing surveillance systems for the vaccines. So starting with the Yellow Card system. How would you describe the level of awareness and understanding of the system amongst the communities that

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

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

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

other therapies in the future.

Could we look, then, at having identified the problems that you have with the Yellow Card system. What are some improvements that you might suggest to make it more inclusive?
A. So, as I mention, I think the translation element is certainly one that warrants further exploration. I'd like to come on later about some of the limitations of translation later in my evidence, if I may. But I think it is important for communities to know that this is available to them, but the way that those -- the Yellow Card is available, for example, if you go to your pharmacy and you wanted to report something to your community pharmacists, are there mechanisms in place there where those trust relationships do exist, particularly in communities where community pharmacies are particularly well anchored into those localities for people to be able to express their concerns about the medicines that they're taking.

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

examples of how the Yellow Card could be improved.
Q. You touched already on communication and accessibility of communications and that's the next topic I would like to come to. The words that you use in your statement are "inexcusable paucity of accessible communications" when it comes to information about the vaccines and how to access them.

Could you expand on that, please. What were the difficulties encountered?
A. I think this -- this, for me, I think brings everything together. So when you have got the situation where we are in, where there is -- where there are existing historic inequalities you've got the issue around distrust and mistrust in the system, you've got systems that may not necessarily be set up well to pick up some of these signals, all the issues that we've identified. I think it then is incumbent upon us to try to identify effective mechanisms to proactively address those. And so I think because the visibility wasn't there, we weren't able to see effective communications come forth.

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

something that is completely nonsensical.

So this BS principle, if I may call it that, is something we saw a lot of. And I say that because for our communities to actually exert that extra effort was an order even greater than what someone else would have to do because we're dealing with so much more issues in our communities to tackle.
Q. Are you referring here to misinformation, or misleading or false information about the vaccines that might take hold and the difficulties in counterbalancing that? Is that what you're referring to?
A. Yes, but also the fact that much of the misinformation had in it kernels of truth, and how do you disentangle the truth from the misinformation is what became a real challenge for us, given the fact that we didn't necessarily have the resources to be able to do that because, as we set out in our statement, that it became incumbent upon us to go out into communities and to do that work on behalf of Public Health England and other agencies.
LADY HALLETT: Sorry to interrupt, Ms Stephenson. What resources would have helped you? It's really difficult, once misinformation gets out there on social media. So how could anybody have assisted you in stopping the spread of misinformation and correcting the position?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Does my Lady have any questions?

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

THE WITNESS: Thank you.

(The witness withdrew)

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

MS YVONNE MACNAMARA (sworn)

Questions from COUNSEL TO THE INQUIRY

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

THE WITNESS: Thank you for inviting me.

MS STEPHENSON: Please can you say your full name.

A. Yvonne MacNamara.

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

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

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

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

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

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

A. That's correct.

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

A. Yes, that's all correct.

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

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

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

A. Yes, yes, similar but different.

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

A. It's a difficult one, a very, very difficult one. I mean, we have the data from the census, the ONS, and there is a very crude Gypsy caravan count which identifies 260, currently, caravan sites in the UK. That's a very crude way of doing it. But we estimate that we're probably looking at over half a million people.

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

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

A. Yes.

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

A. Yes.

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

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

In relation to the literacy, a lot of that would

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

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

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

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

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

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

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

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

A. Yes.

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

A. Yes.

Q. -- these communities?

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

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

A. Exactly.

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

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

Q. So that --

A. Absolutely.

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

A. Yes, absolutely.

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

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

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

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

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

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

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

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

mobile health service, that is an outreach. You're building the relationship with local communities.

As part of a programme like that, you can also develop your education, programmes around that, because people get to know that health worker, they get to know when the mobile service is coming, they can ask the questions they need, they -- there would be regular contact, so they're more familiar with the need for vaccines. They're also kind of getting -- building up their health and wellbeing in so many different ways because they're getting proper health, you know, so they're getting access to dental care, they're getting access to health and wellbeing in so many other different ways, they're becoming aware, so that when something like a pandemic happens, they're much more familiar with the health system and who people are.

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

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

Can you tell us about that concern, please.

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

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

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

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

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

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

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

A. Vital.

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

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

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

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

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

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

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

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

A. Exactly, in Scotland --

Q. -- who have assisted the Inquiry.

A. -- and not here.

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

A. Yeah, you can --

Q. -- in government data?

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

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

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

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

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

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

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

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

rumours --

A. Yes.

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

A. Yes, misinformation.

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

A. Yes, absolutely, absolutely, yeah.

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

A. Yes.

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

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

this, because the relationship wasn't there previously, with the health services.

Q. And what changes do you think could be made to address that?

A. Well, I think, moving forward, building trust with the community before any public health crisis, you know, and as I mentioned earlier, as the saying goes, there is no point in building the ark when the flood has happened, but trust can be fostered through sustained outreach, culturally appropriate services, and inclusion of Gypsy, Roma, Traveller advisers in policy making.

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

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

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

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

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

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

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

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

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

My Lady, do you have any questions?

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

THE WITNESS: Okay, thank you very much.

LADY HALLETT: Thank you.

(The witness withdrew)

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

MS LARA WONG (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 4

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

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

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

please, by giving us your full name.

A. My name is Mrs Lara Wong.

Q. Thank you very much.

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

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

A. That's correct.

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

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

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

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

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

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

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

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

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

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

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

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

They are not recognised as an equality group, they

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

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

Q. Because of Covid-19?

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

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

A. Very much so, yes.

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

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

Access to antivirals has always been hugely

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

So, yes, we have been let down.

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

A. Yes.

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

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

2,600 people on Facebook.

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

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

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

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

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

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

Q. Right, thank you.

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

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

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

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

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

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

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

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

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

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

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

prescribe the precise means by which vaccines are delivered, that must be left to the specialists and clinicians, the administrators, vaccinators, and so on, but you would say, I expect, going forward in the future, systems setting up the delivery of vaccines have to pay closer attention to specific and slightly unusual, but no less worthy, needs of the clinically vulnerable?

A. Yes, and we would like people to be informed of how to reduce their risks. So wearing better masks, these close-fitting masks that don't -- that filter the air coming through and massively reduce people's risks, 99% for an FFP3 mask, 95% for an FFP2 mask. People were never informed about these. When they attended vaccination centres they were given a paper mask and they may have been asked to remove a better mask. The same problem we saw also in healthcare.

Q. All right. By the time the booster campaigns commenced, Mrs Wong, obviously the system had bedded down to a very greater extent, but there appeared to have been considerable difficulties with an understanding of the eligibility for boosters. What was the problem there? Why were your members so concerned about the rollout of the booster campaign?

A. So the booster campaign was problematic, certainly,

and -- sorry, are we talking about the third primaries?

Q. We are.

A. We are, okay, just to clarify. So third primary doses were only offered to a small group of severely immunosuppressed that we have mentioned previously, and it wasn't widely known that this third dose was on offer. They very often did not know that they were within this group, and whilst CVF was very good at informing our members who might be eligible for this, people were -- found it very difficult. They attended these vaccination centres, they would have to self-advocate, bringing documents and things with them to prove that they might meet these criteria, that they had certain medications or that they had certain conditions that should qualify. But even when they did attend those vaccination centres they found very often that the staff did not necessarily understand that even this was something that was on offer, or how to report it or record it within the NHS computer system.

Q. Right.

A. So they were overwriting people's records. Sometimes they'd overwrite and then they'd have the wrong date for their last dose and then there was a knock-on to their future doses. If they didn't record it properly or record it at all, then the six-month gap that they were

expected to have for subsequent doses, there was an impact there.

Q. Right, so there are issues there which overlap data, overlap communication, knowing what their entitlements were in terms of eligibility, and also the practical mechanics of delivering the vaccination on the ground?

A. Very much.

Q. And an important part of your statement, indeed much of your statement, is concerned with the issue of therapeutics. The Inquiry obviously cannot become concerned in directing clinical groups, NICE, the NHS, the many bodies which are concerned in the process by which therapeutics come to be trialled, authorised, and then made available. But in the context of the Covid pandemic, the very great problem faced by your members was that ultimately, there was simply not sufficient access to you, or eligibility for, as wide a range of therapeutics and antivirals as would have brought them health and support, and given them a greater degree of protection; is that the nub of it?

A. I would say with regard to range it very much depended. So some treatments, for example, Paxlovid, are not suitable for many clinically vulnerable people. They are very good for older, healthier people, but there are many contraindications for that particular medication.

So the need for different antiviral treatments certainly was there, and --

Q. I mean, in your statement, Mrs Wong, you make plain that there were obviously a number of therapeutics authorised and made available, authorisation and being made available aren't the same topic, of course, but eventually there were a number of therapeutics that made it to the end of the process, and you describe Paxlovid, nirmatrelvir and ritonavir, there was sotrovimab, the Xevudy therapeutic, and importantly, Evusheld, which is tixagevimab and cilgavimab. We've heard some evidence, and we'll hear a great deal more evidence about the Evusheld decision, but what your members were concerned about was why, in particular, Evusheld wasn't made available and why there weren't other antivirals and therapeutics made available despite the prospect that they might be. Is that the heart of it?

A. Okay, so to kind of put Evusheld within sort of the context of this, Evusheld was more sort of similar to a vaccine for the group of people.

Q. It was a prophylactic --

A. It was a prophylactic --

Q. -- (overspeaking) --

A. -- treatment, exactly. It was not post-infection treatment, and so it would have levelled the playing

field for these people. It would have given them the freedoms that other people received through their own vaccination, and the consequence of not protecting this group was phenomenal in terms of their mental health, in terms of their social connections, in terms of their general ability to re-engage with the rest of the world.

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

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

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

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

Q. All right.

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

Q. Because they suffered from pre-existing conditions.

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

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

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

A. So it wasn't just that.

Q. But it included that?

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

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

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

A. Very much so.

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

MR KEITH: Thank you very much, that was very fairly put. Those are all the questions I have for you.

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

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

THE WITNESS: Thank you very much.

(The witness withdrew)

(11.24 am)

(A short break)

(11.45 am)

LADY HALLETT: Mr Keith.

MR MATT HANCOCK (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 4

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

So thank you for your help.

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

LADY HALLETT: Thank you.

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

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

Q. Thank you very much.

A. -- until June 2021.

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

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

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

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

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

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

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

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

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

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

So it was an extraordinary team effort.

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

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

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

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

Q. That team was led by Robin Shattock?

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

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

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

A. Yeah.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yeah.

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

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

Q. Quite, but it's a policy.

A. Yes.

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

A. Yes.

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

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

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

A. Okay.

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

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

A. Yes.

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

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

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

Q. Can you say why?

A. It's very hard to know.

Q. Or in what way?

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

system having got tougher.

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

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

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

A. Yes.

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

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

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

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

A. Well, we do, actually.

Q. Mr Hancock --

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

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

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

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

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

A. No, but it is important --

MR KEITH: With respect --

A. It is not outside --

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

A. Yes, but --

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

A. Yes.

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

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

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

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

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

Q. All right --

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

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

A. Yes.

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

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

Why was having a proper clinical testing infrastructure so important to this process of identifying vaccines and therapeutics and getting them produced, manufactured, and delivered?

A. Because it is vital to base your decisions on vaccines and therapeutics on proper clinical science, and given the desperation for solutions, there were many solutions put forward before they had clinical validation, most famously the idea that hydroxychloroquine could protect you from the impact of Covid. And I was very strongly of the view, of course supported by the CMO and the scientific bodies, that we needed to make sure this was based on science, and clinical science requires clinical trials to validate.

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

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

Q. And the manufacturers have to be able to have their product tested?

A. Yes.

Q. So the more that can be done by, for example, the United Kingdom --

A. Yeah.

Q. -- to test possible therapeutics and vaccines --

A. Yes.

Q. -- the greater assistance it will be to the manufacturers?

A. Yes, and not only the manufacturers of new drugs, but as we discovered, it was the repurposing of existing old drugs that actually, with dexamethasone in particular, came to the fore in a life-saving way. So this was directly on the critical path to saving lives.

Q. So if we look at this page, and in particular paragraph 5 at the bottom:

"These calls will contribute to the global response by actively collaborating with and being informed by the WHO's Global Coordinating Mechanism ... for [Research and Development ... and (GloPID-R) ... and (CEPI)".

So being well prepared to carry out the clinical

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

A. The UK and the global response, absolutely, yes.

Q. All right. In terms of therapeutics, there is much written evidence before the Inquiry, in particular from Sir Jeremy Farrar, Professor Sir John Bell, and Dame Kate Bingham, that by contrast, perhaps, to the overall co-ordination of the vaccination research and development, the system by which the trialling, particularly the phase II trialling of therapeutics, worked rather less well. There were a great deal many trials. There were a lot of academic bodies, perhaps tripping over each another, there were a number of wide-ranging disparate interests from industry and it didn't appear to have the same degree of co-ordination as the vaccine research and development; would you agree?

A. I don't actually agree with that. The programmes were run differently. On therapeutics, it was run much more within the department, it didn't need the breadth of scope. There's a perfectly good debate we can have about the value of bringing in highly capable, independent externals with -- given a huge amount of

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

It is, by its nature, a messier area in therapeutics. So I can see why it might have looked like that, but it was still incredibly effective.

Q. That may be so, but it's apparent from this evidence that it didn't just look like that; there were too many underpowered phase II trials; there was a degree of tension between the DHSC and the BEIS, the two government departments, over who was in charge, and also, a real problem with recruitment, because there was an absence of proper co-ordination and management in terms of getting people into these trials for therapeutics. You must have been aware of that?

A. Yes, but I was also aware that we were running the largest, fastest recruited trial that had ever happened, and came up with the first clinically valid therapeutics. So I think it's quite hard to -- so at the same time, it's possible to say yes, it could have been done better, but it also worked very, very effectively and saved many lives.

You know, the same is true on the vaccines side. There are many points of detail which could have been done better, but it worked overall very, very effectively, because of the effective co-ordination and teamwork between the four groups I spoke to about earlier.

Q. Quite so. We're looking to see how it could have been done better.

A. Yeah --

Q. -- but --

A. -- from my seat I didn't really, I don't really -- (overspeaking) --

Q. It was going as well as you thought it reasonably could?

A. That's right, even if there was -- there's always noise under the surface in these things when you are moving very quickly.

Q. It's obvious that there was a debate about whether or not therapeutics generally as opposed to neutralising monoclonal antibodies should be within the remit of Dame Kate Bingham's Vaccines Taskforce?

A. Yeah.

Q. And ultimately the position was reached that monoclonal antibodies would be within the taskforce --

A. Yes.

Q. -- but the therapeutics would go off to a DHSC, entirely

DHSC, body --

A. Yes.

Q. -- the therapeutics taskforce. So it didn't have, ultimately, the same degree of external influence as Kate Bingham's Vaccines Taskforce.

Do you think in future it would be better if the therapeutics taskforce was to be put together, if it is utilised, in the same way as the Vaccines Taskforce was utilised by, and managed brilliantly by, Kate Bingham?

A. Well, remember, the therapeutics work was managed brilliantly by JVT, so we had very strong leaders on each. It was very clear to me as Secretary of State who I went to in each case. And, you know, it's perfectly reasonable on the therapeutics side to point to points of detail that could be improved, but overall it was absolutely brilliant.

Precisely the same analysis applies to the vaccines. You know, there were debates about exactly how many we needed to order. I thought we needed to order for the whole population, some argued only for a subset of the population.

These are -- it is correct to have these debates, and entirely reasonable, and that happened on both sides. So I don't really buy this distinction you're trying to draw.

Having said that, I'm a big fan of the strongly-led "bring in the experts" model, and I think the more external expertise you have working alongside civil servants, the better, so long as the accountability is right and the direction of travel and leadership is set. And I think, you know, the VTF demonstrated that.

Q. You've referred to the process of procurement and obviously the range of vaccines that the Vaccines Taskforce was able to procure. I was asking you, though, about the system by which government puts into place a body or an entity to be in charge of it.

A. Yeah.

Q. So can I press you on that? It appears to be generally accepted that the VTF did extremely well. The Therapeutics Taskforce and its successor the Antivirals Taskforce did very well also, but there were distinct problems, it would appear, about the co-ordination and management of the clinical trial process and the way in which antivirals and therapeutics were procured ultimately. The system did not move and work as smoothly as it had for vaccines.

A. No, I reject your characterisation into two different groups. There were -- both worked brilliantly, had clear accountability, from where I sat, and both had an enormous amount of work going on underneath, some of

which was noisy, and there were reasonable disagreements about process and there were things that could be improved.

You know, for instance, if you look back, there was an enormous amount of noise and criticism around some of AstraZeneca's clinical trial work during the summer of 2020, especially when the case rate fell very low in the community. And that was on the vaccine side.

So I just think you're wrong to characterise it as one went really well and one went really badly.

Q. No, Mr Hancock, I said they both went --

A. No, you literally said that.

Q. No, no, no, no, I said the Vaccines Taskforce operated extremely well or very well. I said the Therapeutics Taskforce overall also worked very well, but there were problems --

A. But there were on the vaccine --

Q. -- with the --

A. Yeah, but -- there were on the vaccine side as well. And what we did was we worked through the problems that we found.

And then you also asked about the boundary between the two and where antivirals fell. In essence, my view was it didn't really matter which side the -- where the boundary lay, so long as it was clear. And I remember,

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

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

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

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

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

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

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

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

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

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

Q. Quite.

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

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

A. Industrial strategy.

Q. Innovation and strategy?

A. Industrial strategy.

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

A. Yes.

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

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

good.

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

Q. Quite.

A. It wasn't a blanket.

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

A. Okay.

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

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

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

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

Q. In general terms, I don't want to get into the specifics of the indemnities that were agreed, but was the position taken by the United Kingdom particularly or significantly different from what ultimately was negotiated between the manufacturers and other particularly western European countries?
A. I don't know.
Q. All right. Do you consider that ultimately what was agreed with the manufacturers in terms of indemnities was reasonable and proportionate, given the need to get vaccines manufactured and developed?
A. Yes.
Q. Right. Evusheld. You've referred to Evusheld. Evusheld was, I think, Project Astronaut, it was also known as AZD7442, and just by way of summary, in June 2020, you'll recall that the Vaccine Taskforce agreed provisionally with AstraZeneca to buy a large number of this drug, a long-acting antibody, and that was announced, in fact, by the government in July 2020.

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

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

A body called the VTF Panels Team wrote to yourself and a number of others on the 17 February 2021 enclosing an attached decision paper for ministers -- that's obviously you and Alok Sharma, I'm assuming.
A. Steve Barclay.
Q. Oh, Steve Barclay, thank you.
A. The VTF reported to the three of us, yeah.
Q. "Please find attached decision paper for Ministers on whether the VTF should proceed with the advance purchase of Astronaut antibody treatment. The VTF recommendation is that Ministers agree that VTF should not proceed with the purchase agreement."

Did you in fact receive a number of papers and documents from the VTF and also from the Office of the Chief Medical Officer about the merit of proceeding with advance purchase?
A. Yes. This was a live discussion, because of the importance of antivirals. I mean -- and the antibody treatments, because we knew that the vaccine would not be medically suitable for everybody, and yet we needed a solution for everybody. And in fact, I was at the forefront of the argument that we needed a protection for everyone. Some people said we should only protect the clinically vulnerable. I believed and strongly

believe, with hindsight, that it's right to protect the whole population. If you can't take a vaccine, therefore you need another protection. So I was keen to find an antibody treatment that would work, but when the clinical advice says that we should not proceed, that is obviously a reasonable clinical decision.
Q. And was the advice from the VTF, was the advice from the Office of the Chief Medical Officer, the clinicians and the policymakers organisational all, in fact, pointing in one direction: which was for a number of reasons, this advance purchase should not be made?
A. It was clear and unambiguous on the clinical grounds. My recollection is that it was because the shelf life was relatively short but it was going to take several months before we had clinical validation and therefore if we bought at that point, we weren't to know whether clinical validation would come forward and if it did, anything we'd bought early would by then be out of date. So it was essentially a logistical/clinical decision/explanation that was given to me behind the recommendation not to buy, and when faced with unambiguous clinical advice, I tended to follow it.
Q. And there were a number of other reasons, which I'll summarise for you. Professor Sir Jonathan Van-Tam in particular said that given the background of the

emerging success of the vaccination programme the need was perhaps, to some extent, not a great extent, reduced. There was also a lack of clarity as to how many people might benefit. It was a relatively expensive purchase but that it was important to keep the whole decision under review, particularly for treatment purposes after the event?
A. Yes. Remember, this is a decision, the one in front of us is a decision not to proceed with an advance purchase --
Q. I said that, yes.
A. -- before clinical validation. You know, I have friends who couldn't take the vaccine for clinical reasons. I understand why there was a big push for that by those in that position, and I agreed with that. But there's no point in buying something that might not work if the clinical advice is not to because if we buy it now, the stuff we -- anything we actually physically buy now won't be available because it'll be out of date by the time it could be used.
Q. There are many people who have suggested to the Inquiry that thereby the immunosuppressed and others would have benefited from it were essentially ignored or abandoned, and I want to make it plain -- can we have, please, INQ000066717 -- that although the decision taken by

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

A. There you are.

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

A. Yes.

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

A. Yeah.

Q. So the issue was not forgotten?

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

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

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

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

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

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

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

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

There was an issue in February 2021 about the definition of cohort 6, that's to say number 6 and a list of prioritised groups in the phase I priority list issued by the JCVI, which concerned those persons who were in receipt in a Carer's Allowance or those who are the main carer of an elderly or disabled person whose welfare may be at risk if the carer falls ill. And there was quite a complicated structure in place because there is also something called the Green Book, which is a semi-medical publication which gives a description, of, amongst many other groups, "adult carer".

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

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

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

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

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

"We recommend that you:

"Note the method of implementation ...

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

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

And then note of final issue.

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

change in the proposed definition of unpaid carers, but as, as you say, this was something very much within their expert subject matter.

A. Correct. It was my formal authority to make this decision. However, having asked them to come forward with advice on what is the best way to save the most lives, I then took that advice, rather than second-guessing it.

Q. A second issue which came to you concerned people with learning disabilities. In your diaries, your book, you refer to quite a difficult issue in February 2021 --

A. Yeah.

Q. -- concerning whether or not only those with severe learning disabilities were getting prioritised, and there was a real problem with whether or not local GP registers and other NHS systems were properly recording who was -- who suffers from learning disabilities.

A. Yes.

Q. Do you recall how that was resolved?

A. Well, I -- my recollection is that this was a really important boundary issue. All of these are difficult judgments on where the boundary with a group should be, given that the people who are deemed within that boundary then get access to the vaccine, which is life saving and incredibly valuable.

I know about the areas of learning disabilities very well, not least because I'm a campaigner on neurodiversity. I am dyslexic. That is technically a learning disability in some senses. I did not deserve an earlier vaccine because of my dyslexia, but those with severe learning difficulties were dying at a greater rate than the general population and it was evident that you could save more lives by ensuring that they did. Where is the boundary between a perfectly fit and healthy dyslexic and somebody with perhaps permanent inpatient care with severe learning difficulties? We had to find a boundary somewhere.

Q. Was it apparent to you that the foundation of this problem and what became a definitional debate, lay in part in the fact that GP systems, the data systems at GP level, didn't always capture the severity of someone's learning disability?

A. Yes.

Q. So it was impossible for anybody to say they are entitled to prioritisation because they have condition A?

A. Yes.

Q. Whereas Y doesn't --

A. Yes.

Q. -- and therefore --

A. Yes, and it's even worse than that because many learning difficulties and disabilities are defined essentially educationally, and in the world of Whitehall and the UK Government system, that becomes a piece of data in their education record, not in their health record, and so if you go into their health record you might not find any reference to it. So it's a very complicated area, and, frankly, it could do with a huge amount of improvement.

Q. This is what I wanted to ask you. There are obviously a huge range of issues here from the simple fact of accuracy of recording to the integration of data systems --

A. Yes.

Q. -- as well as, of course, whether they record disabilities and medical conditions, as well as sectorial differences --

A. Yes.

Q. -- ethnicity --

A. Yes.

Q. -- and the like. But can you help us with this: when this problem about registration in GP registers of severity of learning disabilities came to your attention, was anything done at that stage concerning the operation of these data systems? Was it possible to

address --

A. Yes.

Q. -- the overall system at that time in the teeth of the pandemic? Was anything done to try to improve the overall efficiency and accuracy of this system --

A. Yes.

Q. -- the GP --

A. Yeah --

Q. -- registration system?

A. Yes. I mean, throughout the pandemic, as we've heard in other modules, there was a huge amount of data work done to progress the quality of data that was available to government for these sorts of purposes, whether that's, you know, in the shielding programme or in the measurement of the vaccine -- the virus itself, and the NHS, et cetera.

This is another area where there was some improvement but there's still a huge amount that can be done to -- to make these sorts of datasets more interoperable.

Q. That brings us on to the wider area, if you like, of barriers to uptake, equality of access to vaccination because plainly, and it's obvious, despite the overall success of both programmes, there are very real difficulties concerning delivery and access.

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

A. Yes.

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

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

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

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

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

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

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

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

Q. We will --

LADY HALLETT: Can I just interrupt for a second.

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

A. Yes.

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

reduce inequalities?

A. Oh, yes.

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

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

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

proof point.

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

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

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

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

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

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

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

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

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

it, this degree of independence --
A. I know, it was good.
Q. -- so that it could operate outwith some of the well known strictures of Whitehall. So isn't that what needs to be replicated next time?
A. That's what UKHSA should do, yes.
Q. All right. Because it's not, of course, what the Therapeutics Taskforce had?
A. Yes, I mean, I'm going to come -- because you pushed me on this a lot earlier on the Therapeutics Taskforce. I think it's really important for the Inquiry to take into account the fact that because the therapeutics area was driven by civil servants, they are less likely to have a voice now in making an argument for how they did things.

And this is an important thing to consider across the Inquiry's work. Civil servants tend to be dry and cautious in their response to inquiries, as opposed to loquacious and -- (overspeaking) --
Q. As opposed to politicians --
A. -- in their views.
Q. -- Mr Hancock?
A. Indeed. Indeed. We're more freewheeling, I'd say.
Q. Yes, that's one way of putting it.

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

and therefore the more we can do to replicate the bits of the Vaccine Taskforce that worked, the better?
A. Yes, yes.
Q. All right.

A second element, finally, is this: Dame Kate Bingham and others recommend the institution of a vaccine national research registry, to register the willingness of those who participated or want to participate in vaccine trials?
A. Yes.
Q. Your department was -- played a very important role in ensuring that as many people would come forward for vaccine and therapeutic clinical trials as possible. Do you think there is an argument for the creation of a separate body to run, monitor and promote --
A. Yes.
Q. -- participation in trials, not least because of what we were discussing earlier about the problems with recruitment and the --
A. Yes.
Q. -- therapeutic phase II trials?
A. Yes, I would absolutely support the need for a register. Again, this is -- you know, if run well and with the right budget, this another role that UKHSA ought to play, and but the idea of a register is very important

so you don't lose that enthusiasm.

I would add one further thing. I've seen the recommendation here and I agree with it, the thing I'd add to it that is absolutely vital, and doesn't get enough airtime, is the need to set up challenge studies and have people who are willing to take part in challenge studies. These are studies where people are intentionally infected, because then you can seriously accelerate the clinical study work.
Q. This was in fact commenced by Clive Dix and Kate Bingham; they had something called, as you know well, human challenge trials, and I think the DHSC funded £33 million worth of the first phase of that programme.
A. Yes, I think it was actually JVT who kicked that off but it was, I think, I'm sure it was --
Q. But has it lasted?
A. I hope so.
Q. All right. But you don't know?
A. I don't know, but it should.
Q. All right. My final question, please. You've referred already to the importance of onshore manufacturing capability.
A. Yes.
Q. Plainly, there is no one practical measure that can be taken. It's obviously a very complex topic. But what's

your general position on this? Do you say that the onshore manufacturing capability in the United Kingdom has gone backwards since the pandemic or is your understanding that we are still in a relatively good position when it comes to the existence and presence of various sites of manufacturing bodies who can pick up the mantle in the event of a future pandemic?
A. We are in a much stronger place than we were at the start of the pandemic, but even during the pandemic, we didn't get to the point where we could manufacture everything we needed, and of course the speed of manufacture was the rate-limiting factor on the rollout of the vaccine. So there is not yet enough. I don't know whether it's gone backwards or advanced further since the end of the pandemic. What I do know is we still don't have enough, and the pandemic demonstrated the vital need for a sovereign capability that is onshore because the political issues will cause the same sorts of problems in future as they caused us during the pandemic.

And critically, one final point on this, back to this debate about how many vaccines we needed. We took the decision, against advice, to procure vaccines for everybody, for the whole country, which meant 100 million doses in the first instance. That was the

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

MR KEITH: Let's leave it there.

Thank you very much, Mr Hancock.

LADY HALLETT: There are a few more questions --

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

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

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

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

PROFESSOR THOMAS: I would be in trouble.

Questions from PROFESSOR THOMAS KC

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

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

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

I'm sure you remember the quote.

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

A. Yes, of course I do.

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

A. No, they were promoting illegitimate arguments precisely because of their highest infection rates amongst those groups, they would have been the greatest beneficiaries of vaccination, and an anti-scientific approach helped to make it harder for those of us who were trying to

save lives.

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

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

I think the difference between us is that you make the point -- you put forward that these concerns raised by the trade unions were legitimate. Actually, they were not legitimate because they weren't based on science. The right position that the trade unions should have taken was to join in the efforts to reassure, support, and encourage vaccination for those who were meeting a lot of vulnerable people, and who

could have had their own health safeguarded, and especially the health of those in their care safeguarded.

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

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

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

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

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

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

Q. Forgive me, forgive me. What has been suggested is

there'd be better messaging, better communication, so that people can better understand.
A. Yes.
Q. Bring people along.
A. I was in favour of all that as well, absolutely.
PROFESSOR THOMAS: My Lady, thank you very much.
LADY HALLETT: Thank you, Mr Thomas.
PROFESSOR THOMAS: You will excuse me.
LADY HALLETT: I will. Just try not to run too fast, you might trip over.
Ms Morris.

Questions from MS MORRIS KC

MS MORRIS: Thank you, my Lady.
Mr Hancock, I ask questions on behalf of the Covid Adverse Reaction and Bereaved groups, and these groups represent those who have suffered injury or bereavement following their voluntary acceptance of the Covid-19 vaccines. First of all, do you acknowledge that there are people who sadly suffered injury and bereavement as a result of accepting the vaccine?
A. Yes, of course.
Q. I'm going to focus my questions today on the issue of pharmacovigilance and specifically what systems were in place at the time of the rollout of the vaccines to identify and monitor occurrences of adverse effects and

whether they in fact needed improvement.
A. Yes.
Q. You understand. So my first question: at the time of the vaccine rollout, who, to your understanding, was responsible for overseeing the pharmacovigilance going forward? Was that the DHSC or other agencies?
A. Well, the majority of the pharmacovigilance occurred within the NHS and the NHS Yellow Card process was there to capture any adverse reactions, and then a data system was put in place to make sure that that information was fed in, and it came to me through the Chief Medical Officer, if I recall correctly. It was something we cared a lot about, we put a lot of effort into.
In the first instance the data processes were imperfect, but we improved them over time.
Q. It's that kind of first instance I wanted to ask you a bit further about, please. Can I ask you to look at a message exchange between yourself and Professor Sir Chris Whitty on 9 January 2021.
INQ000129666, please.
Thank you. You'll see there --
A. There you are.
Q. -- the WhatsApp messages there. You ask Chris Whitty:
"How strong is our pharmacovigilance system to check [the systems] post-rollout? I was told" -- and I think

that means -- "that we" -- so that means DHSC -- "were doing it but I worry that the details will be shonky."
Chris Whitty goes on to say they're reasonable but they need to get better.
A. Yes.
Q. He then says, "There will be cases".
A. Yes.
Q. Now, I can ask Professor Sir Chris Whitty about that but did you interpret him to mean there would be cases of adverse reactions?
A. It's unclear from this whether "there will be cases" means there will be cases of adverse reactions, although we knew that there would be.
Q. Yes.
A. Because there were in the clinical trials. The question with a vaccine is whether it is net positive in expectation of taking it, and they were only approved where they were net positive.
Q. So under --
A. Hold on. But the -- but he may have been referring to there will be cases like Ara Darzi where somebody gets a case after vaccination, because that was also at the time not known the extent to which, post-vaccination, people would get Covid. And, of course, we now know that people did regularly get Covid after a vaccine but

it tended to be much milder.
Q. Sure, but you would accept you knew there would be cases of adverse reactions?
A. Yes, of course.
Q. They were known about in the clinical trials?
A. And measured, yes.
Q. And that's why it's important to have an effective post-rollout monitoring system?
A. Yes.
Q. But what did you mean by "shonky"?
A. I was worried about the data collection systems and how that would be reported. And as Chris Whitty went on to say, "reasonable but needs to get better".
Q. So what specific examples or evidence did you have at that point, that you had in mind when you used the word "shonky"? What were the concerns you had?
A. The thing I was specifically concerned about was that you needed to make sure that when people had an adverse reaction, they reported it, and that those reports then fed into a data collection system that could assess the net effectiveness of the vaccine.
We came to see the pharmacovigilance system as effectively like a phase IV trial, as in you did the first three phases, got -- reached formal clinical validation, did the rollout across the population, but

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

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

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

A. Exactly.

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

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

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

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

Susan Hopkins being the chief medic at UKHSA.

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

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

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

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

MS MORRIS: Thank you.

Thank you, my Lady, those are my questions.

LADY HALLETT: Thank you very much, Ms Morris.

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

THE WITNESS: Thank you.

LADY HALLETT: I shall return at 2.10.

(The witness withdrew)

(1.08 pm)

(The Short Adjournment)

(2.10 pm)

LADY HALLETT: Mr Keith.

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

PROFESSOR HEIDI LARSON (affirmed)

Questions from LEAD COUNSEL TO THE INQUIRY for MODULE 4

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

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

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

A. Heidi Larson.

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

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

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

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

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

A. Yes.

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

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

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

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

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

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

A. Yes.

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

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

A. Yes.

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

I think assistant professors or research fellows at a number of august institutions but primarily the LSHTM?

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

Q. All right.

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

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

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

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

And the Inquiry has already had some evidence, Professor, about the accepted of the terminology, the phrase "vaccine hesitancy". We note that you describe the report as being into vaccine hesitancy. Ultimately, does the terminology matter? Does it matter whether we call it vaccine hesitancy, vaccine confidence, vaccine

scepticism, or anything else?

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

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

A. Exactly, yes.

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

A. Yes.

Q. So it's a very wide church?

A. Yes.

Q. And just on this point of the acceptability, there are some who say that one shouldn't use the phrase "vaccine

hesitancy". Does anything turn on that, in your professional opinion?

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

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

A. **(Witness nodded)**.

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

In truth, does it help to try to identify the main drivers, or is the picture rather more nuanced than that?

A. It's more nuanced but I think the only reason you want to understand what's driving it is if you want to develop some interventions to help address it. So if the issue is one of convenience and access, that's a different kind of intervention to increase vaccine acceptance, whereas if it's an issue of confidence or trust, that's a different kind of intervention. So to the extent that it helps you inform and change the picture, that's, I think, the most important reason for it.

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

A. Exactly.

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

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

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

And you identify them particularly in the context of

ethnic minority communities, migrants, people with disabilities, people with mental health conditions, vision impairments and hearing difficulties, and also asylum seekers and migrants, I think I have mentioned migrants already, how there are very prominent barriers which may prevent them from practically taking up a vaccine.

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

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

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

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

the Vaccine Confidence Project is trend data, the whole situation of vaccine hesitancy, in the last 10 years has become extremely volatile. In the environment with social media it's changing a lot.

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

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

A. Yes, that's correct.

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

A. That's correct.

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

A. Yes.

Q. And during the course of the pandemic and since, have there been numerous surveys across the United Kingdom including in each of the devolved administrations?

A. Yes.

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

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

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

A. The Vaccine Confidence Index has four components: confidence in the safety of vaccines, confidence in the effectiveness, do they work; confidence in the -- or the religious compatibility; and what we're doing right now is expanding on those domains to look at what else is important but it does give us at least a metric that we

can follow over time. But, of course, you do need still, if you do that at a national level, you still need to look locally because people's reasons are highly varied.

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

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

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

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

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

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

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

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

A. Yes.

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

A. It's a challenge, yes.

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

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

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

A. Yes.

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

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

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

A. No, there isn't.

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

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

A. That's correct.

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

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

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

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

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

A. Mm-hm.

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

A. Yes.

Q. Is that a fair summary?

A. Yes.

Q. All right. Thank you very much.

If we then go back, please, that's the issue of data. We can then pick up the thread, please, on

page 13 at paragraph 25.

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

A. That's correct.

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

A. Yes.

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

A. I think overall it was good, very good, for a long period of time, but over the last decade, pre-Covid, it

was slowly going down. The UK lost their measles elimination status, recovered it again. But there has been a slow trend. Now of course you can't put that all on vaccine hesitancy, it was a real mix of issues, but indeed there was relatively high but a slow declining trend.

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

A. Yes.

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

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

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

A. Well, losing measles elimination status means you start to get measles again circulating. And once that happens, you need to boost your immunisation. And we

were able, as the UK, to again get back to measles elimination, but the fact that it dipped was really an important flagging of the need for more attention.

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

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

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

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

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

A. Well, safety issues go back to the 1800s. So -- but I think that particularly around new vaccines, whenever there's a new vaccine or a new combination of vaccines, it's not uncommon, and it's -- I think it's reasonable to have questions when you have something new, people

want to understand, but you want to address the concerns and, here -- and build confidence.
Q. You've said that the issue of worry about safety is a longstanding one. Was there, once upon a time, in fact, a piece of English or UK legislation providing for mandatory vaccination?
A. Yes, in fact the first anti-vaccine group was actually not anti-vaccine, it was anti-compulsory vaccine, and it was around the smallpox vaccine. And it really was prompted by a mandate, particularly when they lowered the age to I think it was 16, and that created protests in the streets, not unlike some of the protests we saw during Covid. But what relieved the public a bit, and the protests, was giving people the opt-out, the option, and that at least made people feel like they had a choice.
Q. But did the process by which exemptions could be given widen and widen?
A. Yes.
Q. Further, more and more people asked for exemptions until the very effect of the mandatory inoculation act was completely undermined?
A. Absolutely.
Q. And was the general position that it came to be obvious that the more you mandate vaccination and immunisation,

the more you run the risk that there will be a backlash?
A. Certainly in the longer term, yes.
Q. All right. And that's important, isn't it, for the debate about vaccination as a condition of deployment?
A. That's correct.
Q. The second main driver you've already identified as being the position of, in particular, ethnic minority groups, who are prevented, for a variety of reasons, from full access to vaccination. And you identify at paragraph 23, don't you, some of those reasons? They're very diverse, are they not?
A. Yes.
Q. Could you give us some idea of what those drivers in particular ethnic minority communities are?
A. Well, some of the drivers are religious, things like, among the Muslim community, haram and halal, there's porcine, which is derived from pork, is used as a gelatine in some vaccines and there are some communities that do not want those vaccines and we need to think about alternatives. And then in other cases it is language. Some of it is beliefs, just also in different ethnicities and groups, cultural beliefs, but it is also distrust and feeling like they're marginalised and sometimes discriminated.
Q. We're going to come back to some of those, Professor,

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

And as you say, the general picture wasn't bad, it's quite favourable. But was there a general decline in routine childhood immunisation coverage between 2010 and 2019?
A. Yes, there was.
Q. And what do you assess was the reason for that?
A. Well, it was, to the extent we understand it, it was a mix of changes in the system, both delivery as well as some hesitancy but it was really a mix of factors and I don't think there was any one single factor.
Q. How did the United Kingdom, in relation to non-Covid childhood immunisation fare in comparison to other countries? Where do we come in the global comparison stakes? Where did we come in the global comparison stakes?
A. Not the highest globally but among the highest in Europe.
Q. You provide at page 20 some specific figures concerning how acceptance levels towards flu, so not childhood

immunisation but flu, influenza vaccine, have changed. Has that generally "not bad" position for childhood immunisation been the same in relation to flu vaccines, and has there also been a general decline in confidence?
A. Actually with -- and you're talking about adult flu?
Q. Adult flu.
A. Adult flu vaccine. Adult flu vaccination started to decline a bit, but with the news of Covid it got a real boost because particularly before we had a Covid vaccine, I think people felt like we'll get what we can, it's a respiratory virus, and so there's kind of an ironic boosting of the older adult confidence, while we had a more wobbly confidence among -- for children's vaccines.
Q. What was the impact of the pandemic, the Covid-19 pandemic, on childhood immunisation rates and on adult flu rates? Obviously they're different, but has there been an impact from the pandemic on those other pre-existing acceptance rates?
A. Oh, absolutely. I mean -- you're talking about uptake and not confidence, is that correct?
Q. I'm actually talking about both but you're quite right, I didn't make it absolutely plain.
A. Yeah.
Q. But let's deal firstly with confidence.

A. There was a real negative hit on confidence during the pandemic for the childhood vaccine, for the importance of the same Vaccine Confidence Index domains, the perceived importance of vaccine for children, the perceived safety, and effectiveness, dropped from being over 90% before Covid to being 70, 72%. That's a very significant drop in public confidence for childhood vaccines.
Q. And then what about uptake?
A. Uptake also declined, but some of that during Covid was access, for sure.
Q. And then what about adult flu?
A. Adult flu, as I said, there was kind of a boost in wanting to get a flu vaccine, particularly in the absence of a Covid vaccine, but that too has been wobbled a bit. There was a stronger decline among the childhood vaccines.
Q. Then in relation to uptake for adult flu?
A. Initially up, and then down.
Q. All right. Coming now forward, I won't say going forward, coming now to the pandemic period itself, on the cusp of the pandemic, so in December 2019, January 2020, and as the pandemic evolved, and we found ourselves in that terrible predicament, what was the general state of hesitancy or confidence towards taking

a Covid-related vaccine?
A. Well, I think initially there was a big -- a bigger appetite initially in the immediate crisis, in the immediate, kind of, shock to the system when they -- vaccines first became available, I believe December 8 was the first vaccine given, but particularly in January when they started to get more widely distributed, there was an initial positive eagerness for it, but that started to decline over time.
Q. It's obvious and common ground that there was a generally very high level of uptake in the United Kingdom. So if doubts were being expressed to any level before the pandemic or on the cusp of the pandemic, do doubts necessarily translate into an absence of uptake? So putting it bluntly, even if people say that they're concerned about a vaccine or unwilling to take one, does that necessarily mean to say that when it's offered, they won't?
A. No, it -- they might say that they would take it and they don't, and they might say, "No, I don't think I'd take it" but when push comes to shove and they might take it, and "I'll hesitate around the next one".
Q. So if the actual level of uptake was higher in percentage terms than the level that might have been thought to be the case --

A. Yes.
Q. -- defined by the people who expressed doubt or confidence beforehand, why does general levels of vaccine hesitancy matter at all?
A. Well, I mean, the reason we monitor it, and as I say, we monitor confidence, and if you have very low confidence, that's more the hesitancy, but the reason we monitor confidence is it's a predictor. It gives a system a heads-up that people's confidence is waning, and you should pay attention to it, and build confidence. It may or may not have an immediate effect but we see that if it doesn't go uncorrected, it does have an effect on uptake.
Q. So it may, over the course of time, become a practical problem --
A. Yes.
Q. -- if it's not addressed?
A. Not necessarily in the same moment, and that's what we -- that's why we picked that, was to try to be an earlier -- early predictor, a risk mitigator.
Q. So this is absolutely vital. You say on page 32 that as the practical reality of the rollout became more and more apparent, vaccine hesitancy declined. People were taking up the vaccine --
A. Yes.

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

So whatever the doubts were that were being expressed before the pandemic didn't necessarily follow through into a lack of uptake but in April 2021, a few months after the introduction of the vaccine, did vaccine hesitancy begin to increase again?
A. Yes, but we're talking about the Covid situation versus routine childhood vaccine, which is a much more stable state. And in the context of the hesitancy around the Covid vaccine, this was a highly volatile time, and when the first questions were being asked, people didn't see the extent of mortality and illness and, you know, the TV images of people, the amount of people dying, and what was going on, and that pushed, I think, more of an appetite for vaccines, but later on -- so, I think we have to keep in context the highly volatile epidemic environment that really affected people's decisions.
Q. And was there a broad similar picture across the United Kingdom, or did that decision-making process or appetite, as you described it, vary between different sectorial groups, religion, socioeconomic features, educational levels, and no doubt age as well?
A. Yes. Absolutely.
Q. And was there data available during the course of the

pandemic, in the early part of the pandemic, showing the degree of hesitancy or lack of appetite between those various sectorial groups?
A. There was some, but the reality is it's the same groups that had issues before the pandemic.
Q. So there was a crossover between barriers to access and degrees of vaccine hesitancy between childhood immunisation, flu, vaccine uptake, and Covid?
A. What did change during Covid was hesitancy. We saw -- and we'll probably get on to talking about this, but there was a pretty dramatic change, which is not typical pre-Covid, around with young, like, 18- to 24-year-olds. That took a different trend that was totally different than before Covid.
Q. Could you please have a look at page 35, and paragraph 76. Has the area of the impact of vaccine side effects on attitudes to specific vaccines been extensively studied? So we've -- I've asked you some questions already about data collation, but is this an area on which there is a clear picture?
A. Yes, there's been quite a bit of attention to it and alongside of the changing epidemic or Covid disease environment, was also the beginning of some of the safety issues being announced. All of this changing information that people had, including these safety

events, did affect people's hesitation or willingness.
Q. Then what about the four nations? Were there differences in levels of hesitancy between the four nations in relation to Covid-19 before the uptake -- before the rollout?
A. Yes, for the same diversity reasons. A lot of these issues have subpopulation characteristics.
Q. I think there were particularly high levels of vaccine hesitancy in parts of London, overall lower levels of hesitancy in Scotland, Wales, Northern Ireland than England. London appears to have been a bit of an outlier, perhaps associated with its population. But there was nevertheless a strong correlation between pre-vaccine rollout predictions and observed uptake?
A. Yes.
Q. So such hesitancy as there was, didn't necessarily translate again into lack of uptake.

Did that data show also, in the original or the initial assessments of degrees of vaccine hesitancy on the Covid vaccines, an emerging backlash issue? So to what extent was any backlash in response to government policies on vaccine passport or certification or deployment apparent?
A. Well, I think that the -- and what we've seen is the -- creating the requirements for vaccination, that was

another factor that came in. Again, it was a combination, of what was the state of the epidemic, what's the news on vaccine safety events, and these additional restrictive policies that you could only go certain places if you had a vaccination, all of these factors were, in different ways for different people, affecting their willingness to go with the programme, as it were.
Q. Now if you would then turn, please, to page 39, this section, section III of your report, addresses head on the causes of vaccine hesitancy. And I said we'd come back to look in more detail at these various sectors or cohorts or population groups.

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

Are those perceptions common across the population, or are they particularly prevalent in any particular sectoral area such as healthcare workers, amongst pregnant women or ethnic minorities?
A. Yes, I think healthcare workers were affected also because they were getting a lot of the questions. They were the front line of questions from the public, and

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

The issue around pregnant women was a concern. I mean -- and part of that was because the data available around the safety of the Covid vaccine for pregnant women was evolving over time, and that made people very anxious that: wait a minute, you said one thing, now you're saying something different. And I think in the context of a brand new vaccine under emergency authorisation, I think the -- needing to constantly remind people that "You need to understand we're giving you the best evidence, information we have, as we learn more we'll bring you along with it", but it did make people more uncertain.
Q. A second area, broad and important area, is the issue of structural discrimination.
A. Yes.
Q. You refer to a number of aspects of what is described as structural discrimination, such as pre-existing mistrust of state services, in particular healthcare services, misinformation, negative vaccine attitudes from various information sources, all within a general perception that particular groups have been marginalised, ignored, or treated unfairly.

This important issue of historical discrimination,

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

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

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

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

A. Yes, those are the key areas.

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

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

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

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

A. Yes, absolutely.

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

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

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

Q. It's the state?

A. -- a broader distrust -- yeah.

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

A. Absolutely.

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

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

A. Yes, probably more the latter.

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

A. Can you say that again?

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

A. Right.

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

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

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

A. Yes, it's usual multiple factors, that can also change over time.
Q. And does that make this whole subject matter even more complex and probably more difficult to resolve?
A. Yes.
Q. I've mentioned migrant people. In relation to disabled people, are they another particularly important group in relation to whom there were issues about trust of government, perceived past discrimination, as well as intensely difficult practical barriers, communication, access, transport, and so on?
A. Yes, particularly in the disabled community but also in the context of Covid, there were a lot of technology requirements that you really needed to be able and have access to, whether it's digital devices, or whatever, for making appointments, for getting to places, that were more easy for some people than others.
Q. All right. We can now come to an entirely new topic, which is misinformation and disinformation, part III.4 of your report, page 44, please. There appear to be a number of definitions in play: misinformation is false or misleading information; disinformation might be said to be the deliberate dissemination of false or inaccurate information.
It may seem blindingly obvious, but during the

pandemic, Professor, were there many different ways in which dis- and misinformation emerged?
A. Yes, there was an explosion of mis- and disinformation.
Q. And no doubt fuelled or accelerated by, of course, the Internet?
A. Yes, and social media, and I think there's another really important thing to think about with that: the explosive spread of mis- and disinformation, and that's the fact that during Covid or pre-Covid, most people, particularly in the hesitancy -- or in people who were in groups who had issues or had questions, were those who were specifically looking for information on vaccines. Parents, maybe young girls looking about HPV, maybe some older people, but there was a huge part of the population that weren't looking for information on vaccines and had no idea that there were any questions about vaccines, and in Covid, everybody, everybody, was pushed to look for information on vaccines, and a huge part of the population that previous to Covid had no idea that there was any debates or hesitancy, were exposed to a lot of, frankly, very toxic and confusing information, and -- (overspeaking) --
Q. Why were they pushed? Who pushed them or why were they pushed, in a way they hadn't been before, to the Internet to look for this information?

A. Well, they weren't looking for misinformation, they were looking for --
Q. No, that's why I said carefully --
A. They were looking for a vaccine -- (overspeaking) -- because they were --
Q. Why were they doing it?
A. Because before Covid they didn't have to think about vaccines. If I were a truck driver or a hairdresser or somebody who -- it's not part of my life, unless I had a child or maybe an elderly parent who needed a vaccine, I wouldn't have had any reason to look online about vaccines. It was not like in the scope of what I think about. But in Covid, everybody needed to get a vaccine. And that took them down -- so that was the driver.
Q. We needn't investigate the source or the origin of the many stories or pieces of information or, if one wants to be pejorative, conspiracy theories or tropes or myths, but they covered a vast, perhaps an indefinite range of points and claims, some with their foundations, perhaps in a kernel of truth, some completely outlandish, outrageous and tendentious.
Why, in a very general sense, did so many people go to the Internet to get the answers that they deserved, as opposed to government sources? So putting it another way, why was social media and the Internet trusted

perhaps more than government?
A. Well, sometimes it was just an issue that they weren't getting the information they were looking for through a government source, because official information was pushing out what the government and the health, public health felt was important for people to know, but didn't necessarily answer the questions that people had, and therefore, they would turn to alternative sources.
Q. Can we look at that in more detail for a moment. It's obvious, and I'm sure my Lady has that point already, it's obvious that there was no end to government information. There was masses of information being pumped out by the NHS --
A. Yes.
Q. -- in each country, the public health agencies in each country, the UK Government in the form of the Department for Culture, Media & Sport, the DHSC, what became the UKHSA, the JCVI, the MHRA.
A. Yes.
Q. Masses of information was out there. Why didn't it get traction or, I suppose, relative traction compared to the Internet?
A. Well, again, in a way there was, like, too much information, but I think that, again, there were some questions that people had particularly around safety or

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

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

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

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

A. Yes.

Q. As a member of the population, if you're not minded to listen to the government because you don't trust it --

A. Yes.

Q. -- you're less likely to be amenable to receiving the important public health messages that it wants you to receive?

A. That's correct.

Q. So any recommendations about communication need to be grounded in addressing the issue of trust or, more particularly, mistrust?

A. Yeah, and I think it's very much about trust but there are many ways, and there were some very good examples during Covid, where you identify trusted community members in some of these communities that you work with, that you kind of engage them, get them the information that is going to be needed in the community, so that you partner with and collaborate with people within these communities that can help be a partner in making this better.

Q. And so are there two aspects to trust or distrust or mistrust that need to be focused on: one is how do you make people believe in government better or more, and that's to do with how the government behaves; and then there is the perhaps much more important issue of using

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

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

Q. It's a combination of the two?

A. Yes.

Q. Right.

Now a new topic: vaccination policies.

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

A. Say that --

Q. VCOD, vaccination as a condition of deployment.

A. Yes, a condition of --

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

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

A. No.

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

A. Yeah.

Q. -- produced a document on your app, you could -- on your phone, you could show that you're entitled to go in.

Did many or any western European countries go further and mandate vaccination as a condition of deployment?

A. Yes.

Q. France and Germany?

A. Yes. And it depended too on -- predominantly health -- people who are working on the front lines and -- of the response, but also, as I said, for travelling and ...

Q. There is a balance, isn't there, in this policy, quite difficult policy area, between driving rates of uptake up and inadvertently fostering a backlash?

A. Yes.

Q. By and large, did schemes of vaccinations as a condition of deployment work in Western Europe for the purposes of driving vaccination rates upwards?

A. Yes, there's quite a bit of evidence that these requirements, in the short-term, increased uptake, but in the long-term was a trust breaker.

Q. And how do we know that in the long-term it was a trust breaker?

A. Because there's been a good bit of research on it. France in particular has done quite a bit, where they

show that people -- both qualitative research and surveys, that they felt like they did not take a -- the Covid vaccine because they were confident about it, they took it because they wanted to travel, they wanted to go to that restaurant, they wanted to meet with colleagues or friends. But you can be sure that they would say, "You're not going to see me in that vaccine clinic again", and they resented the fact that they had to get it. But they did it because they had a bigger ambition, which was to travel or to go to that restaurant or to go somewhere.

So it was more a functional thing for the immediate frustration of not being able to do things, but in retrospect they regretted or resented it. And then that's where sentiments hardened.

Q. And then when the sentiments harden, that contributes to a general growth in vaccine hesitancy or lack of confidence?

A. Yes, absolutely.

Q. Which then, coming full circle, has a tendency to have an impact in the months and the years to come?

A. Potentially, yes.

Q. Potentially. On the subject of VCOD, can we just please look at page 28 of your report because you've set out in a number of pages the main highlights of the

UK Government and then the Scottish, Welsh and Northern Irish approach to VCOD.

In April 2021, we can see from the bottom of that top paragraph, there was a public consultation by the UK Government, for England of course, between April and May on a proposal to make Covid-19 vaccination a condition of deployment in care homes. That's to say in registered care homes.

A. Yes.

Q. If we then go down the page to June, following that consultation process the UK Government confirmed vaccination would be mandatory for staff working in care homes with effect from October.

And then the Welsh Government said they weren't going to consult on that issue because they took the view that the uptake rate was sufficient already, in essence.

Then over the page, page 29.

In September there was then a fresh consultation for mandatory vaccination for healthcare staff and related professions in England. The response was heavily divided. So there were -- some sectors of the health sector were strongly in support, mainly employers and health bodies, but individual staff and workers and the unions were very concerned about the implications of

that policy.

November 2021, the UK Government announced that frontline health workers would be required to be vaccinated from, I think, 15 March 2022.

A. Yes.

Q. The Northern Irish decided that was not a route they would go down, and they didn't consult on it, and Scotland similarly decided, as a matter of policy, they wouldn't pursue VCOD for healthcare workers. And then on page 30, March 2022, following that consultation process for the wider VCOD scheme, in fact on 1 March, the UK Government, in England, scrapped the policy two weeks before it was due to be introduced. Is that a fair summary?

A. Yes.

Q. What was the outcome, as far as you're able to tell, in terms of whatever backlash there may have been to those consultation processes, and the introduction of the first policy, that's for care home workers, as well as the withdrawn second policy which was the wider healthcare staff? Was there a general backlash?

A. Well, there were definitely protests with NHS workers in Trafalgar Square, who were very much against this, and I think it was a bit of a surprise to people to see them spread their scrubs across Trafalgar Square with

posters, but I think what can be confusing to the public is it looked like they were against vaccines, but they were against the mandate, and the requirement. And I think the whole discussion towards this mandate hardened some people, because they felt like they weren't trusted, and they felt like they're working 24/7, and now you're, you know, pushing this on us, and you don't trust us to make up our own mind, and I think it took a toll.

I mean, on the one hand, the consultations are a good thing. On the other hand, the issue fired up some sentiments and --

Q. So we are exactly back to there we were with the compulsory Vaccination Act of 1853?

A. Yes, we're back to square one.

Q. Back to square one. And in terms of -- are you able to say anything about whether or not that first policy, the care home worker policy of VCOD, did it work at all in terms of pushing rates of uptake upwards, or were they in fact already at quite a high rate already?

A. Well, I think it -- it was an issue of also the confidence of the residents and the families of the residents. I think it was already a good rate, but I think it did help. Again, what helps from a public health practical sense versus the sentiments --

Q. The individual --
A. Yes.
Q. -- or discriminatory --
A. Yes.
Q. -- or societal impact?
A. Yes, is different.
Q. So the rates did actually go up in terms of the uptake of vaccination, notwithstanding the backlash, but there may have been trouble stored up for the future?
A. Exactly.
Q. And in terms of the numbers of staff in that sector, are you able to say whether or not there was an impact in terms of people leaving the care home sector and then subsequently as a result of the second policy consultation process, the wider healthcare --
A. People did leave their jobs because of these.
Q. All right. So is it your view that -- well, it's an intensely difficult balance, and that obviously any government attempting to mandate vaccination in the future as a condition of deployment has to weigh up extremely carefully the public health benefit against the wider, longer-term societal impact?
A. Yes.
Q. Do you think it would be a good idea for the government now, for the purposes of any future pandemic, to have

a better understanding of how that balance might properly be struck, and of the, I suppose the mechanics and the facts and the figures underpinning it?
A. It's a very difficult sentiment. I think the particular period when this was going on, emotions were running high already, people were stressed, people were ... it was a very difficult time, as you know. Well, there are vaccine requirements for some healthcare workers, particularly hepatitis B. I think -- personally, I think that people who work in settings with very vulnerable person for health or elderly, vulnerable reasons, should have their vaccines.

I mean, I think people sometimes look at the mandates as requiring it for you as an individual when in fact it's about protecting others. It's about putting other people at risk. And I worked in the UN for 12 years, and in terms of the issue of human rights and responsibilities, you have your rights and your personal freedoms until they harm other people, and then it's -- you start to move into responsibilities. And I think this really sits on the line of: this is not just about you, this is about -- and in some cases like in this case with the Covid vaccine, it's -- it wasn't that they had to do this forever. I mean, it was, like, if you don't want to get your vaccine, they could have

said you can take a pause from your job, if you really don't want, because this is -- we understand this is a new vaccine, it's under emergency authorisation, if you're really uncomfortable and don't want to take this, we just ask that you stay at home and you come back when this storm is over.

That would have been maybe something that was a compromise. It was a difficult time because we needed all hands on deck.

But I think we need to look at ways to be sensitive to the issues. And again, this was a particularly complex situation because of the nature and the newness of the vaccine, and the -- and of, you know, the stresses and emotions on these people.
Q. In the context of a pathogen that killed --
A. Yes.
Q. -- the primary driver has to be first the medical creed "first do no harm"?
A. Exactly.
Q. And that might have to --
A. That's a very good reference.
Q. That might win out over individual societal or human rights individualism?
A. Exactly.
MR KEITH: My Lady, is that a convenient point?

LADY HALLETT: Certainly. I shall return at 3.45.
(3.28 pm)
(A short break)
(3.45 pm)
LADY HALLETT: Mr Keith.
MR KEITH: Professor Larson, we're in the final furlong.

You set out from page 52 onwards the number of ways in which the UK Government and the devolved administrations tackled what was obviously an issue concerning vaccine hesitancy, so just a number of very brief questions.

From the evidence you've seen and all the material, was it absolutely obvious and foreseeable that in the context of the delivery and rollout of vaccines, there would be issues about barriers to access and vaccine hesitancy that the government would have to address?
A. Yes, the extent of it was not clear and not obvious --
Q. It was worse than they thought or more difficult than they thought?
A. No I think that, actually, some places managed in very creative ways that you might not have expected, but I do think -- well, not just think, there were clear pre-Covid issues in some of the same groups we were talking about before Covid, and those were predictable as being challenges.

Q. Right. And nobody seriously disputes that many parts of the government machinery, in all four nations, did their bit to try to meet those challenges, and you've set out in very broad terms the work done by the Public Health Agencies, by the NHS and care sectors in each of the -- by particularly NHS boards and trusts in each of the countries. How, in England, Scotland and Wales, there were vaccine equity committees of one shape or another. In Scotland there was a vaccine equities committee and the vaccine directorate, in England there was a vaccine equity group, and similarly in Wales. The Race Disparity Unit in London issued four quarterly reports -- could we have page 53 -- the final report of which we can see, in 130.1 down to 4, some of the main broad lessons which it sought to promulgate: ensuring that success of normal vaccine deployment is carried over to other public health programmes; not treating ethnic minorities as a homogenous group; don't stigmatise; and improve data.

So all the topics broadly that we've discussed.

But in general terms, do you think all the governments or any of the governments went far enough in terms of what they were able to do practically? Did they miss opportunities or misstep? Did they do enough, in the course of the pandemic, to reduce barriers to

access and challenge vaccine hesitancy at a very high level?

A. Well, I think it's always easier to be critical in retrospect, but I would find it difficult to say that -- it's always -- there's always things you -- we could have done better, but at the time I think people were doing what they could in a very uncertain situation.

I do think that extra attention to the places that were predictably going to be challenged would -- more work could have been done there, particularly in this context.

Also, and I know I should keep this short, but these were not typical situations. I mean, some of the issues we heard were, like with the elderly: why am I going to a tent to get my vaccination? Why aren't I going to my doctor? Some people wanted to be walked through. It was unfamiliar, it was different.

So I do think that there is always more you could do. There was ...

Q. Looking at this section of your report, you note that, notwithstanding the steps that were taken, and just by way of identifying the broad headlines, there was still quite a high degree of failure in terms of the clarity or coherence of communications and guidance. Important parts of the population simply didn't receive the

necessary degree of clear and cohort communication. The pre-existing rates of hesitancy and of existence of barriers continued, in particular amongst ethnic minority communities, amongst pregnant women, amongst disabled people and the migrant population so in fact all the areas we've discussed already, and there was a generally quite a high rate of under-vaccination in the young?

A. Yes.

Q. Are those the broad main areas?

A. **(Witness nodded)**

Q. So in light of that, do you set out in your report from page 63 onwards the lessons which we must learn and what might be done by way of recommendation to address the problems that we've just highlighted.

You identify, and we've done this already today, the broad policy areas that need to be readdressed and they are these: there's the issue of trust and distrust; the issues about longstanding structural discrimination and perception of being treated badly or unfairly or being forgotten or marginalised amongst in particular ethnic minority groups; there is the issue of communication and misinformation; and there is the important topic of how, practically, the government might introduce policies to try to address hesitancy, for example VCOD.

And you identify from page 65 onwards four broad areas, is this right, and I hope you'd agree that these are the approached areas that you've sought to focus on, I've addressed data already, but the three remaining areas might be described as: trust building, communication planning and educational initiatives.

So on the first one, trust building, that tackles this issue of trust and distrust and marginalisation and historical discrimination.

How best can one rekindle, if it was ever there at all, trust in government and in healthcare services and particularly in vaccination?

A. Well, I think one, we shouldn't wait for the next pandemic, or next crisis. That can start now. And I think there were a lot of missed medical appointments, vaccinations, during Covid, and I think making that extra effort to -- so that people feel like what they didn't get then, there's an explicit effort to catch people up with their vaccinations, to ask them about their other issues. We are trying not, I think, paying -- personally, I don't think we're paying enough attention to Covid recovery, we kind of wanted to bounce back quickly. But there is quite a bit of recovery that still needs to happen.

I think one of the things that is already going on,

that I think is a positive contributor to trust building, is things like the listening, like what you're doing here, and the listening to Every Story Matters. It's giving an opportunity for people to talk about their issues, and that's a trust builder, the fact that you're willing to listen.

Q. And if, through the practical prism of clinical trial and that process, and the delivery process, marginalised or ignored groups can be brought closer into the planning process, so by way of, perhaps, the institution of expert groups and panels to help design better the clinical trial process, the research and development process, the delivery, the rollout of vaccines, would that help, do you think, to engender more trust?

A. Absolutely.

Q. And therefore, that links into the second topic: communications and planning.

If people who are required to be brought into the planning process and the communication networks are brought in in that way, do you think that would help? Do you think that would help the dissemination of communications in the teeth of a crisis? So if groups, ethnic minority groups or disabled people, or migrant people, or pregnant women, are listened to more when it comes to planning these structures, when they come to be

used, they're likely to have more trust in them?

A. Absolutely, and I don't think that should be seen as -- as they say, it's not a luxury, it's an essential, because they understand the days and the ups and downs in the community, they understand what the issues are in general, so I think it's only an asset.

Q. And then the final topic I've identified as educational. You make the point on page 66, I think at 176, thank you very much, about pre-bunking.

"In the context of the growing challenges of misinformation, consider educational initiatives on misinformation such as 'pre-bunking' ..."

Much of what we've discussed has focused on the planning and the procedures and the technical aspects of delivery of vaccines. But do you think the government needs to be more proactive in terms of educating us all and attacking head on some of the myths, some of the tropes, some of the disinformation or misinformation that's out there?

A. I don't think head on is productive, with some of the mis- and disinformation, but I do think we have to listen and pay attention to the mis- and disinformation, and have a better story.

Q. How do we do that?

A. Well, if the misinformation is eating garlic is going to

prevent Covid, you don't directly react to that post or whatever it is, but you start to, in your own communication, start saying things like garlic and other, you know, are not going to help you; they may be good for your nutrition but they're not going to prevent Covid.

So you listen and pay attention to the misinformation and disinformation to hear what are the issues you need to give a better story, a more accurate story to, and then pre-bunk or you inoculate people around so that they're hearing another story.

The problem is when you don't react to it at all, you're rolling out the red carpet for it to spread. But we have learnt that if you engage in, and maybe that's not -- and I didn't mean to -- you need to deal with the issue head on but not directly react to the post because it just makes it go more viral.

Q. Bluntly, Professor, Professor Sir Chris Whitty and Professor Sir Jonathan Van-Tam and the head of NHS England, and a number of others, including the heads of the public health agencies, are clear in their written evidence that they didn't try to engage with misinformation head on. What they did was try not to engage with it and get into a fight, but to repeat the facts, to repeat, through government communications, NHS

communications and all the various communication routes available to the government, the broad facts again and again and again. This is the position. This is the position.

But to a large extent it didn't appear to gain traction. It may not have worked quite as well as they expected. Should they have gone about it in a different way? Should they have tried to engage more in the detail of what was being propagated? Or do you think that was the right approach, which is simply to stand back and just hold your position and repeat the reality of what you believe the position to be?

A. Yeah, I don't think that's the best way to do it. I mean, I think it's fine to keep repeating coherent and important facts, but it's not going to help to address the mis- and disinformation.

The information -- what is needed is to make information relevant to people's concerns and misunderstandings, but also, it's not just about the information, it's about the way it's communicated.

Q. So trusted community figures?

A. Trusted community figures, in stories, in -- I mean, engaging on social media. Getting there in a way that's not kind of dry facts but appeals, and relevant. And that's where we're working with communities to say:

listen, we need to get the community to -- it's important that the community understands that drinking chlorine is not going to cure your Covid. You know, who in the community -- we've done this with 10, 12-year old girls in designing strategies around HPV, on social media. They -- you know, when you engage them, they -- you can do very creative -- it's also about the style of communication, not just the content.

Q. So as the witness earlier today said, sometimes the messenger is more important; perhaps is as important as the message?

A. Certainly, as important.

MR KEITH: Certainly as important.

Thank you very much, Professor.

LADY HALLETT: I think we have two sets of questions, nearly finished. Mr Thomas is over there.

I hope you made your appointment, Mr Thomas.

Questions from PROFESSOR THOMAS KC

PROFESSOR THOMAS: I did, my Lady, thank you very much. And I didn't have to fly.

Good afternoon, Professor.

A. Good afternoon.

Q. My name is Leslie Thomas and I'm representing FEMHO, the Federation of Ethnic Minority Healthcare Organisations. I have a small handful of questions for you in relation

to this matter, so I trust I won't keep you too long.

A. Okay.

Q. In your report you cite many causes of vaccine hesitancy, including safety concerns, historical distrust, and inequalities. This went in tandem, you say, with ethnic minority groups also experiencing disproportionate Covid-19 morbidity and mortality burdens, largely linked to pre-existing inequalities.

Then you say this, then you say:

"[Overall], there ... [is] a legacy of mistrust among ethnic minorities in the UK ... and ongoing discrimination which [has shaped] their perspective on ... health and wider governance systems."

Yes?

A. Yes.

Q. Right. So here's the question, can you help us with this: how best is this legacy of mistrust addressed to improve vaccination outcomes?

Can you help us with that?

A. Well, I think legacies can change, and I think -- but it's going to take a lot of attention. It's not a -- there's no quick fix for this kind of situation.

It's not unique to the UK. I'm -- although I've lived here for 12 years, I am from the US. We have similar -- different kinds of issues. And what I've

seen -- and it's in other countries too -- I think some of the points have been raised already, and that's, really, engaging with the communities and trusted figures. I mean, and it doesn't even have to be that local health community. We've done things with barbers, with shopkeepers in the Bangladeshi community. Of all the people that came out as being proactive in their community were the restaurant owners, who were doing selfies of their Covid -- getting their Covid shot. And why the restaurant owners? They know that it's not just getting back to business, they knew that they had a lot of mortality in their community, but also the restaurants, especially in crowded housing and large families, is a social gathering. It's a family gathering.

So they actually rose up as proactive vaccine advocates in the community. And I think different communities will have different -- I'm not saying that that's necessarily the solution, and it'll be in different communities, but it really needs taking the time and sitting down with certain communities and creatively thinking it through, and not just doing it as an exercise, but actually following up on it.

Q. Can I just piggyback just on something you've just said, and then I've finished, and it's this. Would you agree

with this: in terms of this concept of legacy of mistrust, earlier you were having a conversation about vaccine hesitancy, yes, and whether that's problematic or not. But would you agree that a term like that tends to put the emphasis on individual behaviour and attitudes, and therefore diverts attention from known causes of unequal vaccine uptake, and a lot of which, following your report, tends to be to do with historical and/or deep-rooted issues about systems and institutions? Would you agree with that?

A. I do think we have to take it away from the individual.

PROFESSOR THOMAS: My Lady, that's all I ask. Thank you very much.

LADY HALLETT: Thank you very much, Mr Thomas.

Ms Mitchell. Ms Mitchell is over there.

Questions from DR MITCHELL KC

DR MITCHELL: I'm obliged.

Professor, I appear on behalf -- as instructed by Aamer Anwar & Company on behalf of the Scottish Covid Bereaved. And an issue that arises particularly in relation to Scotland is the fact that it has a significant amount of its community in rural and island areas.

We've heard a lot about issues of hesitancy and I was wondering whether geographical factors such as

having to travel a long way to get a vaccine could prove to be something which makes people more hesitant to accept it?

A. Absolutely. I think access is a big issue, particularly in remote or rural areas. Also, when there's -- you're trying to reach as many people as possible, and you have limited manpower, it can be challenging. But I do think again, thinking about alternative ways, I believe it was yesterday we heard from community pharmacists, they were talking about, you know, how could they be more engaged early. And I think one of the things that we've heard in a lot of interviews with people about their experiences, a lot of people wished they could have done more, who were sitting at home, who felt like, you know, I can contribute in some way. Help me find a way to contribute, and maybe there were more able people in that -- a remote community who could help get better access, who might be more mobile, who might be able to help on that.

I think -- I'm not giving an easy answer because really I don't know the communities themselves but just in general, I think the more we can try to engage locally. And again, that doesn't have to wait and shouldn't wait for another crisis.

Q. Well, that helpfully leads into the second question

that I wanted to ask you about. You said in your evidence just earlier that people might ask, "Why am I going to a tent, why aren't I going to my doctors?" And yesterday, her Ladyship heard in Scotland a new system is in place where doctors no longer give vaccines, and that's, I think, been in place since April 2022.

The question that I would like to ask you, based on the fact that people are now no longer going to their doctors for vaccines, would it assist in combating hesitancy amongst those in rural and island communities for the vaccine to be delivered at the most local level possible, such as their GP surgery?

A. I didn't actually hear everything, but I do think getting -- whether it's through a local GP or a pharmacy, the more we can bring vaccines closer to people is only an asset.

LADY HALLETT: I was surprised, and Ms Mitchell obviously spotted that I was surprised, yesterday to hear that the system -- basically in Scotland, they've moved to the vaccination centre/clinic model, and so your GP doesn't give you your vaccine.

A. Oh boy, yeah.

LADY HALLETT: That's the basis of the question.

DR MITCHELL: People are invited, for example, to attend

halls, retail parks, et cetera, some distance away. And looking to assist her Ladyship in the future, we're wondering whether or not we should go back to the other model --

A. Yes.

Q. And given what you've said about locality and given what you've said about using trusted figures, would you agree that it might be best to return to a system which places people close to vaccines, with trusted members of the community delivering it?

A. I would absolutely support any effort that tries to bring the vaccines or, frankly, other health services closer to the people that need them.

DR MITCHELL: I'm obliged, my Lady.

LADY HALLETT: Thank you very much indeed. I'm very grateful.

That completes the questions. That last furlong has now been run. Thank you very much indeed for your help, Professor, I'm very grateful to you. And although, obviously, Mr Keith wasn't able to go, in the time available, through all of the report -- probably to your relief -- I will make sure that all of the relevant matters in it are covered and I'm advised on them by Counsel to the Inquiry. So I'm really grateful to you.

THE WITNESS: Thank you very much.

(The witness withdrew)

LADY HALLETT: Very well, 10.00 tomorrow, please.

MR KEITH: Thank you, my Lady.

(4.11 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X